

Achievement for all

Working with children with special educational needs
in mainstream schools and colleges



Professional
development series



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Introduction

Special educational needs and mainstream education

The term special educational needs (SEN) was first used in the Warnock Report of 1978 and then in the 1981 Education Act in an attempt to focus on the needs of each individual child rather than on categories of disability. However, it is not possible or helpful to ignore categories altogether and some are still used to describe different kinds of provision. The chapters in this publication are based on the main areas of difficulty embraced by the term SEN.

Following the 1993 Education Act, a Code of Practice regarding provision for children with SEN came into force in September 1994. This identified a five-stage approach to the identification and assessment of SEN. Although the Code of Practice raised the profile of SEN and established nationally agreed procedures, it soon became clear to teachers in mainstream education that the Code was a long way short of a panacea. The increasing amount of paperwork required to gain support for a child added to the bureaucratic burden, and the time taken to assess a child's needs varied widely across the country. Over the years that followed, concerns grew as cash-strapped local authorities (LAs) closed support services and openly admitted that they needed to cut down on formal assessments.

In 1998, the government's Green Paper *Excellence for all children* recommended greater inclusion of children with SEN into mainstream education. While ATL agreed in principle with the idea of inclusion, it also cautioned against the wholesale closure of special schools on the grounds that the interests of the child must remain paramount. In the light of concerns – voiced particularly by Ofsted and the Audit Commission – about how the Code of Practice was working, a revised version was issued for implementation from 1 January 2002. In the 2002 Code of Practice, therefore:

- the right for children with SEN to be educated in a mainstream school is strengthened
- LAs have duties to provide advice and information for parents and a means of resolving disputes
- schools and nursery education providers have a duty to inform parents when making SEN provision for their child

- schools have the right to request a statutory assessment of a child.

The 2002 Code of Practice established a 'graduated approach' to provision under the headings 'School Action' and 'School Action Plus', with assessment to be regarded as a continuing process. The main emphases of the Code of Practice are:

- early intervention
- the planning and strategic functions of schools and LAs
- accountability for SEN funds
- support for the SENCO by provision of non-contact time, IT support and clerical assistance
- the writing of statements.

The Code of Practice's main focus is on teaching, learning and achievement, rather than on bureaucratic procedures. The Code identifies four areas of need:

- communication and interaction
- cognition and learning
- behaviour, emotional and social development
- sensory and/or physical needs.

Weight is given to:

- child participation and the voice of the child
- partnership with parents
- an improved partnership between schools and other agencies (eg health and social services). The Code of Practice calls for 'a seamless service'.

The Code of Practice's main focus is on teaching, learning and achievement, rather than on bureaucratic procedures

From September 2001, infant class sizes were limited to 30 by law. However, the Code of Practice makes an exception for children from special schools attending mainstream classes.

Children with a statement naming the school can be admitted outside the normal admission round, but for that school year only. In an attempt to reduce bureaucracy, individual education plans (IEPs) now only record what is additional to or different from curriculum plans (that already show differentiation as part of normal provision). IEPs are to be concise, with a maximum of three to four targets.

In a welcome change, speech and language therapy are normally to be regarded as part of education, rather than health, provision. The timescale for the production of statements is set at a maximum of 26 weeks.

From Year 9 on, transition plans are to be put in place for children leaving school.

The push for greater inclusion was given further impetus by the passing of the Special Educational Needs and Disability Act 2001. The provisions came into force in January 2002, and the disability provisions from September 2002.

The main points of the Special Educational Needs and Disability Act 2001 follow:

- Strengthening of the right of children with a statement to a place in a mainstream school (if parents wish), as long as this is not incompatible with the efficient education of other children.
- Establishment of parent partnership services by LAs.
- Statutory guidance is to be published.

There are two core duties for schools and LAs:

- not to treat a disabled child 'less favourably' for a reason relating to his/her disability
- to make reasonable adjustments as required by the child.

The legislation applies to every aspect of school life (for example, admissions, exclusions, curriculum, breaks and lunchtimes, discipline policies, extra-curricular activities, educational visits and school journeys).



There are two exemptions:

- there is no requirement to provide auxiliary aids and services, because these are to be accessed via the SEN route
- there is no requirement to make physical alterations, because this is covered via the planning duty.

LAs in England and Wales are under a duty to plan to:

- increase access to school buildings for disabled children
- increase access to the curriculum for disabled children
- improve the delivery of information provided in writing to children who are disabled (eg visually impaired).

From 3 November 2008, the SEN and Disability Tribunal became part of a two-tier tribunal structure; the First-Tier Tribunal and the Upper Tribunal. Judges and non-legal members of the SEN and Disability Tribunal all transferred into the new two-tier system, with SEN and Disability sitting in the Health, Education and Social Care Chamber of the First-Tier Tribunal. Appeals against the panel's decisions go to the Upper Tribunal rather than to the High Court as they had done previously.

For reasons of consistency, *Achievement for all* refers to 'the teacher'. Please note however that the advice and information contained in these pages has also been prepared for the use of non-teaching professionals who are directly involved in the delivery of education, and for lecturers. Similarly, this publication generally refers to 'the child', but the term should also be read to include older students, to whom we would generally refer to as 'young people'.

1. Cognition and learning

Children with learning difficulties

Children with learning difficulties form the largest group of children with SEN. Learning difficulties range from mild, through moderate, to severe:

- **Children with mild learning difficulties generally experience problems in acquiring basic literacy and numeracy skills.**
- **Children with moderate learning difficulties may also have problems with speech and language development and/or emotional or behavioural difficulties.**
- **Children with severe learning difficulties are likely to have major problems in some or all of these areas, and possibly difficulties with personal care.**

Children with learning difficulties will find it hard to keep up in all, or most, of the academic areas of the curriculum. Their all-round development is likely to be delayed, so they may be socially and emotionally immature and may have problems with gross and fine motor skills. Unless these children receive considerable support, their difficulties will become increasingly apparent throughout their education. They are unlikely to progress as quickly as their peers, and there will be a tendency for the gap to widen with every passing year. Children with learning difficulties are inclined to rely more heavily on adult support than their peers. As there is little incidental learning and an inability to generalise, they need carefully structured teaching where new skills are built up step by step.

Children with Down's syndrome usually fall somewhere in the general range of slower learners. Some have additional problems, such as a hearing loss.

Identification

Children with learning difficulties are usually identified by their teachers at an early stage. It may be helpful, however, to bear in mind that they exhibit some of the following characteristics:

- slowness in picking up new ideas
- an inability to remember new skills without constant reinforcement and repetition – to the point of over-learning
- difficulty in absorbing abstract ideas
- a lack of imagination
- poor listening skills and difficulty in following instructions addressed to the class as a whole
- poor concentration and a short attention span
- immature speech and phraseology, coupled with a limited vocabulary (slow learners may prefer giving one-word answers)
- problems remembering what they have seen or heard
- poor coordination, affecting both gross and fine motor skills
- responding best to being given practical experience and apparatus to support their learning
- slowness in learning to read, and then a tendency to read 'parrot fashion' with understanding lagging behind
- slowness in establishing number concepts
- tendency to gravitate towards younger children rather than socialising with their peer group.

Remember that short, daily repetition is more valuable than longer, weekly sessions

Almost every child responds to praise and encouragement, and such strategies are particularly helpful in raising the self-esteem of learners

Strategies

Whereas children with severe learning difficulties may be unaware of their weaknesses, other slow learners may be all too conscious that they are progressing less well than their classmates. Everything possible must therefore be done to enhance their self-esteem. Some children may be so aware of failing that they begin to believe they are incapable of learning. They need to be convinced that, although they may not find it easy, they can and will learn if they persevere.

Some of the following strategies may help to support children with learning difficulties:

- Establish what the child knows and go back to the point at which the difficulty starts to occur.
- Allow the child to work at his/her own pace, setting tasks that can be realistically completed within the time available.
- Structure learning in small stages and in a sequential manner – a child cannot be expected to understand place value, for example, if he or she does not have a thorough mastery of number bonds.
- Present the same concept in a variety of ways, so that learning is reinforced.
- Find time for frequent repetition of routine learning (eg reciting tables and the alphabet, learning to read and spelling key words).
- Remember that short, daily repetition is more valuable than longer, weekly sessions.
- Show the child what to do as well as talking about it. Give concrete examples and allow practical apparatus to be used for as long as it is needed.
- Keep tasks short, and work towards a gradual increase in concentration.
- Encourage a passive child to become more actively involved in discussion and group activities to give him/her the practice needed.
- Provide a starting point for creative writing tasks, rather than presenting the child with a blank sheet of paper.
- Teach study skills at all levels, so that the child has access to sources of help.
- Listen to what the learner is saying, so that his/her viewpoint is understood and any distress becomes apparent.
- Provide immediate feedback to reward effort.
- Publicly acknowledge the child's talents so that he or she has status within the group.
- Give the child experience of success in the non-verbal areas of the curriculum where he or she can excel.
- Discuss evidence of progress with the child.



A child may appear unmotivated because the task, or the way it is presented, is inappropriate. Try, as far as possible, to differentiate tasks and materials so that the child can be motivated through achieving success. Instructions may need to be repeated in different ways (as a check, the child can be asked to say what he or she has been asked to do), and it is best to avoid giving too much information at once. Almost every child responds to praise and encouragement, and such strategies are particularly helpful in raising the self-esteem of learners.

Specific learning difficulties

Dyslexia

Children with specific learning difficulties may exhibit an uneven pattern of strengths and weaknesses. There is likely to be a discrepancy between their verbal and/or practical abilities and their facility to acquire some or all literacy skills. Learning to read and write involves visual and auditory discrimination and memory, sequencing and practical awareness, eye/hand coordination and fine motor skills. A child with a weakness in one or more of these areas may experience considerable difficulty in becoming literate, and other areas of learning may also be affected. There may well be a family history of difficulties of this type.

The term dyslexia is often used to describe problems with learning to read and spell. However, many people prefer to use the term 'specific learning difficulties' as it encompasses a wide range of problems and also makes it clear that various factors may lie at the root of the child's difficulties.

Identification

The most obvious sign that a person has dyslexia is that, unlike a slow learner, he or she makes markedly better progress in some areas of the curriculum than others.

The following is a list of some of the weaknesses a child may exhibit, but it is as well to remember that the pattern of difficulties will vary from child to child. A child with specific learning difficulties/dyslexia may:

- confuse similar letters and words, either when spoken or written
- mispronounce words, eg 'cobbler's club' for 'toddler's club'
- find it difficult to remember familiar words
- have problems in recalling facts learned by rote
- read inaccurately and confuse letter/word order
- reverse letters and numbers, eg 15 instead of 51
- have difficulty tracking or focusing on words on the page, lose his/her place, or omit lines
- have difficulty in sequencing events, eg days of the week
- experience difficulties in distinguishing direction, eg left/right, east/west, and in spatial awareness – including problems with the layout of work



- have poor coordination, eg with throwing, kicking, catching, skipping, or trip or fall over excessively
- have difficulty copying correctly, particularly from the blackboard
- have persistent difficulty in dressing and undressing, putting shoes on the correct feet – or be late in learning these skills
- have difficulty in clapping out rhythms
- have obvious ‘good’ and ‘bad’ days, for no apparent reason
- enjoy being read to, but show no interest in letters or words
- use substitute words or ‘near-misses’, eg ‘lampshade’ for ‘lamp-post’
- mislabel – for example, know colours but mislabel them, eg ‘black’ for ‘brown’
- have an early lisp
- not be able to remember the label for known objects, eg table, chair
- confuse directional words, eg up/down; in/out
- find difficulty with rhyming words, eg ‘cat’, ‘mat’, ‘sat’
- find difficulty in selecting the ‘odd one out’, eg ‘cat’, ‘mat’, ‘pig’, ‘fat’
- have difficulties with time sequence and getting things in chronological order (first for last, now for later)
- reverse the sequence of words or form (*there once was* for *once there was*, was/saw, out/not) or reverse the concept (go/stop)
- be over-dependent on contextual clues
- mix upper and lower case letters, eg ‘BeTter’
- show great difficulty in remembering whole-word patterns and not learn easily by the ‘sight method’
- repeat speech errors in writing, eg ‘would of’ for ‘would have’
- have erratic handwriting and an inability to stay close to the margin
- confuse maths symbols and concepts.

Not all dyslexic children experience all of the difficulties listed above. Many very young children make similar mistakes to dyslexic children, so clues to identification are:

- the severity of the trait
- the clarity with which it may be observed
- the length of time for which it persists.

Learning to read and write involves visual and auditory discrimination and memory, sequencing and practical awareness, eye/hand co-ordination and fine motor skills



Help children to learn to follow instructions by starting with only one or two, for example “please pick up the pencil and put it in the box”

Strategies

As children with dyslexia are weak in one or more channels of learning, a multi-sensory approach should be used wherever possible. This involves helping the child to learn by every available means: visual, auditory, spoken, tactile and kinaesthetic.

The advantage of a multi-sensory approach is that it enables the learner to use points of strength, while supporting weaker areas. It is a good idea to:

- Let the child know you are interested in his/her difficulties, and encourage him/her to ask for help.
- Make sure he/she is seated close enough to you to receive help easily.
- Give credit for ideas and content when marking work.
- Repeat new information and check that it has been understood.
- Allow sufficient time for work to be organised and completed.
- Teach study skills.
- Link spelling and handwriting in order to improve the motor memory.
- Encourage the use of the look/cover/write/check technique when spellings are being learned, and use finger tracing in the air or on the page.
- Teach spelling rules.
- Make use of mnemonics, eg ‘because’ is ‘big elephants cannot always use small entrances’.
- Consider encouraging the child to use touch-typing to aid composition.
- Encourage the child to use the spell-checker on a word-processing package.
- Provide the child with a variety of ways of recording work, eg via audio recording, charts, diagrams, word-processing on a computer.
- Use books with CDs or other audio components to help with reading.
- Experiment with coloured filters if the child dislikes the glare of black print on white paper.
- Emphasise routine to help the child acquire a sense of organisation.
- Try to find something the child does well and give him/her a chance to shine.
- Give praise whenever possible.
- Encourage the child to help in practical jobs.

Be careful not to:

- assume the child is lazy or careless
- compare him/her with the rest of the class
- make him/her read aloud in class
- correct every mistake
- give long lists of spellings
- insist on rewriting, unless there is a definite purpose
- spoil every experience by making him/her write about it
- ridicule untidy writing.

With very young children, saying nursery rhymes together, reading poems, making up jingles and limericks, mime, drama, talking about pictures, using action games, using board games to develop taking turns, playing pairs, Pelmanism or other memory games, clapping out syllables, and singing songs involving memory and sequencing, may all be helpful.

Help children to learn to follow instructions by starting with only one or two, for example: “please pick up the pencil and put it in the box”. Gradually make the sequence longer – “go to the shelf, find the red box, bring it to me”. Encourage the child to repeat the instruction before carrying it out.

Some of the following strategies may also help:

- Encourage the child to practise physical skills such as throwing, catching, kicking balls, skipping, hopping, jumping and balancing.
- Encourage large writing movements, eg as part of music and/or movement lessons, or by using the forefinger with materials such as sand.
- Talk about books, using the language of books – pictures, words and letters – to demonstrate that books can be looked at, read and enjoyed over and over again.
- Show the child how to hold a book, which way it opens, where the story starts, where the top of the page is and in which direction the words flow.

Dyspraxia and developmental co-ordination disorder/delay

Definition

Dyspraxia is a difficulty in the way the brain processes information, which results in messages not being properly or fully transmitted. It affects the coordination of movement, perception and thought, and is a difficulty in formulating the plan rather than a primary problem of motor execution.

If a child's performance in daily activities requiring motor coordination is significantly below that expected given his/her age and measured intelligence, he or she may have developmental coordination disorder/delay (DCD).

Identification

Dyspraxia/DCD may be shown by marked delays in achieving motor milestones (eg crawling or walking), dropping things, difficulties with balance, 'clumsiness', or poor performance in sports or handwriting. Affected children may have problems using knives and forks, tying shoelaces or holding a pencil. When handwriting, they may also show difficulties with directionality and pressure on the page. Visual and perceptual difficulties (with copying from the board, or following sequential instructions, for example) can also be symptoms of dyspraxia/DCD.



Strategies

An occupational therapist should assess the child and suggest activity ideas and strategies to encourage development and limit the impact of difficulties both in school and at home. The child should possibly attend a treatment group and his/her progress should be closely monitored and regularly reviewed. The following strategies may also help:

- giving clear and unambiguous instructions
- breaking down activities into small steps
- arranging a 'buddy system'
- allowing extra time for completing work
- teaching the child strategies for remembering things.

Encourage the child to practice physical skills such as throwing, catching, kicking balls, skipping, hopping, jumping and balancing



Useful organisations

British Institute of Learning Disabilities

Tel: 01562 723 010

Email: enquiries@bild.org.uk

Web: www.bild.org.uk

Provides services that promote good practice in the provision and planning for people with learning disabilities.

Equals

Tel: 0191 272 8600

Email: admin@equals.co.uk

Web: www.equals.co.uk

National organisation for teachers of pupils with learning difficulties within special school and mainstream education.

British Dyslexia Association

Helpline: 0845 251 9002 (for all dyslexia-related enquiries)

Tel: 0845 251 9003

Web: www.bdadyslexia.org.uk

Offers advice, information and help to dyslexic people and their families, and to professionals.

Dyslexia Action

Tel: 01784 222300

Email: info@dyslexiaactionorg.uk

Web: www.dyslexiaaction.org.uk

Offers assessment and teaching for people with dyslexia, and training for teachers.

Dyspraxia Foundation

Helpline: 01462 454 986

Tel: 01462 454 986

Email: dyspraxia@dyspraxiafoundation.org.uk

Web: www.dyspraxiafoundation.org.uk

Exists to support individuals affected by dyspraxia and their families.

Down's Syndrome Association

Helpline: 0845 230 0372

Tel: 0845 230 0372

Web: www.downs-syndrome.org.uk

Provides information about Down's syndrome to those with a professional interest, as well as information and support for people affected by the condition and their families.

MENCAP

Tel: 020 7454 0454

Email: information@mencap.org.uk

Web: www.mencap.org.uk

MENCAP Cymru

Helpline: 0808 808 1111

Tel: 02920 747588

Email: helpline.wales@mencap.org.uk

MENCAP Northern Ireland

Helpline: 0808 808 1111

Tel: 02890 691 351

Email: mencapni@mencap.org.uk

Works with people with a learning disability to fight discrimination against them.

2. Sensory and physical impairments

As children with a sensory or physical impairment may be dependent on others for some of their needs, it is important that they have opportunities to excel at something. Aim to allow each child to emerge in his/her own right so that he or she is not seen just as someone who is 'disabled'. Give him or her every chance to join in, to express opinions and to interact with the peer group.

Whatever the sensory or physical difficulty involved, the first support strategy for a teacher or teaching assistant to adopt is to become as well-informed as possible. Read any medical or other records the school holds, and then find out who is available to help.

General points

Lifting

Remember that lifting a child is not as easy as it looks when done by an expert. Unless you have been properly trained, do not risk being injured yourself. The school SENCO should have risk assessments for each moving and handling requirement for every student with these needs.

If it is important that the child maintains a good sitting position, ask health professionals whether there is a local seating clinic that can help.

Administering medication

There are no national guidelines for schools or teachers on giving medication to pupils. Teachers have a general duty to act in *loco parentis*, but they are not contractually obliged either to administer medicines or to supervise pupils taking them. If they choose to administer medicine, they should have appropriate first aid training and an agreement with parents in writing, with a record kept of what was administered and when. For more information and advice, see ATL's advice factsheet *Administering medication to pupils*, available from www.atl.org.uk/factsheets.

Always be on the lookout for informal as well as formal opportunities for recognising achievement



Mobility

If a child has difficulty getting about, the school will need to assess the extent to which classrooms and corridors are wheelchair friendly. Issues to consider include:

- the layout of the classroom (aim to maximise space)
- the position of the child in the classroom – are resources accessible to him or her?
- the best route from one area of the school to another (the shortest route may not be the easiest)
- the time the child needs to get from one area to another
- whether another child should be asked to help push a wheelchair (if the user does not control it) or be available to lend a hand or carry a bag, etc
- if the child has a wheelchair, whether he or she can transfer in and out of it, eg to sit at a desk, or lie on a PE mat.

Hand control

If a child's hand control is weak, consider using:

- jumbo pencils, wax crayons, thick felt pens, paintbrushes held in the teeth or velcro-ed to the hand
- non-slip mats or even sellotape to hold paper, books, plates, etc in place
- foam rubber around cutlery handles
- rimmed, rather than flat plates
- specially adapted computer switches and concept keyboards
- different ways of recording work, such as word-processing, talking into a recording device, and dictating to a friend.

Working towards independent learning

Almost inevitably, some children with serious sensory and/or physical impairments will be highly dependent on others. It is therefore all the more important to create opportunities for some degree of independence in terms of learning as well as living. Give the child time and the opportunity to initiate and/or complete an activity he or she is carrying out as independently as possible. If the child has a dedicated teaching assistant, he or she should step back occasionally to facilitate this. Opportunities for the child to be among his/her peers, independent of the assistant, should also be encouraged.

Always be on the lookout for informal as well as formal opportunities for recognising achievement.

Give the child time and the opportunity to initiate and/or complete an activity he or she is carrying out as independently as possible



Hearing impairment

Hearing impairment has been described by some people as a 'hidden' SEN, because it is not always immediately obvious but its effects can lead to misunderstanding and confusion.

Definition

There are very few people who are unable to hear any sounds at all – a hearing loss may range from a very slight impairment to profound deafness. An estimated one in four children under the age of seven have, at some time, suffered from a hearing loss of some kind. There will be different degrees of loss, and it may affect one or both ears.

Whatever the hearing loss, the acquisition of language and development of communication skills are vital if a child is to have access to information and receive his/her educational entitlement. This can be achieved through an oral/aural, total communication or bilingual approach.

There are two main types of hearing loss, conductive and sensori-neural.

Anything which interferes with the transmission of sound from the outer to the inner ear will result in a conductive loss of hearing. The interference may arise from congestion in or damage to the ear/s, and it may be temporary or permanent. An infection can cause fluid in the middle ear cavity, leading to what is known as 'glue ear'. Glue ear can cause a delay in acquiring literacy skills because sounds are heard indistinctly. If symptoms do not clear up within a few months, a referral to an ear, nose and throat specialist or an audiologist may be necessary. In persistent cases of glue ear, grommets are inserted to help drain off the fluid.

Conductive hearing loss causes sounds to be muted – a normal speaking voice may sound like a whisper. Depending on its cause, it may be treated or alleviated by medicine, surgery or electrical aids. While hearing aids can be helpful, as the volume of all speech sounds is amplified, background noise will be amplified as well.

As it is caused by damage to the mechanism of the inner ear, sensori-neural loss of hearing is less common, but more likely to be permanent. While it can result in a hearing loss similar to conductive deafness, it generally results in sounds becoming distorted, because some sounds are heard but not others. For instance, a high frequency loss will affect the person's ability to hear most of the consonants. Speech will sound like a series of vowel sounds, and word endings – which indicate plurals and tenses – will be missing. Less common is low frequency loss, which affects a child's ability to hear vowels.

Hearing aids, while beneficial, will not enable a person to hear the missing sounds so the distortion will still be there – they will not restore normal hearing in the way that glasses correct sight. Children with sensorineural loss find it harder to acquire speech, and their language development may be delayed. Cochlear implants – devices that help improve the hearing of many profoundly or totally deaf people by electrically stimulating the auditory nerve – are being used with more and more children.

A child with a hearing loss has to work extra hard to reach his/her potential and to be accepted socially

Identification

Older children with any degree of hearing loss should have had their condition identified at an earlier stage, but it is easy for younger children to escape detection and to be labelled as slow, lazy or inattentive. This is particularly true of children with conductive hearing loss, which may fluctuate from day to day and cause adults to remark that “they can hear when they want to”.

Sensori-neural loss is being detected at a much younger age as universal neonatal hearing screening is adopted in more regions. This identifies any possible hearing impairment within days of birth. Children with a significant loss will have impaired speech; this will be apparent in the flatness of their intonation, the absence of certain sounds, or the omission of words that are less important for conveying meaning. Speech therapy and ‘audiology trawling’ may help address this problem. However, children with a less significant impairment, but one that may nonetheless affect their progress, can all too easily slip through the net. Watch out, therefore, for the child who:

- is slow to react
- is the last to follow instructions
- watches others’ reactions and then copies
- is always coming to check what he or she should be doing
- has a friend who helps and lets him/her copy work
- seems to be day dreaming
- is tense and over-anxious
- watches faces intently
- turns his/her head to one side when listening
- can’t locate the source of a sound
- keeps saying ‘what’ or ‘pardon’

- tires easily when working
- finds it hard to hear when there is a great deal of background noise, eg in the dining room
- finds it hard to follow discussions
- has poor language development
- can’t regulate his/her voice – either shouts or whispers
- finds some sounds difficult to pronounce, particularly ‘s’, ‘sh’ and ‘t’
- changes topic abruptly when conversing
- finds oral work harder than written work
- takes expressions such as ‘I’m pulling your leg’ literally
- has tantrums due to frustration
- has aggressive outbursts
- has problems socially.

Latch on to the child’s strengths and provide opportunities for him or her to shine



Strategies

All hearing-impaired children will lip-read to some extent. This takes a great deal of concentration, as does the effort to follow what is being said. Teachers and teaching assistants should therefore keep activities short and make allowances if the child tires towards the end of the day. Check whether he or she is supposed to wear a hearing aid and find out about the particular type of aid by asking the parent or advisory/specialist teacher. Providing a radio aid may also help. The following are strategies that can make a real difference:

- Speak clearly but do not shout, over-pronounce or exaggerate your words.
- Cut down on background noise, eg by having chairs with rubber stoppers.
- Seat the child near the front of the class, on the window side of the room, so that the light falls on your face.
- Try to seat the child away from sources of noise – traffic, noisy heaters, the hum of computers or whiteboard projectors.
- Don't talk while writing on the blackboard – when speaking try to look in the direction of the child.
- Use animated facial expressions and point to sources of information.
- Don't use single words – help the child by providing the context.
- Use visual support, eg objects, pictures, photos.
- Keep your hands and any visual aids away from your mouth.
- Speak naturally at a normal speed (unless you normally speak very fast, in which case try to slow down).
- If the child doesn't understand, don't just repeat what has been said, try to rephrase it.
- Make sure the child is paying attention before you start speaking.
- If using a radio, CD player or TV, give the child some indication beforehand of what the programme is about; if necessary, provide a transcript. Pause when convenient to summarise what has happened so far and reinforce any new vocabulary.
- Develop listening skills by playing auditory discrimination games, eg identifying instruments, and auditory memory games, eg 'I went shopping and bought...'
- Make sure the child is included in group discussions; place him/her with others who will be sympathetic, and allow him/her time both to follow what is said and to contribute.
- Remember that class discussions are particularly hard to follow, so repeat children's contributions.
- Be aware that it is impossible to lip-read and to take notes at the same time; provide notes, or ask another adult or child to help with note-taking.
- Realise that older children will need help with mastering the technical language of a range of subjects. New terms, acronyms or familiar words used in a new context should be written out and then explained.
- If a child uses sign language and has an interpreter, speak directly to the child and not the adult (interpreting is extremely wearing and there will be a need for frequent breaks).
- Make sure instructions about homework are understood, for example getting the child to repeat what he or she is to do.
- Encourage the child to indicate when he or she has not understood, as it is important for him or her to take increasing responsibility for his/her learning.

A child with a hearing loss has to work extra hard to reach his/her potential and to be accepted socially. Be sympathetic, offer encouragement and do everything you can to ensure that other children realise that being deaf does not mean that the individual is any less intelligent than others or does not have language. Latch on to the child's strengths and provide opportunities for him or her to shine.

Most children with a visual impairment are diagnosed before they reach school age. However, some children slip through the net

Visual impairment

Definition

Visual impairment is a low incidence condition affecting approximately two children per thousand. There are many causes of blindness and partial sight and the effect of particular conditions is unique to the individual. The broadest definition is that vision can be considered to be impaired if, even with the use of contact lenses or glasses, a person's sight cannot be fully corrected.

Very few people can see nothing at all. Some may be able to perceive light and be able to use this information to know where a window is, or a light source and be able to orientate themselves in a room. For some people, a visual impairment will mean that they can see up to a certain distance. Others may have a reduced field of vision and may only be able to see objects held directly in front or to one side. Some people will see blurred images, for others what they see appears to be constantly 'dancing up and down', others may have patches of vision which 'disappear', or difficulty perceiving depth and perspective. Some colours may be easier to see, with others being effectively indistinguishable or invisible. Some people may be able to see fine detail close up, while others perceive bold outlines but not details.

A child who has little or no vision from birth will need more help to understand visual concepts than a child who has previously had some sight.

Some children may have more minor sight difficulties, perhaps colour blindness or a squint in one eye, or a lazy eye. These may have only a limited effect on their learning and may not warrant individual education plans. However, if there is any doubt about a child's vision, it should be thoroughly investigated and assessed. The first person to contact is one of your LA's qualified teachers of visually impaired children.

More than half of children who have impaired vision have additional SEN. Where this is the case, the totality of the individual's needs must be addressed by a multi-disciplinary team of health, education and social work professionals.

Identification

Most children with a visual impairment are diagnosed before they reach school age. However, some children slip through the net, others develop a sight difficulty during their school years and those who are known to have a visual impairment may also experience difficulties if their sight deteriorates further.

The following are potential indicators of a visual difficulty. If in doubt, it is best for the child's vision to be assessed. Watch out for the child who:

- has watery, itchy or inflamed eyes
- keeps blinking rapidly or rubbing his/her eyes
- frowns, squints, or peers at work
- tilts their head, or holds work at an odd angle or distance
- closes or covers one eye when looking at books
- turns their head to follow the line across the page when reading
- appears clumsy
- bumps into people or objects
- has difficulty throwing, kicking and catching
- finds difficulty in copying from the blackboard or from a book
- confuses letters of similar appearance, such as c, e, a, o
- writes in large letters and not on the line
- presses hard with a pencil or pen
- uses a finger to keep his/her place on the page
- misses out words and lines when reading
- complains that worksheets are too faint
- complains that he or she can't see the blackboard
- has difficulty setting out sums
- dislikes strong light or glare
- complains of frequent headaches
- works slowly
- has a short attention span.



Strategies

Assessing what a child can see in different conditions (for example in a well-lit room, in a corridor without natural light, outside in bright sunshine) is a complex skill. The assessment needs to encompass what a child can see and how he or she uses his/her vision.

A qualified teacher of children with impaired vision should conduct a functional vision assessment and advise on how the child's educational needs should be met. Such advice should include:

- guidance on teaching methods
- advice about the presentation and modification of learning materials
- information about how the child will read, obtain information, and write, for example using braille, typing or handwriting
- recommendations of special equipment including
- computer technology
- recommendations of specialist learning resources
- advice on classroom management
- arrangements for national curriculum assessments and other examinations.

Get as much information as possible from the child, his/her parents and the advisory teacher. Find out whether the child is supposed to wear glasses, and if so, when. The advisory teacher should also explain what other visual aids the child might need (for example magnifiers) and whether worksheets, maps or diagrams should be presented in a particular way.

Much depends on the degree and type of visual impairment. With appropriate support, partially sighted and blind children can and do succeed in the mainstream classroom. The following strategies for using sighted and non-sighted methods of learning may help:

- Consider that there may be an optimum place for the child to sit in the classroom, eg in good light, away from glare, near a power point, at a particular distance and angle from the blackboard.

- Bear in mind that visually impaired people do not have extraordinary powers of hearing. On the contrary, a visually impaired person needs help to identify, locate and interpret sounds to make sense of what is happening. For this reason, unnecessary noise in the classroom should be minimised and, where appropriate, sounds explained as they occur.
- When addressing the child, use his/her name first to get their attention (this equates to eye contact). This enables a visually impaired child to know when he or she is receiving praise or instructions and when it is appropriate to ignore comments directed at others.
- Use descriptive language – 'it is to the left of the bookcase' is more useful than 'over there'.
- Keep the classroom tidy so that a visually impaired child doesn't knock into objects or trip on bags or toys. Always remember to inform the child if furniture has been moved around, and allow him/her time to familiarise him/herself with the new layout. Use a heavy black pen, which is clearer to read than pencil.
- Find out which colour contrast suits the child. Black writing on a white matt surface makes effective contrast without glare, although black on yellow is sometimes better.
- On worksheets, provide clear lines for the child to write on. Avoid cluttering pages of worksheets with illustrations and italic or ornate fonts. Lower case text is easier to read than capital letters.
- Cut out unnecessary detail on diagrams, and enhance with colour where helpful.
- Learn how to make tactile diagrams, simplifying detail and introducing contrasting textures, labelling in braille if appropriate. In each case consider whether a diagram is the best way to communicate the information.
- Make outlines clear and bold.
- Allow time for writing and let the child record some work orally.

A school-wide policy on communication is essential to enable the deafblind child to be integrated into the school's physical and social environment

- Allow extra time for reading print or braille and for the acquisition of any specialist skills such as touch typing, mobility, learning braille and pre-braille activities.
- Find out whether the child has an optimum length of time during which he or she can work efficiently and effectively – reading print with impaired vision often causes fatigue, and reading in braille requires great concentration.
- Make use of word-processing programmes, both to assist the child in the presentation of his or her own work and also to prepare learning materials. Experiment with different font styles and sizes to find out which are easiest for a partially sighted child to read. Often, enlarging the text to 16 point or 18 point can help. Braillists can also use computer translation packages to create braille and print versions.
- Use computer technology to give children greater access to material.
- Create audio recordings of a substantial amount of text.
- Magnify books and worksheets if necessary, but remember that the enlarged version will take longer to scan, and that the child will see fewer words at one time. The text may need reformatting to keep the page size manageable.
- Dictate as you write on the board. Some children may find a paper copy helpful.
- Go over classroom displays, explaining them in detail, so that the child can enjoy them for further learning. If a child's work is in braille, put a print version with it so that other children can read it.
- Use a multi-sensory approach – allow children to handle, smell and look closely at objects. Involve a visually impaired learner with practical demonstrations such as science experiments.
- Encourage the child with impaired vision to make full use of any low vision aids recommended by the advisory teacher, such as magnifiers.
- So as to maximise the child's independence, refer to an orientation and mobility officer for advice to ensure that the classroom is organised, structured and accessible. Label equipment in large print or braille where appropriate.
- Obtain specialist equipment such as tactile rulers, heavy-lined stationery, and talking calculators. Keep in touch with new services, equipment and developments and seek advice from curriculum specialists.
- Negotiate extra time for preparing individual learning materials and for liaising with specialists such as a teacher of visually impaired children or a mobility specialist.
- Contact other teachers with experience of teaching your subject area to children with impaired vision through curriculum groups supported by the RNIB.
- Develop a whole-school approach to understanding visual impairment and its implications for teachers, teaching assistants and children.

A child with a sight problem may be over-protected by other children, ignored by them or excluded from social activities. Try to help the peer group to appreciate the child's whole personality and not define him/her only as 'someone with a sight problem'. Use the child's strengths and encourage him or her to be as independent as possible.



Deafblindness/multi-sensory impairment

Definition

Deafblindness is a combination of both hearing and sight impairment. It does not necessarily mean the total loss of both senses – indeed the majority of deafblind people do have some degree of residual hearing and/or sight. Those with a severe degree of both sight and hearing impairment may also be referred to as having a multi-sensory impairment or loss.

A person is regarded as deafblind or multi-sensory impaired when the combination of his or her two sensory impairments intensify the impact of each other, and prevent the individual functioning as fully as a blind or partially-sighted person who can hear, or a deaf or hard-of-hearing person who can see. A precise definition of deafblindness is difficult because the degrees of deafness and blindness, possibly combined with different degrees of other disabilities, are not uniform and the educational needs of the affected child therefore have to be decided on an individual basis.

Identification

Deafblind children will find it difficult to utilise, and benefit fully from, educational support for deaf people or blind people; meeting their needs therefore requires a separate approach. In particular, deafblind children experience problems with:

- the development of communication skills – to a degree that they require adapted or augmented forms of communication
- mobility – they may need specialised learning programmes and modifications to their environment, eg a multi-sensory room
- integrating information received through other senses – as a result, they may require individual activity-based programmes that have been differentiated to meet their specific needs
- social interaction and the development of independence skills – they may need positive interaction on the part of the teacher/teaching assistant, and specific curricular programmes.

Congenitally deafblind children are born with a dual sensory loss and often develop additional and/or multiple disabilities, including learning disabilities. Some deafblind people develop their dual sensory loss later in life – children with Usher Syndrome for example are born deaf or hard of hearing, then gradually start to lose their sight in late childhood.

Use a multi-sensory approach – allow children to handle, smell and look closely at objects



Strategies

The needs of deafblind/multi-sensory impaired children vary considerably, and cannot be assumed or generalised. In many cases, an individual, needs-led approach to their education is necessary. The following points suggest key areas that should be considered.

1. Curriculum

- An individual curriculum, based on an individual assessment of educational and social needs, is required to ensure all the needs of the child are met, including communication needs, access to information, mobility and social skills.
- Deafblind awareness training and development is necessary for all school staff and other pupils in the class. The postgraduate qualification in multi-sensory impairment facilitated by the University of Birmingham, or the certificates in communication with deafblind people offered by the charity Signature, may be appropriate for staff.

2. An adapted physical environment

- Classrooms need to be well lit to facilitate lip-reading, following sign language, reading and mobility. Overhead fluorescent strip lighting is best.
- Light, plain floor coverings and medium to dark furnishings are helpful. Colour and texture differences will help children to differentiate their surrounding environment and aid visual communication and independent mobility.
- Carpeted rooms are preferable as they tend to be quieter and reduce echoing. Avoid using rooms next to busy roads or other noisy environments.
- Induction loops may be necessary for hearing aid users.
- Consider providing mobility trails.

3. Communication needs

A school-wide policy on communication is essential to enable the deafblind child to be integrated into the school's physical and social environment.

The communication needs of the child will be highly individual. There are many different forms of communication including:

- total communication, eg the use of voice, objects of reference, textured communication, symbols, pictures, etc
- finger spelling, deafblind manual or block
- visual sign language, eg British Sign Language (BSL) or hands on signing
- lip reading
- portable communication aids, eg text to speech devices.

A one-to-one staff/child ratio is needed. Intervenorers are support assistants who help the deafblind child to access learning opportunities. They have a range of communication skills and knowledge of alternative methods of communication.

4. Specialist aids

- CCTV, large print, audio recordings, computers and technical support aids and textured communication, eg braille, Moon may all be helpful.
- Communication by computer is increasingly popular. It is, of course, only useful in schools if the child has access to a computer with braille display, speech synthesisers or large character software.
- braille printers, text phones, scanners, and induction loop systems should be considered.

5. Social needs

Deafblindness is a low-incidence disability which by its very nature is isolating. The social needs of the child are therefore an important element in his/her educational needs. Mobility, environmental awareness, socialising and communicating with fellow children need constant consideration. A communicator guide is someone who acts as the eyes and ears of the deafblind person to enable two-way communication and to interpret in informal situations – shopping, socialising, and accessing services like banks and post offices, for example.

Physical impairment

This section covers a wide range of physical and medical conditions. Some children with a physical disability will be easily identifiable, but others less so if their condition can be effectively controlled. Medical conditions that affect children's stamina and therefore their ability to participate fully in all aspects of the curriculum are also considered here.

Some physical disabilities have allied medical conditions that require regular medication, sometimes to be taken during school hours.

Children with some medical conditions are at an extra disadvantage if their absences are frequent enough to get in the way of their learning. Home learning programmes can be helpful, although time consuming for the teacher who oversees them.

Some physical and medical problems are congenital; others emerge later on. Schools need to know enough about children's medical conditions to help them access their educational entitlement.

If the child has a statement, then the statement itself may be a valuable starting point



Finding the information you need to support a child's education

If the child has a statement, then the statement itself may be a valuable starting point.

Strategies

If not:

- consult your colleagues
- look at any records from the previous school
- talk to the child and his/her family
- make contact with your local SEN adviser, advisory teachers, and support teams
- seek information from special school colleagues if you are in a mainstream school
- consider arranging a meeting with the school doctor/nurse/therapist.

The following are some of the questions you might need to ask:

- Is the child on medication and, if so, does the drug affect his/her capacity to learn?
- Is the child likely to have frequent absences from school? If so, do I need to set work to be done at home?
- How far does the disability limit participation in school life? For instance, can the child go out to play regardless of the weather; participate in PE, swimming, games and other activities; go on school trips?
- What can the child do independently?
- When should I offer help?
- When you have collected the information you need, plan how you will overcome or modify any potential problems.

Hereditary problems

Cystic fibrosis

Cystic fibrosis is the UK's most common life-threatening inherited disease among Caucasians (people of Indo-European origin). It occurs in approximately 1 in 2,500 children. Children with cystic fibrosis can have gastrointestinal problems resulting from a damaged pancreas. This is caused by the presence of thick mucus, which is characteristic of cystic fibrosis and which affects other organs, notably the lungs.

At the beginning of the twentieth century, children with cystic fibrosis did not live very long, but the discovery of powerful antibiotics and other effective treatments such as physiotherapy and dietary care now mean that most children with cystic fibrosis live into adulthood with a manageable degree of disability.

Identification

The most noticeable feature of cystic fibrosis is a non-infective persistent cough. For the affected child, this may be embarrassing in front of other children, especially as a severe attack of coughing sometimes leads to coughing up mucus, or vomiting.

The main digestive problem caused by cystic fibrosis is a malfunctioning of the pancreas. The pancreas is a gland that produces insulin, regulating the amount of sugar in the blood. It also produces digestive juices or enzymes, which pass into the intestine where they aid the digestion and absorption of food.

Children with cystic fibrosis may be more prone to sinusitis, hay fever, arthritis, diabetes, heart strain and cirrhosis of the liver, but these are fairly rare complications which usually develop in older children or adults. Most children with cystic fibrosis respond to childhood diseases in the same way as their non-affected peers but they do run a slightly higher risk of chicken pox pneumonitis, and some children may need to be withdrawn from school if there is an outbreak of chicken pox.

Other complications are the possibility of delayed sexual maturity and probable future sterility for boys with cystic fibrosis.

Strategies

Children with cystic fibrosis are as academically able as their peers, and teachers should expect the same standards. They may, however, be absent from school for significant periods because of chest infections or hospitalisation, and so will require extra help to catch up with the rest of the class.

If a child is not seriously ill, work can be set for him/her to complete at home or in hospital. Some older children use portable intravenous antibiotic equipment, which means they can attend their normal lessons but cannot cope with the rough and tumble of the playground.

Physical exercise is extremely beneficial to children with cystic fibrosis, so full participation in PE lessons is likely if a child is well. Sympathetic understanding is required though for times when a child is tired and lacks energy after a cold or chest infection.

Many children with cystic fibrosis learn from an early age to administer their own antibiotics and set up their nebulisers. School staff who find the whole prospect alarming may be reassured by the matter of fact way in which these children carry out their daily routine. If you need information and advice about administering medicines to a child, please refer to page 11. You could also see ATL's advice factsheet *Administering medication to pupils*, available at www.atl.org.uk/factsheets.

Haemophilia

Haemophilia is a disorder affecting blood coagulation. In severe cases, minor injuries cause severe bleeding and spontaneous bleeding in vital organs. In less severe cases, severe bleeding occurs only after major injury. Treatment is by injection of 'Factor VIII'.

With treatment, haemophiliacs can lead normal lives, but dangerous and/or contact sports should be avoided. Parents should always be consulted about how best to manage their child's education and care during school hours.

Think about curriculum access – allowing extra time, teaching styles, and appropriate support

Sickle cell anaemia

Sickle cell anaemia is so called because of the sickle shape of the red blood cells. This is caused by abnormal haemoglobin, which results in increased viscosity of the blood, thereby obstructing blood flow. In the UK, it is most common in people of Afro-Caribbean descent.

School staff should be aware that people affected by sickle cell anaemia can experience severe pain. The sickle cells are more fragile than normal cells, have a shorter life and so cause anaemia. Parents should be consulted about how best to manage their child's education and care during school hours.

Congenital conditions

Cerebral palsy

Cerebral palsy affects around 1 in 400 people. It occurs when part of the brain is not working properly or has not developed properly – this happens either before birth, at birth or during early childhood. It is permanent but non-progressive and affects the individual's ability to control his/her movements. It can affect mobility but may also affect speech and communication, manipulation, vision, hearing, perception, cognition and/or eating and drinking. Epilepsy is sometimes also present.

Types of cerebral palsy include spastic (involving stiffened muscles and decreased joint movement), athetoid (involving involuntary muscle movement and problems controlling the tongue, breathing and vocal chords), and ataxic (involving difficulties with balance, shaky hand movements and jerky speech).

How well a child succeeds in education will depend on the degree of severity and whether there are other learning difficulties present, for example in the ability to concentrate. The child may have regular therapy and/or may attend intensive courses at different centres, for example at The Bobath Centre, a specialist treatment centre. He or she may, therefore, be occasionally absent from school.

Limb deformities

An affected child might have a prosthesis and may require help to change it, depending on the activity taking place. He or she may have a wheelchair or walking aid. As the child grows, the prosthesis will need to be changed and this will mean that he or she will be absent from lessons. The child may experience some soreness as he/she gets used to the new prosthesis.

Spina bifida and hydrocephalus

Spina bifida – literally meaning 'split spine' – is a condition where a child is born with a defect in the formation of the spine. There are various types of spina bifida and, while some children are severely disabled, others have the condition in only a minor form.

As a teacher or teaching assistant, you need to be aware of some of the implications for a child with spina bifida. He or she may have limited or no sensation below the spinal lesion and so fail to notice cuts and bruises. To prevent burns, for example, ensure the child knows if a radiator is on. As the child gets older, he or she will take more responsibility for him/herself.

Many children with spina bifida also have hydrocephalus (water on the brain) and need a shunt, a device to help drain fluid away from the brain, to rectify this. A child whose shunt becomes blocked or damaged may become seriously ill, so you need to be aware of the signs.

Strategies

- Use a buddy system.
- Talk to parents.
- Make use of audio-visual aids.
- Think about curriculum access – allowing extra time, teaching styles, and appropriate support.

If the child is unconscious, seek medical aid and stay with him/her

Other conditions

Accidental injuries

If a child suffers a serious accident that results in permanent or long-term disability, he or she will need to learn to adapt to a different lifestyle – emotionally as well as in terms of his/her physical abilities. For example, a child who has suffered a permanent spinal injury due to a road traffic accident may require a wheelchair. The whole class may require some form of support or counselling when a friend and peer has suffered such a severe trauma.

Allergies

An allergy is an adverse reaction caused by a hypersensitivity to a substance. Allergies generally cause problems in one of three ways:

- 1 Intestinal allergies may cause vomiting, abdominal pain and diarrhoea.
- 2 Skin allergies may show as a red skin rash, a 'nettle rash' or dermatitis.
- 3 Respiratory allergies may result in asthma or hay fever.

Treatment

- Try to identify the problem.
- Advise the child to see his or her doctor.
- Seek immediate medical aid if necessary.

Anaphylactic shock

Anaphylactic shock is the name given to a rare, generalised and dangerous allergic reaction that requires urgent medical attention. It is a massive allergic reaction within the body. Individuals may develop this reaction to:

- the injection of a particular drug
- the eating of a particular food, eg peanuts, or other nuts
- the sting of a particular insect, eg a bee or wasp.

An anaphylactic shock will cause:

- substances to be released into the blood that dilate the blood vessels and constrict air passages
- a fall in blood pressure
- difficulty in breathing
- an increased risk of suffocation as the face and neck swell
- an urgent need for oxygen and a life-saving injection of adrenaline.

Symptoms displayed may include:

- widespread red, blotchy skin eruption
- anxiety
- swelling of the face and neck
- puffiness around the eyes
- impaired breathing
- a rapid pulse.

Treatment

- Seek immediate medical aid.
- Dial 999 for an ambulance or ensure that the child is taken urgently to a hospital.

Asthma

Asthma is a distressing condition which causes a narrowing of the tubes in the lungs, resulting in wheezing, coughing and shortness of breath. The trigger may be dust, pollen, fur or some other substance, certain foods, emotional upsets or physical exertion. Affected children will have difficulty in breathing. They may also experience:

- wheezing when breathing out
- distress and anxiety
- difficulty speaking
- a blueness of the skin.

Treatment

An asthma attack can last for a few minutes or several hours. You should:

- Help the child to sit down, encourage him/her to sit upright and lean forwards.
- Ensure a good supply of fresh air and offer a drink of water.
- Locate the child's inhaler (assuming that they are a regular asthma sufferer) and encourage him/her to use it.
- Seek medical aid if necessary, especially if medication fails to relieve the attack in five to 10 minutes.
- Reassure and calm the sufferer (but do not put your arm around him/her).

Eczema

Eczema is an inflammation of the skin. Unless the itching is so intense that it affects concentration, or the condition so severe that it involves regular time off school, eczema should not cause educational difficulties.

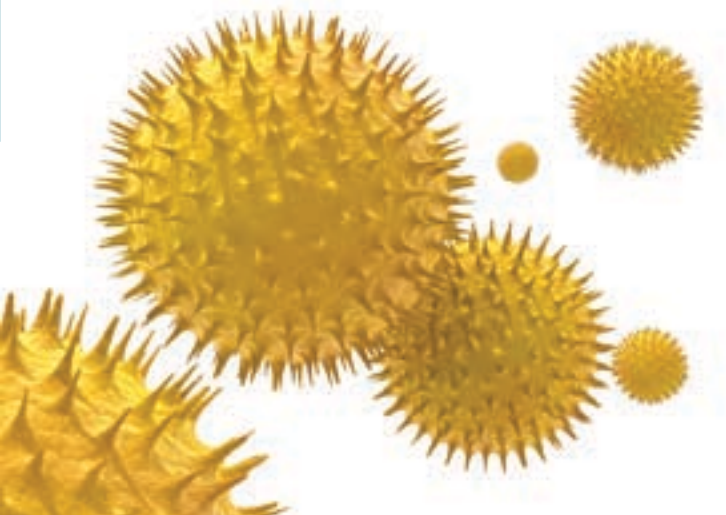
Diabetes

Diabetes is a condition that causes the body to fail to regulate the concentration of sugar (glucose) in the blood. Diabetics are usually aware of their condition and are well prepared if the blood glucose level changes. If the glucose level in the blood becomes too high or too low, a child may display some of the following symptoms:

- weakness, faintness or hunger
- palpitations and muscle tremors
- strange actions or behaviour
- sweating
- pallor and cold, clammy skin
- a strong, bounding pulse
- a deteriorating level of response
- shallow breathing.

Treatment

If the child is conscious, help him or her to sit or lie down, and give him/her a sugary drink, sugar lumps, chocolate or other sweet food, in order to raise the sugar content of the blood as quickly as possible. Seek medical aid. If the child is unconscious, seek medical aid and stay with him/her. Remember to open his or her airway, check breathing and pulse (be prepared to resuscitate if necessary, if you have recent, appropriate training) and place the child in the recovery position.



Epilepsy

Epileptic fits are caused by an occasional sudden reaction of the nerve cells in the cortex of the brain. Seizures can be severe (causing loss of consciousness) or very mild (almost like daydreaming). Taken regularly, anti-convulsant drugs can suppress the fits. In some cases it is also possible to identify and then avoid factors that trigger attacks. Children with epilepsy can therefore take part in normal school activities, including swimming, as long as they are adequately supervised. In some cases, children will themselves recognise the warning signs of an impending fit. One person in every 200 or so suffers from epilepsy and will be subject to fits or seizures. Epilepsy can occur at any age.

Symptoms of minor epilepsy include:

- sudden 'switching off' or 'daydreaming'
- staring blankly ahead
- slight twitching movements
- strange movements, eg making odd noises, or 'fiddling' with clothing
- no awareness that anything out of the ordinary has happened.

In cases of more severe epileptic fits, the child may:

- suddenly fall unconscious
- have a rigid and arching back
- have a blue tinge to the lips
- have breathing difficulties
- show convulsive movements.

Within a few minutes, the muscles will relax, breathing will return to normal and the child will return to consciousness.

Communicating positively and openly with children allows the epilepsy to become just another aspect of their lives

Treatment

In cases of minor epilepsy:

- help the child to sit down in a quiet area and remove any possible source of harm
- talk calmly to the child, do not 'pester' him or her to recover
- stay with the child until he or she has recovered.

In cases of major epilepsy:

- protect the child from injury during the fit (make space around him/her and ask people to move away)
- loosen clothing around the neck and try to protect the head
- stay with the child until he or she has fully recovered
- seek immediate medical aid, if the seizure lasts longer than five minutes, if a second seizure quickly follows the first, or if the child is having trouble breathing
- do not use force to restrain the child, place anything near his or her mouth, or attempt to lift or move him/her unless there is immediate danger.

Strategies

One of the most important factors in the impact of epilepsy upon children is the reactions of peers, family, and teachers or other professionals to the condition. Communicating positively and openly with children allows the epilepsy to become just another aspect of their lives. Educationally, a child with epilepsy can achieve as much as any other child who is not affected by the condition. Encouraging self-confidence and self-belief is one of the key ways in which schools can support affected children to fulfill their learning potential.

Some children with epilepsy may suffer from poor attention and confusion, memory problems, fatigue, poor processing abilities, irritability or behaviour problems. Encouraging a child with epilepsy to repeat information given may counter some periods of lost consciousness. The drug treatment for epilepsy can also have an adverse affect on the child, as it may cause behaviour difficulties, extreme tiredness, weight gain, hair loss and acne – all of which affect self confidence and ability to learn.

HIV and AIDS

Human Immunodeficiency Virus (HIV) is a virus that can damage the body's immune system. The immune system fights the virus and if the body's defences are severely weakened this can lead to Acquired Immune Deficiency Syndrome (AIDS). AIDS is the name of a collection of different diseases that can cause serious illness or death in both adults and children.

HIV is very fragile and is not easily transmitted. For example, it cannot survive in very hot water, in bleach or in detergent. HIV is transmitted in three ways:

- through unprotected vaginal or anal intercourse
- by infected blood entering the blood stream (eg from a blood transfusion or from needle stick injuries)
- from a woman with HIV to her baby either during pregnancy, during delivery or from breast feeding.

There is no evidence that HIV can be caught from social contact. Hugging, touching and kissing, as well as being close to people, presents no risk of infection. HIV cannot be spread by: coughing, sneezing, sharing a toilet seat, sharing a drinking fountain, showers and swimming pools, sweat, tears and saliva, or animals and pets.

Confidentiality

There are special legal rules to protect the confidentiality of information held by the NHS. All LA staff, including school staff, have a legal duty to keep confidential all information that is given to them about a child's health. Details of the HIV status of any child must not be passed on without the parent's or child's permission. This means that in most schools, staff will not know if a child is HIV positive. It is therefore essential that health and safety procedures for cleaning up blood and blood-stained body fluids are rigorously adhered to, and that disposable gloves are worn when bleeding children are treated.

Muscular dystrophy

Muscular dystrophy is the term for a group of diseases that involve a progressive degeneration of the muscles, particularly those affecting movement. The rate at which this occurs varies according to the form of the condition. There are several inherited forms of the disease, one of which, Duchenne's, mainly affects boys. The commonest form in children affects particularly the upper part of the lower limbs. The child is clumsy, weak on his/her legs and has difficulty getting up after a fall. In another form, which begins usually about age 14, the muscles of the upper arm are first affected, spreading to the spine and lower limbs. In another, the face is first affected.

The severity of the condition varies greatly, as does the life expectancy of the affected person. There is no cure for muscular dystrophy, but therapy often helps to alleviate symptoms.

Schools can support children with muscular dystrophy by using a buddy system, fostering positive attitudes in others through personal, social and health education, and considering any necessary improvements to classroom layouts and use of stairs.





Useful organisations

Hearing loss

National Deaf Children's Society

Tel: 020 7490 8656

Email: ndcs@ndcs.org.uk

Web: www.ndcs.org.uk

A charity dedicated to supporting deaf children, young deaf people and their families.

British Association of Teachers of the Deaf

Email: secretary@batod.org.uk

Web: www.batod.org.uk

Promotes the educational interests of all hearing-impaired children and young people, and represents the interests of their teachers.

British Deaf Association

Tel: 02476 550936

Email: england@bda.org.uk

Web: www.bda.org.uk

British Deaf Association Wales

Tel: 0845 1302851

Email: wales@bda.org.uk

British Deaf Association Northern Ireland

Tel: 02890 437480

Email: northernireland@bda.org.uk

Works to build a strong and vibrant community of deaf people who use sign language, ensuring that they enjoy the same rights, responsibilities, opportunities and quality of life as everyone.

Royal National Institute for Deaf People

Info line: 0808 808 0123

Tel: 020 7296 8000

Email: informationline@rnid.org.uk

Web: www.rnid.org.uk

Aims to achieve a better quality of life for deaf and hard of hearing people through information, training, education, research, campaigning and employment programmes.

Visually impaired

Royal National Institute for the Blind

Helpline: 0303 123 9999

Tel: 020 7388 1266

Email: helpline@rnib.org.uk

Web: www.rnib.org.uk

RNIB Cymru

Tel: 029 2045 0440

Helps people with sight problems with practical solutions to everyday challenges. Campaigns, promotes eye health and funds research.

Visual Impairment Centre for Teaching and Research

Tel: 0121 414 6733

Email: victar-enquiries@bham.ac.uk

Web: www.education.bham.ac.uk/research/victar

A research centre that also teaches and provides advice and resources in the area of visual impairment and education.

Deafblindness/multi-sensory impairment

Sense

Tel: 0845 127 0060

Email: info@sense.org.uk

Web: www.sense.org.uk

Services and support for people who are deafblind or who have associated disabilities.

Deafblind UK

Helpline: 0800 132 320

Tel: 01733 358 100

Email: info@deafblind.org.uk

Web: www.deafblind.org.uk

Deafblind Cymru

Tel: 02920 601 471

Email: deafblindcymru@deafblind.org.uk

Offers a range of services for deafblind people, including a helpline and specialist support.

Signature

Tel: 0191 383 1155

Email: durham@signature.org.uk

A charity, formally established as The Council for Advancement of Communication with Deaf People, and a recognised awarding body offering nationally accredited qualifications in communication methods used by deaf and deafblind people.

Physical impairments**Equality and Human Rights Commission**

England helpline: 0845 604 6610

Scotland helpline: 0845 604 5510

Wales helpline: 0845 604 8810

Email: info@equalityhumanrights.com

Web: www.equalityhumanrights.com

Information and advice about all aspects of the Disability Discrimination Act, as well as signposting specialist organisations where necessary.

Phab

Tel: 020 8667 9443

Email: info@phab.org.uk

Web: www.phab.org.uk

Runs a national network of clubs for disabled people, offers residential holidays for young people and funds a variety of projects.

Cystic Fibrosis Trust

Helpline: 0300 373 1000

Tel: 020 8464 7211

Email for general enquiries:

enquiries@cftrust.org.uk

Email for medical enquiries:

AskTheExpert@cftrust.org.uk

Web: www.cftrust.org.uk

Provides advice and support for people affected by cystic fibrosis, and for their families.

The Haemophilia Society

Helpline: 0800 018 6068

Tel: 0207 8311020

Email: info@haemophilia.org.uk

Web: www.haemophilia.org.uk

Offers information and advice on issues relating to haemophilia.

Sickle Cell Society

Tel: 020 8961 7795

Email: info@sicklecellsociety.org

Web: www.sicklecellsociety.org

Information, caring and counselling for those with sickle cell disorders and their families.

Scope

Helpline: 0808 800 3333

Email: response@scope.org.uk

Web: www.scope.org.uk

A disability organisation offering a range of services for people affected by cerebral palsy, including information and support.

National Institute of Conductive Education

Email: foundation@conductive-education.org.uk

Web: www.conductive-education.org.uk

Conductive Education is a form of special education and rehabilitation for children and adults with motor disorders.

Association for Spina Bifida and Hydrocephalus

Helpline: 0845 4507755

Email: helpline@asbah.org

Web: www.asbah.org

Offers advice, support and specialist services on all issues related to spina bifida and hydrocephalus.



Useful organisations

Other conditions

Headway – the brain injury association

Helpline: 0800 800 2244

Tel: 0115 924 0800

Email: helpline@headway.org.uk

Web: www.headway.org.uk

Provides information, support and services for people with brain injuries, and for their families and carers.

The Anaphylaxis Campaign

Helpline: 01252 542029

Tel: 01252 546 100

Email: info@anaphylaxis.org.uk

Web: www.anaphylaxis.org.uk

Information on anaphylaxis for anyone with an interest in the condition, including health and education professionals.

Asthma UK

Adviceline: 0800 121 6244

Tel: 0800 121 6255

Email: info@asthma.org.uk

Web: www.asthma.org.uk

Researches and campaigns on all aspects of asthma, as well as offering advice and information to those with an interest in the condition.

National Eczema Society

Helpline: 0800 089 1122

Tel: 020 7281 3553

Email: info@eczema.org

Web: www.eczema.org

Works for people with eczema, dermatitis and sensitive skins.

Diabetes UK

Tel: 020 7424 1000

Email: info@diabetes.org.uk

Web: www.diabetes.org.uk

Funds research, campaigns and helps people to live with diabetes.

National Centre for Young People with Epilepsy

Confidential enquiry line: 01342 831342

Tel: 01342 832243

Email: enquiry@ncype.org.uk

Web: www.ncype.org.uk

Provides specialist services for young people who have epilepsy.

National Society for Epilepsy

Helpline: 01494 601 400

Tel: 01494 601 300

Web: www.epilepsynse.org.uk

Provides information, training and education about epilepsy as well as medical services.

The Terrence Higgins Trust

Helpline: 0845 1221 200

Email: info@ttht.org.uk

Web: www.ttht.org.uk

Offers services, support and information on HIV and AIDS.

Muscular Dystrophy Campaign

Helpline: 0800 652 6352

Tel: 020 7803 4800

Email: info@muscular-dystrophy.org

Web: www.muscular-dystrophy.org

Charity focusing on all muscular dystrophies and allied disorders. Pioneers the search for treatments and cures and provides practical, medical and emotional support to people affected by the condition.

The Medical Conditions at School Partnership

Tel: 0845 603 8143

Email: info@asthma.org.uk

Web: www.medicalconditionsatschool.org.uk

A new website, launched as a policy resource to help schools create a safe environment for children living with a medical condition.

Resources available include an information pack on asthma, anaphylaxis, diabetes and epilepsy – medical conditions that can have a substantial and potentially life-threatening impact on a young person's time at school.

3. Communication and interaction

There are many different kinds of speech and language difficulty, but all of them affect communication. Such difficulties may arise from an inability to cope with some aspect of the structure of language (phonological, grammatical or semantic), or with the way language is used to communicate.

Children may exhibit problems with receptive language (processing the language they hear) and/or with expressive language (verbalising their thoughts and feelings).

Delayed and disordered development

Definition

There is a well-defined pattern of normal phonological and grammatical development, and a child with delayed language will go through the same stages of development – but at a slower rate. However, a child with a speech and language disorder will deviate from the usual progression and exhibit abnormal development.

Phonological problems will be apparent in the way a child articulates sounds, syllables and words (sounds that are produced at the front of the mouth are commonly mastered before those at the back). Difficulties with grammar or syntax will show up in faulty word, phrase or sentence structure. (Young children learn to use single words to convey a complete thought, then two-word phrases.) Semantic problems may be either receptive (a child has difficulty understanding what is said) or expressive (a child is unable to convey meaning satisfactorily).

If the problem relates to using language rather than to the structure of language, the child has difficulty in using spoken language in a meaningful way. This may manifest itself in the child echoing what has been said, or not understanding either how to hold a conversation or to reply appropriately to questions.

Delayed language development may be due to an insufficiently stimulating environment, where a child is neither spoken to nor encouraged to speak. Conversely, an environment where there is constant noise and activity, but very little conversation, can also be detrimental. Disordered development is more likely to be the result of minimal brain damage, affecting a small but vital area of the brain. Physical abnormalities, such as a cleft palate, may lead to problems with articulation, while cognitive difficulties or hearing impairment can also delay the development of speech and language.

It is therefore important to notice how children respond to spoken language and how they use it themselves



Identification

While problems with articulation are easy to spot, other difficulties may be less apparent. This is particularly as teachers become very skilled at interpreting what a child is trying to say and, in an effort to be helpful, don't always listen to what has actually been said. It is therefore important to notice how children respond to spoken language and how they use it themselves.

Watch out for:

- an inability to understand when addressed one-to-one, in a group situation, or when the whole class is addressed
- an inability to follow more than one, more than two, or more than three instructions, depending on age
- the use of one sound to cover two or more sounds, eg 'w' for both 'r' and 'w' (leading to 'wabbit' instead of 'rabbit')
- the use of a few sounds to cover a range of sounds, eg simplifying blends as in 'b' for 'br'
- muddling or simplifying words/phrases, eg 'winkipers' for windscreen wipers, 'par cark'
- a tendency to give one-word replies
- a tendency to avoid speaking
- a failure to initiate conversation with other children or adults
- 'parroting' or using stereotypical phrases (saying the same expressions over and over again)
- a very restricted vocabulary
- a reluctance to join in group discussions or participate in oral lessons
- difficulty in recalling anything learned by rote (the alphabet, tables, rhymes etc)
- difficulty in recalling information given orally
- a child who gives inappropriate answers during question or discussion times
- a child who only understands literal expressions
- a child who cannot understand jokes
- a child who watches the behaviour of other children in order to know how to act, eg does not line up until he/she observes others lining up
- a child who always needs the instructions to be repeated or modified in some way.



Make use of rhythm, eg tapping or clapping names, phrases, making up question and answer phrases



Strategies

There is much that can be done in the classroom to help children with delayed language development, and these strategies will also benefit the class as a whole. Problems associated with delayed development should be largely overcome by the secondary phase. The strategies suggested are equally relevant to children with disordered language. However, such children are also likely to need some support from the speech and language therapy service, so that the nature of their difficulties can be investigated and ways of helping them identified. This is a specialised field, and both school and child should be able to draw on outside expertise. (Speech therapists, who in the past dealt mainly with articulatory problems, now have a much wider role and are able to advise on all aspects of speech and language problems.)

To assist a child with delayed or disordered language development, try some of the following strategies:

- Improve his/her listening skills by keeping information short and straightforward.
- Speak clearly and not too quickly.
- Give the child a good role model.
- Progress the child from listening one-to-one to being able to follow in a small group, then in a class, then as part of the school.
- Don't expect too much of an inattentive child, but work to increase the length of time he or she can concentrate.
- Find out how many commands can be understood and remembered, and work to improve this; for example, if a child can cope with only two commands such as 'hang up your coat and come and sit down', work towards incorporating a further command – 'hang up your coat, come and sit down and take out your reading book'.
- Use the child as a messenger, even if at first he or she is only taking a written note.
- Ask questions that need more than a monosyllabic reply.
- When grouping children, ensure that all have a chance to contribute.
- Don't monopolise discussion; it's the children who need the practice!
- Value children's contributions and the place of talk in the classroom.
- Use synonyms to expand vocabulary and to help children put the same information in different ways.
- Encourage the reluctant speaker – he or she may be the one who needs the most practice.
- Encourage children to listen to, and respect, each other's points of view.
- Read aloud, whatever the age of the children – it will improve listening skills and enrich their language.
- Use radio programmes so that children have to concentrate on making use of the auditory channel.
- Expand utterances without appearing to correct them, for example:
 - 'Where you going?'
 - '*Where am I going? I'm going to the staff room.* Where are you going?'
 - 'Go play.'
 - '*You're going out to play, are you?*'
- Do the same with missing sounds, avoiding overcorrection as this can make children self-conscious, for example:
 - 'Bick, peas'
 - '*Do you want a brick?*'
 - 'Bick'
 - '*Here's the brick. May I have another one, please?*'
- Play memory games.
- Use a recording device (this is useful for the play-back and also as a record of progress).
- Use improvisation, drama, puppets and repetitious songs and stories.
- Give a starting point for discussion, eg a television programme, outings, photographs, pictures.
- Make use of rhythm, eg tapping or clapping names, phrases, making up question and answer phrases.
- Increase the child's confidence by encouraging relationships with adults and supporting relationships with other children.
- Include the child in small group work as often as resources allow.
- Provide a quiet area in the classroom for talking and listening.
- Modify your language of instruction until you have clear evidence that the child has understood you (without any gestures or contextual support).
- Look for ways to encourage the child to talk more, eg using the telephone (a real one, or as a prop).

Autism

Definition

Autism is a developmental disorder that affects social and communication skills and impairs the natural instinct within most people to relate to their fellow human beings. A child with autism shows little curiosity or imagination, frequently seems uninterested or indifferent, and often has an accompanying learning disability. There are approximately four times more males than females with autism.

Autism is considered to be a disability that lies on a continuum, with people being affected to different degrees of severity. Asperger's Syndrome is related to autism at the more able end of the spectrum, and children with autism who have been integrated into mainstream provision are often those described as having Asperger's Syndrome.

In some cases, children with autism may have an isolated area of ability – one or two aspects, such as mathematics, art or music, in which they are markedly more advanced than their general developmental level. This is a rare occurrence however, and certainly not typical of children with autism.

It is important to remember that each child with autism is a person in his or her own right with his or her own individual characteristics, as well as those typically displayed by a person with autism.



Identification

Many children with autism will have had their condition identified during their pre-school years, particularly those at the severe end of the continuum. However, children with Asperger's Syndrome may not be identified until they are of statutory school age, when they are sometimes mistaken for children with emotional or behavioural difficulties.

All children with autism will have some impairment in three developmental areas (often referred to as 'the triad of impairments'), although the degree of impairment in each area is individual to each child:

- impairment of social interaction
- impairment of social communication
- impairment of imagination.

The following characteristics are associated with autism, although not all of the following symptoms will necessarily be shown by every autistic child:

- a difficulty understanding or using language
- using limited, repetitious phrases
- using pedantic speech
- thinking and talking obsessively about one topic
- echoing the speech of others rather than responding appropriately
- relying on the situation, rather than words, for meaning
- using verbal fluency to disguise a lack of comprehension
- interpreting speech in a literal way, eg 'it's raining cats and dogs'

Make use of pattern and routine so that the child feels secure

- using an adult's hand as a 'tool' to indicate what is wanted, rather than communicating needs verbally or pointing
- exhibiting bizarre behaviour and mannerisms
- making poor use of eye contact
- failing to answer when spoken to
- being unable to explain actions
- making inappropriate social advances
- having difficulty with social relationships, and avoiding situations where social interaction is demanded
- being unable to empathise with injured or upset children, and displaying indifference to the needs of others
- lacking imagination when playing
- lacking awareness of common dangers such as deep water or fire
- resisting any change in routine, possibly with tantrums
- playing with objects in a ritualistic or obsessive way, eg spinning or flapping
- having an unusual response to sensory stimuli, ie sound, light, smell, shadows
- preferring activities with mechanical procedures
- becoming obsessive or getting 'hooked' on unusual things.



It is important to remember that each child with autism is a person in his or her own right with his or her own individual characteristics, as well as those typically displayed by a person with autism

As far as possible, maintain good relationships and open lines of communication between school, carers and the family

Strategies

Not all of the following strategies can be put into practice simultaneously, nor are they all appropriate to every individual. As far as possible, maintain good relationships and open lines of communication between school, carers and the family; this will ensure that the child knows what is expected of him/her and is secure in a positive environment.

- Use pictorial instruction and physical prompts to ensure that the child succeeds with new tasks.
- Make eye contact easier for the child by getting down to his or her level when working or playing. Do not turn the child's face up to look at you.
- Give the child longer to do something you have asked before you repeat what you say or give the answer. He or she is likely to need longer to process the instruction.
- Start your instructions with the child's name, as the child with autism often has difficulty in realising that you are addressing your comments and instructions to him/her.
- Actively teach social as well as cognitive and language skills, eg teach how to initiate or maintain a conversation by instructing the child where to stand, how to make contact, when to look at the person, what to say, and to wait for the other person to speak.
- Structure learning experiences very carefully.
- Make good use of computers.
- Acknowledge the need for personal space – consider providing an individual work area.
- Teach a whole routine, rather than separate skills to be linked at a later stage, eg toilet/wash/dry/coat on.
- Reward action in a natural 'low key' manner.
- Be aware of the child's favourite activity and use it in sequence as the final task and/or instruction (as long as it is not an all-absorbing activity).
- Prepare carefully for new situations, so that children know exactly where they are and what is expected of them.
- Think ahead for the child with autism – talk through, and prepare pictorial clues for a new experience or change of circumstance (a sudden change in timetable for example can cause a traumatic scene). Videos can be very useful for this. Some teachers of children with autism deliberately make changes to the classroom routine and organisation so that the children learn to cope with change.
- Make use of pattern and routine so that the child feels secure.
- Record language samples and analyse them for vocabulary and grammatical structure.
- Revamp stories and rhymes to incorporate new forms of speech patterns, and use new patterns in conversation.
- In the event of a tantrum, distract the child by any acceptable means, or leave and ignore the child if he or she is safe.
- Be aware of the child's current habit or obsession; avoid it if possible, or use it as a reward at an appropriate time.
- Communicate using music; instructions that are sung rather than spoken can be very useful.
- Try 'cloze' procedure with familiar songs – this tempts a non-talker to fill in the gap without realising that he or she has spoken a word.
- Encourage the child to copy rhythms using a variety of instruments.
- Sing and talk using simple rhythms to create a dialogue and effect a response.
- Liaise with all the adults who are involved (carers, specialists and family) in order to ensure that there is consistent management and to focus training and learning programmes.
- Don't rely on verbal directions alone.
- Don't use unclear, non-contextualised gestures as they may confuse the child.
- Don't rely on a child with autism to pick up social knowledge simply by exposure to situations.
- Don't overwhelm a child with gushing praise or hugs – they may simply alienate him/her.



Useful organisations

AFASIC

Helpline (UK): 0845 355 5577

Tel: 020 7490 9410

Web: www.afasic.org.uk

A parent-led organisation to help children and young people with speech and language impairments, and their families.

Royal College of Speech and Language Therapists

Tel: 020 7378 1200

Email: info@rcslt.org

Web: www.rcslt.org

Works to improve understanding of all aspects of communication impairment.

I CAN

Tel: 0845 225 4073

Email: info@ican.org.uk

Web: www.ican.org.uk

A national educational charity for children with speech and language difficulties.

National Autistic Society

Helpline: 0845 070 4004

Tel: 020 7903 2599

Web: www.nas.org.uk

Works to provide education, treatment and care to people with autism and related conditions.

4. Behaviour, emotional and social development

The term 'emotional and behavioural difficulties' is used in relation to children who have difficulty controlling their behaviour and emotions. Their ability to learn is affected, and they may also find it hard to operate in a social setting. Many children will go through periods when they are anxious, moody or difficult in response to situations that have arisen at home or at school, but the problems of those with emotional and behavioural difficulties are more intractable. Some will become very withdrawn, while others may be disruptive or disaffected. Statistics suggest that boys are more affected by emotional and behavioural difficulties than girls.

Emotional and behavioural difficulties

Children with emotional and behavioural difficulties have sometimes been described as being unlovable and unloved. Indeed, it seems fair to assume that if they become less loveable it is because they feel unloved. They can make it hard for school staff to build up relationships with them, yet opening positive channels of communication is the main way of reaching them. It takes time and patience to communicate with an uncommunicative child, or to try to understand the disturbed child who, in turn, disturbs the whole class. It is far from easy to strike up a rapport with troubled and troublesome children; even if teachers make the effort, they may not always succeed, but at least they will have given these difficult children a better chance of making a success of their education.

Withdrawn children under-react to situations and may be quiet and passive. They may have a very poor self image and appear unhappy. They may suffer from depression or a deep-seated feeling of insecurity, or they may be emotionally damaged through physical, sexual or verbal abuse.

By contrast, 'acting-out', aggressive children can be a problem to others as well as themselves. Their inability to fit into the socially-accepted norms of behaviour make them difficult to control in the classroom. They may have been over-indulged and allowed to believe that their own needs are more important than anyone else's, or they may have become undisciplined through inappropriate social modelling and/or a lack of care, control or understanding.

Recently, the term 'disaffected' has been used to describe older children who begin to reject their school and its curriculum as irrelevant to their needs.

Try to find out why the child behaves as he or she does

Identification

1. The withdrawn child:

- is expressionless, but deeply unhappy
- is over-sensitive to any criticism – unable to tolerate teasing or personal remarks
- has low self-esteem
- is anxious to conform
- lacks interest in work and under-achieves, but may exhibit obsessive behaviour or an all-absorbing interest in a particular hobby or topic
- may be the victim of bullying and try to avoid coming to school
- is a loner, who is ignored by other children rather than being actively disliked
- is unable to form close relationships and is ill at ease in social situations.

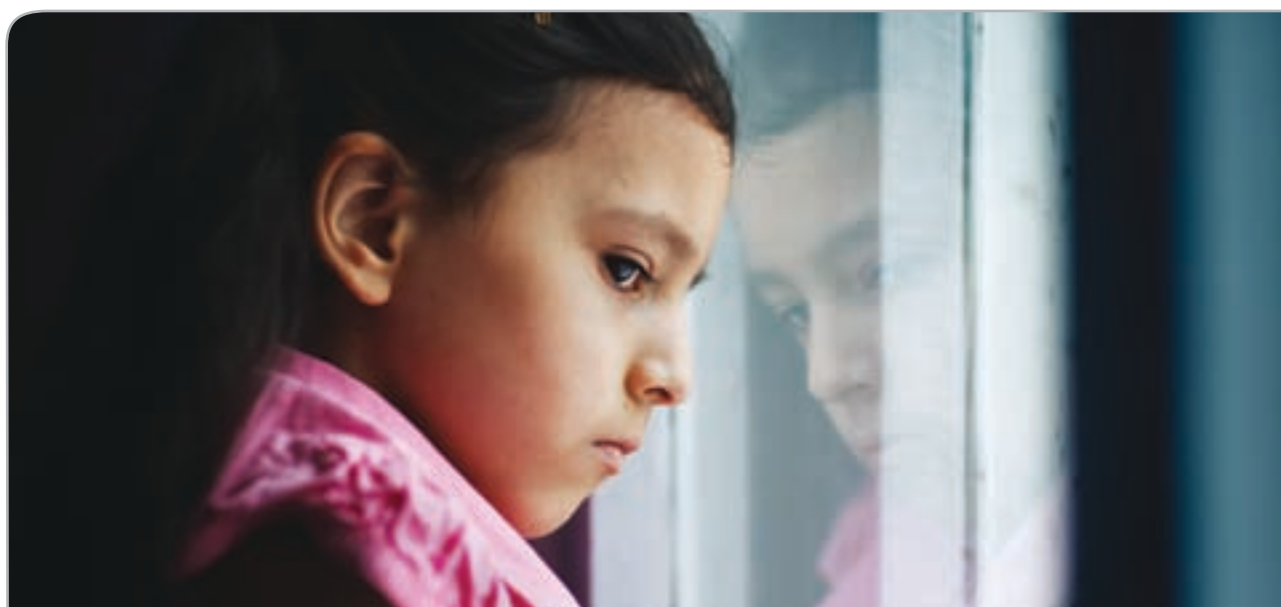
It is easy to overlook the withdrawn child whose needs may be just as great as those of the aggressive, disruptive child.

2. The aggressive child:

- is noisy and demanding, wants his/her own way and immediate attention
- has poor concentration
- is verbally and physically aggressive – will hit out, push, punch and kick, and could be a bully
- shouts out in class and is disruptive
- wanders about and is disobedient
- uses unacceptable language
- disregards rules
- under-achieves
- may truant.

3. The disaffected child:

- is uninterested in school work
- is unmotivated
- fails to complete homework regularly or on time
- is unimpressed by school rules, particularly those relating to appearance
- lacks consideration for others
- may truant.



Strategies

Try to find out why the child behaves as he or she does. A greater understanding may help you and your colleagues to empathise rather than perceiving the child as a nuisance. It is important to convey to the child that, while you disapprove of his/her behaviour, you care for him/her as an individual. Try to be consistent in your approach and, where appropriate, work with colleagues to ensure that the same parameters are laid down for the child, whatever the lesson or occasion.

Depending on the nature of the difficulty, some of the following strategies should also help:

- Try to raise the child's esteem by setting tasks where success is achievable, and give the child regular feedback on progress.
- Provide the child with opportunities to take on responsibilities and give praise when these are carried out.
- Find out what kind of reward matters to the child – stars, certificates, praise, choosing an activity, etc – and use that approach.
- Liaise closely with parents if at all possible, so that the child knows that the home and the school are working together to help him/her.
- Maintain a positive attitude and encourage the child to do likewise. Make it clear that you expect an improvement, but avoid sarcasm.
- Work on the principle that rewarding appropriate conduct is a more effective way to alter behaviour than punishing inappropriate conduct.
- Establish clear class rules and routines that are understood by all (it may be possible to involve some children with emotional and behavioural difficulties in devising the rules in the first place).
- Try to phrase rules in a positive rather than a negative way.
- Remind children of these rules from time to time, but try to avoid nagging.
- Remember that quiet reprimands can be more effective than a public telling-off.
- Help the child to develop social skills, ie knowing how to join in, how to ask for things, how to express his/her point of view.
- Create situations where the child is included in activities first with one other child, and then with a small group. Later on, encourage him/her to join a club or society that he or she will find interesting.
- Find out what his/her interests are, and try to incorporate these in school work, so that motivation increases.
- Be aware of what he/she is good at and provide opportunities for the peer group to recognise these attributes.
- Give as much individual attention and support as possible, so that the child learns that he/she can trust you enough to share his/her worries and concerns.

It is important to convey to the child that, while you disapprove of his/her behaviour, you care for him/her as an individual

Other strategies for aggressive children

- Endeavour to become aware of anything that triggers unacceptable behaviour, and intervene or distract the child before the problem occurs.
- Avoid confrontation whenever possible by maintaining eye contact with the child, using his/her name and not becoming emotional. Sound confident and in control, rather than using a loud voice and threatening gestures.
- If a child is too wound up to listen to sense, don't try to reason with him/her but allow a cooling-off period (up to five minutes for younger children, 10 to 15 minutes for older ones).
- When the child has calmed down, try to find time to discuss together what has happened and how it can be avoided next time.
- Don't expect too much all at once. Work on one aspect of behaviour at a time and reward the child when any progress is made. For example, work on stopping the child calling out for five minutes, then build up to 10 minutes and so on. The same strategy is useful to encourage a child to remain seated and 'on task'.

Other strategies for disaffected children

- Give disaffected children an opportunity to talk about their grievances and help them to see the situation from the school's point of view, eg why there are rules about dress etc.
- Help disaffected children understand that they will get the most out of school not by rebelling, but by concentrating on the positive aspects: companionship, favourite lessons, clubs and activities etc.
- Encourage children to see that the more they put into school, the more they will get out of it; while they remain negative, school will be an unrewarding experience.



Find out what kind of reward matters to the child – stars, certificates, praise, choosing an activity, etc – and use that approach

Bullying

Bullying is one of the most damaging forms of discrimination, whether emotional, physical or both. It can be defined as behaviour, usually repeated over time, that intentionally hurts another individual or group. Examples of bullying behaviour are verbal taunts, ridicule, rumour spreading, physical injury or damage to property. As well as through direct contact, it can take place through more indirect means such as mobile phones or email (cyberbullying). Bullying is sometimes manipulative, for example causing a pupil to do something they are not supposed to in order that they are reprimanded.

Bullying is an especially important issue when working with children with SEN and disabilities, as research shows that these children are more likely to become victims than their peers. In addition, some children with SEN and disabilities may not recognise that they are being bullied or that their own behaviour may be seen by someone else as bullying.

Children with SEN and disabilities may:

- be adversely affected by negative attitudes to disability and perceptions of difference
- be more isolated, not have many friends
- not understand that what is happening is bullying
- have more difficulty in resisting bullies
- have difficulty reporting bullying.



Strategies

Approaches to tackling bullying divide into two categories, preventative and responsive. Preventative work needs to be ongoing, with the aim of providing a consistent ethos and framework, while responsive work involves dealing with the bullying behaviour itself. Preventative work requires the whole school community to agree a set of standards on behaviour in school. In order to achieve this, all learners, parents and staff need to understand exactly what is meant by bullying. Some learners with SEN and disabilities are less likely than others to recognise, let alone report bullying behaviour. They may therefore need help to do this. There are many effective approaches to address bullying behaviour, these should be used within a whole school approach to maximise their effectiveness. Strategies may include:

- posters to remind pupils that bullying is not tolerated
- drama productions about bullying or difference
- online activities including researching topics
- assemblies with a focus around different needs.

Preventative work requires the whole school community to agree a set of standards on behaviour in school

Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) affect at least two percent of the population. These disorders cause children to behave poorly and to underachieve academically, often despite having a good intellect and good home support. There has been much research into the causes of these conditions in recent years, and it is thought that they are due to an imbalance of chemicals in the brain, especially in the area controlling 'self-monitoring'. Drug therapies such as Ritalin re-balance these chemicals, and in this state of equilibrium the child is able to focus his/her attention. Medication is widely used to treat these conditions and has been shown to be effective in 80% of cases in the short to medium term. Other research looking at the effects of fatty acids in the diet suggests that a change of diet can alter the behaviour of some children.

Children with ADD/ADHD often display:

- a poor concentration span
- difficulty in focusing on conversations or instructions – they do not seem to listen
- difficulty in remembering things, and a propensity to lose things
- a tendency to daydream
- difficulty in organising their work – they cannot prioritise
- problems staying 'on task' and finishing work
- difficulty in staying still
- a need to move quickly – they are always 'on the go'
- a tendency to be restless
- problems with considering the consequences of their actions, and with waiting their turn
- a need for immediate reward
- excessive movements
- over-frequent changes of activity
- coordination problems with gross and fine motor skills affected
- problems developing verbal expression – they may have problems sequencing or with stuttering or mumbling

- social clumsiness (misreading social clues, intruding into other people's space).

They are often:

- impulsive
- talkative
- quick tempered
- demanding
- intolerant
- impatient
- unpredictable
- easily frustrated.

Strategies

Children with ADD/ADHD need to be taught how to structure their work, pace activities and manage their emotions.

A structured behaviour programme should:

- build in reminders of what tasks need to be done and by when – tick-lists, diaries, work-plans, etc
- include self-monitoring of completed tasks and behaviour within clearly defined rules
- be consistent
- teach social integration skills
- teach anger management skills.

It may help if you:

- try to keep instructions, routines and rules short, precise and positive
- make eye contact with the child when speaking
- have very clear routines
- liaise with parents and any other helpful organisations or people
- use a variety of short 'stepped' activities to aid learning
- arrange the room to minimise distractions
- use interesting material.

Obsessive Compulsive Disorder

Obsessive Compulsive Disorder affects at least one percent of young people. Although most children experience worries as a normal part of growing up, those with OCD spend at least an hour each day worrying, becoming particularly distressed as a result. The condition is two-fold, with children experiencing an obsession (or several); they fear something may happen, such as something bad to their family or friends, and a compulsion (or several); eg an excessively repetitive act, such as handwashing or saying sorry. Both the obsessions and compulsions can be multiple and varied.

Common obsessions affecting children with OCD:

- order and accuracy
- lucky and unlucky numbers, eg 666, 13
- fear of contamination, dirt and/or germs
- fear of illness
- fear of dying or of someone close dying
- aggressive or suicidal thoughts.

Common compulsions affecting children with OCD:

- ordering or arranging objects
- counting rituals, such as counting backwards or in a specific order
- repeating rituals, such as moving in a certain way
- hand washing, showering and teeth brushing
- avoidance rituals, such as not touching 'contaminated' objects.

If left untreated, OCD can continue into adulthood. However, OCD in children can be identified early and with support is something that can be overcome.

Strategies

The main treatments for children and young people with OCD include psychological treatment or therapy; talking to someone and getting help with anxiety resulting from thoughts or actions. This may include cognitive behavioural therapy with exposure and response prevention.

Only once psychological therapy has been explored fully will medicines be considered; very young children are less likely to be offered medicine.

OCD can continue into adulthood. However, OCD in children can be identified early and with support is something that can be overcome



Tourette Syndrome

Tourette Syndrome is one of a number of 'tic' disorders. A 'tic' is an involuntary movement or sound that is repeated over and over again. It is often worse during times of stress or excitement.

Strategies

- preventing teasing by making sure other children know and understand the condition
- providing 'time out' when tics become disruptive
- allowing the child to sit at the back of the class so he or she doesn't feel 'stared at'
- have a discreet signal so that the child knows he or she can leave the room to release tics in private.

Pupil referral units can offer a very significant second chance to children who gain in self-esteem and begin to make real progress, both personally and academically

Pupil referral units

Pupil referral units (PRUs), also known as short-stay schools, are a type of school established and maintained by an LA to provide education on a temporary basis for children of compulsory school age who are unable to attend a full-time school.

Children may be referred to short-stay schools for a wide range of reasons including exclusion from mainstream or special schools, disruptive behaviour, persistent absence from school, medical and psychiatric problems, or special needs that cannot be coped within mainstream or an existing special school and require further assessment. Probably the great majority of children attending them have emotional and behavioural difficulties and most have a background of underachievement. They can be seen as having SEN although they may not be statemented or undergoing assessment.

PRUs schools are intended to offer short-term placements – for younger children at risk of exclusion this may mean dual registration so that they continue on the roll of their school but also attend a PRU, where work is undertaken that will support their eventual return full-time. With older children the emphasis is on preparing them to make a successful transition to further education, training or the world of work. In practice, re-integration can be difficult to achieve and some children spend longer than is desirable on roll with a short-stay school. These schools offer a range of provisions but are most likely to offer part-time placements.

PRUs are not required to teach the national curriculum nor to undertake assessment at the end of key stages. However, with re-integration as an aim, they need to work with reference to the national curriculum although they will be unlikely to be able to offer the full range of subjects.

PRUs schools may be used inappropriately to cater for children with SEN, and it is worrying that successful re-integration from these schools into mainstream education is often difficult to achieve. However, short-stay schools can offer a very significant second chance to children who gain in self-esteem and begin to make real progress, both personally and academically.



Useful organisations and further reading

Attention Deficit Disorder Information and Support Service

Tel: 0208 952 2800

Email: info@addiss.co.uk

Web: www.addiss.co.uk

Offers advice, information and resources about ADD to parents, young people and professionals.

Tourettes Action

Helpline: 0845 458 1252

Tel: 0207 793 2352

Web: www.tourettes-action.org.uk

Support and research charity for people with Tourette Syndrome and their families.

MIND

Info line: 08457 660 163

Tel: 020 8519 2122

Email: contact@mind.org.uk

Web: www.mind.org.uk

MIND Cymru

Tel: 029 2039 5123

Web: www.mind.org.uk

Mental health charity working for those who are diagnosed, labelled or treated as mentally ill. Activities include campaigning, community development, training, publishing and an information service.

National Institute of Clinical Excellence guidance written for patients and carers

Available to download from

www.nice.org.uk/CG031

ISBN 1-84629-089-9

Bullying Involving Children with Special Educational Needs and Disabilities,

Available to download from

www.teachernet.gov.uk/publications.

ISBN: 978-1-84775-158-4

Managing classroom behaviour,

Available to download from www.atl.org.uk

ISBN: 1 902466 14 4

5. Gifted and talented children

Defining and identifying children as ‘gifted’ or ‘very able’ has been fraught with controversy over the years. Taking a normal distribution of pupil attainment, the top 20% are generally now identified as ‘able children’ and the top two percent as ‘very able’. Under the government’s ‘Excellence in Cities’ programme, those with evident high attainment or latent high ability in one or more academic subjects are taken to be ‘gifted’, while those with evident or latent high ability in a creative or an expressive art or in a sport are taken to be ‘talented’. These definitions are problematic in themselves, implying that music and art, for example, are in some sense ‘not academic’. They also bypass the vexed issue of ‘nature versus nurture.’

Definition

It is widely accepted that able children will have good all-round ability, and will often be divergent thinkers with an aptitude for original ideas. Although learning will come easily to them, they do not necessarily have an easy passage through school. As their intellectual prowess frequently outstrips their social and emotional development, they may find it hard to relate to their peers and to conform. Talented children may also have an uneven pattern of development, since they may have one outstanding talent and yet be otherwise average in attainment.

Apart from spasmodic bursts of concern, very little provision has been made for gifted children, in contrast to the specialist provision that may be available for children with other SEN. Few authorities have advisory teachers for very able children and, apart from those who attend one of the handful of specialist schools, they will be found in mainstream classes. Yet the very able child may find it hard to fit in and benefit from the curriculum on offer.

Identification

Children with a particular talent will be readily identified, provided there is scope for them to exercise the talent at school, or if the home/school links are well enough developed for teachers to be aware of this important area of the child’s life. Very able children may not necessarily be obvious, as some become adept at pretending to be ‘average’ in order to be accepted, or to avoid being teased. Whereas it is acceptable in a school setting to demonstrate physical prowess, superior intelligence is often mocked by other children. Strangely enough, although our school system is geared to academic success, children who are so able that they feel different do not always thrive.



Strenuous efforts should be made to identify gifted and talented children and to meet their needs by stretching them and enabling them to fulfil their potential.

Look out for the child who:

- is exceptionally musical
- excels at sport
- creates three-dimensional working models
- has an advanced moral and social awareness
- is a born leader
- is original, imaginative and creative
- is persistent, resourceful, self-directed and can concentrate for an inordinate amount of time on one topic
- has an unusual hobby, such as astronomy or the study of hieroglyphics
- is inquisitive, sceptical and will argue without giving way
- has an advanced vocabulary
- shows initiative and does not follow the herd
- is versatile and has many interests, although one may be particularly absorbing
- has good judgement and enjoys debating
- has a well-developed sense of humour
- is either unusually extroverted or introverted
- finds it more comfortable and challenging to communicate with adults
- pays great attention to detail
- grasps new concepts with ease
- links areas of knowledge without specific teaching
- is very motivated and self-disciplined
- is a lateral or divergent thinker.

Strategies

Like other children with SEN, very able children need a supportive environment if they are to fulfil their potential. They may have to be helped to become an accepted member of the group. They should be both stretched academically and praised.

Some of the following strategies may help:

- Make sure the gifted child is not afraid to show his/her ability.
- Recognise the child's individuality, but encourage him/her to mix socially.
- Give stimulating work, so that the child doesn't 'switch off'.
- Provide opportunities for enrichment and working in depth, as opposed to simply accelerating the child's path through the basic curriculum.
- Make sure he/she is sufficiently challenged by giving scope for individual research in an area of interest.
- Encourage the school to build up a resource bank of extension/enrichment material.
- Do not be put off if the child outstrips your knowledge in some areas; treat this as a bonus and make use of it.
- Make use of a research model of working, where both children and teacher operate at the boundaries of their own knowledge.



- Help the child to become self-critical and evaluate his/her own work.
- Give the child responsibility for organising some of his/her own work.
- Help the child to work in a team situation at times.
- Help the child to feel valued as a person, not just because of their unusual gift.
- Try to ensure that he/she has contact with children of similar ability or adults with similar interests.
- Consider whether there is enough flexibility in the system to allow gifted children to work outside their age group for some of the time.
- Provide appropriate, and properly differentiated, homework and school work and ensure that it does not involve irrelevant practice.
- Work closely with parents.
- Encourage the gifted child to take part in games such as chess and bridge.
- Give him/her information about out-of-school clubs and associations involved with able and gifted children.
- Provide information about community resources, eg museums and theatres.
- Involve parents and encourage them to take the child on visits and answer his/her questions.

Give the child responsibility for organising some of his/her own work



Useful organisations

Gifted Children's Information Centre

Tel: 0121 705 4547

Offers free telephone counselling.

National Association for Gifted Children

Helpline: 0845 450 0295

Tel: 01908 646 433

Web: www.nagcbrtain.org.uk

Works to support gifted children and their families. Also provides information regarding gifted children.

6. SEN and English as an additional language

To quote the 2002 Code of Practice, ‘the identification and assessment of the special educational needs of children whose first language is not English requires particular care. Lack of competence in English must not be automatically equated with learning difficulties’.

The UK is a multicultural and multilingual society, and linguistic diversity is the norm in many classrooms. The term ‘bilingual’ can often be an understatement of the number of languages to which a child is exposed and the term ‘multilingual’ may actually be a more accurate description of many children.

Definition

The problem with the term ‘bilingualism’ is that it gives no indication of the degree of proficiency in the languages spoken. It is therefore helpful to define the term ‘bilingualism’ in the following ways:

- Balanced bilinguals – people who function equally well in two or more languages. Some definitions demand complete fluency in all language skills, including reading and writing. The majority of bilingual children would not fulfil this criterion.
- Dominant or incipient bilinguals – people who may have only the surface aspects of a second language. The majority of two-language speakers in the UK fall into this category.
- Semilinguals – people in whom neither language has been fully developed, preventing them from operating successfully in either language. Although a minority group, there are considerable difficulties involved in dealing with semilingual children.

Bilingual learners may come from any of the following groups:

- Those born outside the UK with home languages other than English. This group may include refugees, those with little or no schooling and those with excellent skills in literacy and oracy.
- Those born in the UK who have little initial experience of English on school entry, as they are not exposed to much English, either at home or in the wider community.
- Those whose parents have been born and educated in the UK and for whom English is the preferred language for daily communication, although one or more other languages may also be used within the home.

Children from these groups will have different starting points, knowledge about language and experience of using English. There are bilingual children who may have SEN in any of the areas identified in the Code of Practice, and these children have the same rights of access to the Code of Practice procedures as monolingual children. Outside agencies who become involved with the child should always be aware of his or her specific requirements with regard to language.

If both languages are fully maintained, bilingualism is educationally enriching and can have a positive effect on intellectual performance

Identification

The Task Group for Assessment and Testing Report of 1988 expected bilingual children to have 'difficulties' and 'where this problem is so severe', exemption from the SATs assessment would be allowed. A 'low level of performance' is expected, indicating the need for special help in 'English language skills'.

Clearly, if a child is not a balanced bilingual, he or she will be disadvantaged when being assessed against English attainment targets. The subsequent 'low level of performance' may well be regarded as learning difficulty, especially as some of the characteristics of children learning an additional language are similar to characteristics of cognitive difficulties demonstrated by children with SEN – for example a failure to grasp basic concepts within a subject area, or underachievement in the area of literacy.

The old assumption made about bilingual children was that they suffered due to having two languages, that in school language should be monolingual and English, and that any underachievement was due to the mental confusion of having two languages. The project team for Language in the Curriculum (LINC, 1992) contradicts this view:

'This is not so; multilingual language learning is not subtractive... but mutually additive, whereby the growth of competence in one language enhances that in another through constant comparison of the ways the two languages achieve... or sometimes fail to achieve... identical or similar meanings'.

There is also good evidence from cognitive psychology that if both languages are fully maintained, bilingualism is educationally enriching and can have a positive effect on intellectual performance. There will, however, be a minority of children whose progress gives cause for concern. The difficulties of disentangling problems in 'learning the language' from 'learning difficulties' or SEN are compounded when there is an open acknowledgement by educational psychologists that the most traditional assessment procedures are inadequate.

Every person assessing a bilingual child must avoid two potential errors:

- diagnosing a learning difficulty when one is not present, so labelling the child inappropriately, and perhaps instituting an IEP that may detrimentally alter the method of teaching or place the child into an unsuitable environment
- failing to diagnose a learning difficulty, so not providing entitlement to the Code of Practice processes or specifically targeted and appropriate help.



Strategies

Consider some of the following strategies to support children:

- Wherever possible, conduct a full bilingual language assessment to determine language proficiency.
- See the first language skills of the child as a valuable potential channel for supporting their learning.
- Do not assume that because a child is fluent in the daily social routines of the classroom (which are often cognitively undemanding and context-embedded), that he or she will be able to perform with a similar level of competency across the curriculum.
- Ensure access to a broad and balanced curriculum: lack of fluency in English need not prevent a bilingual child from working at an appropriately demanding level in mathematics, in arts subjects or in sport.
- Make every effort to ensure that assessment is as culture-fair as possible, even if it cannot be culture-free.
- Use non-verbal tests where possible.
- Carefully review items used in assessment that require verbal or visual recognition, for example:
 - household objects, such as furniture and kitchen utensils
 - vehicle types, such as ambulances and police cars
 - sports equipment or actions
 - Outdoor fixtures and building types

- values represented by pictures such as freedom, honesty, etc
- professions, such as doctor, judge, firefighter
- clothing
- historically-related items.

Items such as these do not need to be omitted but potentially biased items should be marked so that it is possible to monitor how the child performs.

- Remember that straightforward simplification of tasks is not appropriate for bilingual learners – this can result in divorcing the learning from meaning, making the work harder rather than easier to understand.
- Using actual size, real life objects are more successful than trying to operate with abstract concepts.
- Make use of dual language books to allow the parents to support reading development.
- Keep the parents informed. This may mean enlisting the support of an interpreter, but care needs to be exercised as there are issues regarding confidentiality and appropriateness.

Support for children for whom English is an additional language is most fruitfully delivered in the mainstream classroom and any withdrawal should be carefully considered. Within the mainstream classroom, children will still have access to all aspects of the national curriculum, will maintain relationships with their peers and will be exposed to a wider range of language models.



Useful organisations and further reading

A Parents' and Teachers' Guide to Bilingualism

Baker, C (2000)
Multilingual Matters Ltd.
ISBN: 1853 594 563

Refugee Council

Tel: 0207 346 6700
Web: www.refugeecouncil.org.uk

Provides impartial advice to refugees and asylum seekers, and those who work with them.

7. Portage

Portage is a home-visiting educational service for pre-school children who have special needs. It is based on the common-sense principle that parents are the key figures in the care and development of their child. Portage assesses the needs of a child with SEN, and then, in partnership with parents, builds on the abilities that the child already has, teaching skills that the child has yet to master.

A portage team of home visitors offers a carefully structured but flexible system to help parents become effective teachers of their own children. Portage aims to help parents continue to gain satisfaction and success in their role as the main influence on their child's development. With portage, the parent/child link is consolidated and enriched.

Portage home visitors have wide experience of working with families and children. Among those working as portage home visitors are teachers, nursery nurses, health visitors or speech therapists, and everyone involved in providing or managing a service is specially trained in portage methods.

Increasingly, portage is becoming involved in supporting children with special needs in maintained and private nurseries. The portage service will advise early years settings on ways of including children with a variety of special needs.



Useful organisations

National Portage Association

Tel: 0121 244 1807

Email: info@portage.org.co.uk

Web: www.portage.org.uk

Offers advice and information about portage.

8. ICT and special educational needs

There are numerous ways in which information and communications technology (ICT) can be used both to support learning and to provide access to learning for children with SEN. Its use is most effective when planned as part of a continuing programme. Through the use of ICT resources, children are able to concentrate on the content of learning without being disadvantaged by their particular special needs.

Computers should be used as a tool to aid both the teacher and the child. By using certain software, worksheets can be made more visual with the introduction of pictures or symbols. Word banks can be created to ease the writing process.

It is essential that pupils have access to appropriate ICT resources and that teachers and support staff have appropriate training in specific equipment and software. For some children, accessing a computer may be difficult, but there are ways of reducing or solving these problems. In recent years, major developments have taken place in using ICT to provide greater access to all subjects of the curriculum, especially in arts subjects. Subject-specific guidance is issued from time to time by the Qualifications and Curriculum Development Agency and subject associations.

Computer keyboards now come in a variety of sizes. Key guards may be helpful for children with weak muscles who need support for their hands without depressing all the keys. Keyboards are available with the letters in alphabetical order as well as in the original 'qwerty' layout.

The computer mouse may be difficult to manipulate for some children. A trackerball may be used as an alternative to a mouse, with the child being able to roll the ball to move the pointer across the screen. The 'click and drag' operation on the mouse is then converted to a single press on a particular key.

Concept keyboards allow users to design their own overlays and can be used independently or in conjunction with the standard keyboard. Children who tire easily when required to write using the keyboard find this particularly helpful.

Speech-activated word-processing programmes are now available. These, together with sound and animation, all enhance the use of the technology and act as a motivator for certain users.

LA support services and other organisations can help assess particular ICT needs for children. For children with statements, some equipment may be funded from the LA, usually after an assessment of the child's ICT needs has been carried out. Technology is a fast-moving industry and new products are continually being developed. Children's needs also change, and so it will often be necessary for ICT assessment to take place on a regular basis.

Children's needs also change, and so it will often be necessary for ICT assessment to take place on a regular basis





Useful organisations

Aiding Communication in Education Centre Advisory Trust

Tel: 01865 759 800

Email: info@ace-centre.org.uk

Web: www.ace-centre.org.uk

Aiding Communication in Education – North

Tel: 0161 358 0151

Email: enquiries@ace-north.org.uk

Web: www.ace-north.org.uk

An independent charity offering information, support and training for parents and professionals in the use of technology for young people who have communication difficulties.

The Advisory Unit: Computers in Education

Tel: 01707 281102

Email: sales@advisory-unit.org.uk

Web: www.advisory-unit.org.uk

Independent organisation offering IT services and educational software to schools. Can offer specific information on special needs requirements.

Inclusive Technology Ltd

Tel: 01457 819 790

Email: inclusive@inclusive.co.uk

Web: www.inclusive.co.uk

Suppliers of a range of resources that facilitate the use of technology by people with special needs.

SEMERC – Granada Learning

Tel: 0845 602 1937

Email: info@granada-learning.com

Web: www.granada-learning.com

The special needs division of Granada Learning; offers advice to teachers and parents on ICT, curriculum and special needs issues.



9. Further education and special educational needs

Much of the practical information on SEN in this book will be relevant to students and lecturers in further education, although clearly structures and access to services are not the same as in the maintained school sector.

It is not a statutory requirement for an FE college to have a SENCO or someone with a similar title to oversee SEN provision, but government guidelines recommend it and most colleges will have one. The same is true of staff to support students with SEN in mainstream teaching sessions. Although these are not statutory, FE colleges must 'have regard to' the SEN of students, and in some instances this will mean providing support staff in mainstream teaching. If the college has a special unit – for example for teaching independent living skills to students with learning difficulties – its staff may well be involved in supporting these students (often unobtrusively) when they mix with other students in social situations or activities.

Funding for additional learning support in FE is provided by LAs, with support from the Young People's Learning Agency, with a specific statutory duty to consider the needs of people with learning difficulties and/or disabilities in discharging their duties. Providers funded by the LAs must have regard to the Disability Discrimination Act 1995 and the Special Educational Needs and Disability Act 2001. A distinction is made between additional learning support (teaching etc) and learner support (equipment, special transport, signers for the deaf, costs of childcare etc). Additional learning needs are assessed using diagnostic tools or a statement of SEN. Information to inform assessment should be passed on by the Connexions service.

A separate category of additional social needs is also recognised, and these are identified via a list of nine 'barriers to employment'.

To support a disabled student within mainstream further or higher education, the university or college needs to enable the student to access not only direct teaching – lectures, tutorials and seminars – but also libraries, information and materials relevant to the course, facilities within the college, practical activities, general welfare services and, if necessary, accommodation. There are also social life needs, in particular interaction and socialising with fellow students. For students with a sensory impairment, a college-wide policy on communication is necessary to enable integration and inclusion of students with their peers. Specific awareness training is therefore essential.

Strategies

Support should be forthcoming from the college staff and through the college's disability officer and students' union. Consulting with the student to identify his or her needs will help colleges to address them and to put in place relevant provision. The most important need to be established is communication and the method by which the student can best access teaching.

For students with a sensory impairment, these needs are generally addressed by using the most relevant interpreting method:

- British Sign Language
- hands on signing
- deafblind manual alphabet
- keyboard interpreting, with dialogue interpreted through either large print or braille
- Sign Sighted English
- Tadoma
- lipspeaking.

The structure of lectures, tutorials and seminars should be reconsidered in order to address practical implications arising from the use of interpreters. The following issues should also be considered:

- the environment
- interpreter breaks
- an awareness on the part of fellow students and tutors.

Mainstream provision is not appropriate for all SEN students. For example, the nature of deafblindness in particular often results in developmental delay. There is specialist college provision for deafblind young people, based on the belief that this group have the right to a continuing education programme, and that they have much still to achieve between the ages of 19 and 24. The focus of this further education centres on developing independence, social and life skills within a supported communicating environment. Frequently, residential colleges enable a 24-hour learning programme and consistent communication support in a variety of settings.

For advice about students with special needs, lecturers' first point of reference should be the SENCO or their equivalent at the college. Most FE colleges (except very small institutions) will also have a college nurse who can give some advice on medical aspects of SEN.

The main external sources of support and advice on special needs for FE colleges are LAs, which have support from the Young People's Learning Agency in discharging their planning and commissioning functions and ensuring funding and budgetary control within the system. Informal networks of lecturers working in SEN also exist, while the Learning and Skills Improvement Service and the Learning and Skills Network run courses for the professional development of further education staff.



Useful organisations

Skill: National Bureau for Students with Disabilities

Information service line: 0800 328 5050
Tel: 020 7450 0620
Email: info@skill.org.uk
Web: www.skill.org.uk

Skill in Northern Ireland

Tel: 028 9028 7000
Email: admin@skillni.org.uk

Promotes opportunities for young people and adults with any kind of disability in post-16 education, training and employment. Provides individual support and advice as well as a range of printed material.

Young People's Learning Agency

Tel: 0845 019 4170
Email: enquiries@ypla.gov.uk
Web: www.lsc.gov.uk

Responsible for planning, allocating and funding education and training for 16 year-olds in England.

LSN

Tel: 020 7492 5000
Email: enquiries@lsnlearning.org.uk
Web: www.lsnlearning.org.uk

Strategic resource for the development of policy and practice in post-16 education and training.

Appendix 1

Special Educational Needs Coordinators

The 2002 SEN Code of Practice outlines the roles and responsibilities of the SENCO as follows (paragraph 1:39):

‘the SENCO... working closely with the headteacher, senior management and fellow teachers, should be closely involved in the strategic development of the SEN policy and provision. The SENCO has responsibility for day-to-day operation of the school’s SEN policy and for coordinating provision for children with SEN, particularly through School Action and School Action Plus.’

It also states that the key responsibilities of the SENCO may include (paragraphs 5.32 and 6.35):

- overseeing the day-to-day operation of the school’s SEN policy
- coordinating provision for children with SEN
- liaising with and advising fellow teachers
- managing learning support assistants
- overseeing the records of all children with SEN
- liaising with parents of children with SEN
- contributing to the in-service training of staff
- liaising with external agencies including LA support and educational psychology services, health and social services, and voluntary bodies.

The 2002 SEN Code of Practice states quite unequivocally that SENCOs need adequate non-contact time for planning and coordination, record-keeping, managing and supporting learning support assistants, observing children, and liaising with colleagues and other schools (see paragraphs 5.33 and 6.36).

It also states that it would be inappropriate for a SENCO to have other management responsibilities, the role being ‘at least equivalent to that of curriculum, literacy or numeracy coordinator’, (see paragraphs 5.34 and 6.37.) and implies that it will usually be appropriate for the SENCO to be a member of the leadership group.

SENCOs should also have access to ICT for SEN management systems and for preparing and recording IEPs (paragraphs 5.36 and 6.39).

SENCOs can only fulfil their responsibilities if they have the full support of governors, senior management and their colleagues, and of the LA.

Recommendations for SENCOs:

- get training on time management – you will need it
- pace yourself
- admit you don’t know things – ask for expert help
- request staff support – SEN is everyone’s responsibility, not just the SENCO’s
- maintain close dialogue with your headteacher and with the SEN governor.

As of September 2009, all SENCOs must either have QTS or be on track to get QTS by September 2011. Also since September 2009, regulations require new SENCOs to achieve the national award for SEN coordination. The Training and Development Agency for schools developed a framework of nationally approved training for teachers new to the role of SENCO. Training takes approximately a year to complete and SENCOs will have up to three years from when they are designated as lead SENCO to achieve the qualification.



Appendix 2



Useful organisations

The Alliance for Inclusive Education

Tel: 0207 737 6030

Email: info@allfie.org.uk

Web: www.allfie.org.uk

A national network offering materials and ideas for people interested in inclusive education.

Association of Educational Psychologists

Tel: 0191 384 9512

Web: www.aep.org.uk

Professional association and trade union for education psychologists in England, Wales and Northern Ireland.

The British Psychological Society

Tel: 0116 254 9568

Email: enquiry@bps.org.uk

Web: www.bps.org.uk

Responsible for the development and promotion of psychology, and for the application of psychology for the public good.

Inclusion UK

Web: www.inclusion.org

A consortium of four organisations supporting inclusion in education.

Department for Education

Tel: 0870 000 2288

Web: www.education.gov.uk

Government department responsible for education. The website provides a wide range of advice and materials for teachers, parents and others interested in or working with children with SEN.

Disability Wales

Tel: 029 2088 7325

Email: info@dwac.demon.co.uk

Web: www.disabilitywales.org

National association of disabled people's organisations in Wales.

Independent Parental Special Education Advice

Advice line: 0800 018 4016

Web: www.ipsea.org.uk

Offers free independent advice on special educational needs, advice on appealing to the Special Educational Needs Tribunal, and second professional opinions.

Appendix 2 – continued



Useful organisations

National Association for Special Educational Needs

Tel: 01827 311 500

Email: welcome@nasen.org.uk

Web: www.nasen.org.uk

Aims to promote the education, training, advancement and development of all those with SEN. Has over 60 branches across the country and 11,500 members.

National Children's Bureau

Tel: 020 7843 6000

Email: enquiries@ncb.org.uk

Web: www.ncb.org.uk

The centre of several networks through which professionals involved in supporting children can learn from each other and develop policy.

Found this helpful? ATL has lots of other resources – all free to members – that you might be interested in:

Assessment literacy for wise decisions
Product code: PED09

Managing classroom behaviour
Product code: PED01

Supporting education
Product code: PED15

Finished with your copy? Pass it on to other colleagues who might find it useful.



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