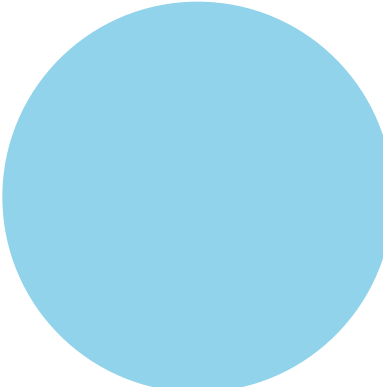
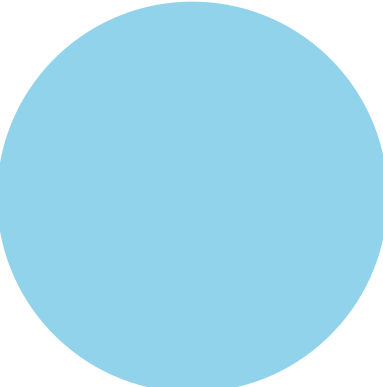
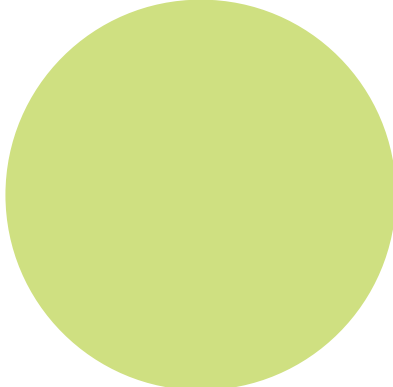
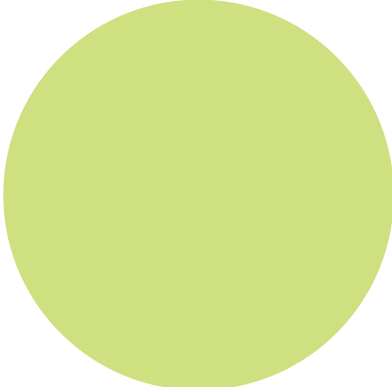
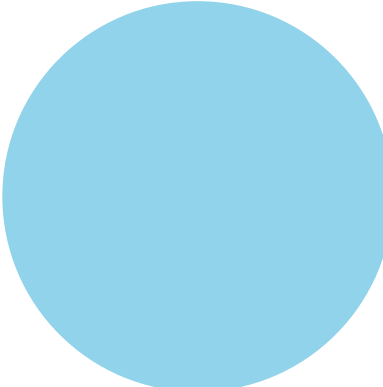
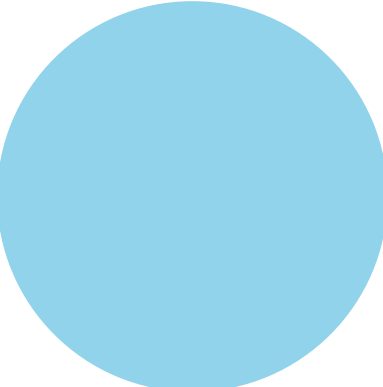
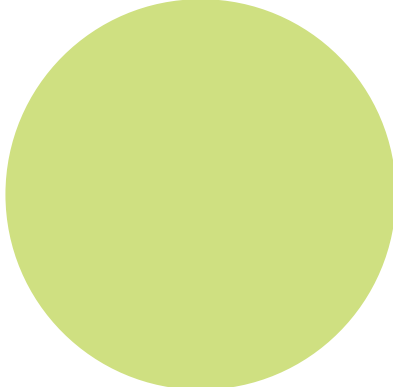
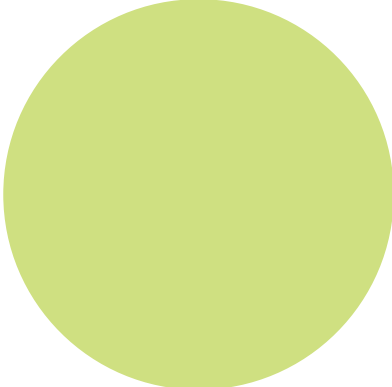
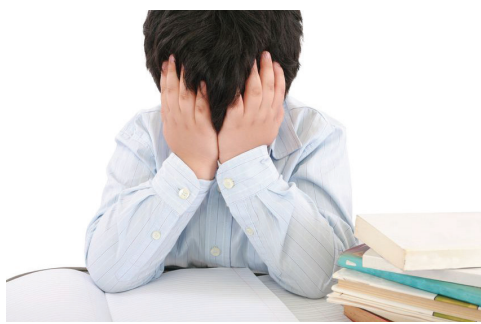


Special Educational Needs in the Early Years.



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1. Introduction

The wholehearted acceptance of those with special needs is an unquestionable element of basic humanity expected of any civilised society. Indeed, as this playworker account confirms, even young children can apply this principle naturally and intuitively:

‘He was a normal little boy with a love of play and sport, and a real competitive nature. But his legs didn’t work very well and he spent a lot of time on his hands and knees. He was a great crawler!

One sports day he lined up with other kids for a beanbag race. When it was his turn to race, the boy who lined up against him, when he saw who he was up against, just instinctively dropped to his hands and knees without any cue or instruction so that they could have a fair race. I thought that was quite special.’

(Voce, 2016)

However, chapter two’s overview of the SEN landscape reveals that our modern society has often been unforgivably slow to adopt dignifying legislation for children with special needs. Now that mainstream inclusion is a legal obligation, teachers and other early-years professionals have an important responsibility, outlined in chapter three, to ensure any necessary support for language – a child’s primary learning tool – is promptly put in place.

Chapter four outlines the puzzling field of autistic spectrum disorders (ASD), a suite of conditions which remain poorly understood. Besides presenting as a crippling disability, ASD phenomena also include savants and the paradoxical enigma of Asperger’s Syndrome. Following this, chapter five looks at learning difficulties and the process of assessment. Researchers have found intelligence a tricky concept to measure, and often fail to explain why those labelled as less intelligent so often share a similar socio-economic background.

Dyslexia, which is discussed in chapter six, is another example of a relatively common learning impairment which stubbornly refuses to surrender all its causal secrets. Here, the contemporary inter-disciplinary elements are unravelled and traced over time, and areas of common ground are identified and evaluated.

Examining behavioural, emotional and social difficulties (BESD), chapter seven notes BESD’s relative position on the mental health continuum, delves into some biological, cognitive and behavioural explanations, and also considers parenting issues. With boys still driving the statistics, chapter eight focuses upon ways of conceptualising BESD, and charts remedial measures operating at various levels.

This exploration of special needs concludes with two chapters on impairments more readily discerned but no less life-changing in their impact: chapter nine, which addresses sensory needs, and chapter ten’s analysis of physical needs. In each case, research suggests younger educational practitioners seem more accommodating, whilst some of those with such impairments entirely reject the notion their condition is a deficit.

Naturally, all children in early years settings are fully dependent upon the sound knowledge, proficient skills and watchful vigilance of childcare professionals who have a unique opportunity to request early SEN interventions whenever such action may appear necessary. Time and again this vital function has proved pivotal for the enhanced development and upgraded life prospects of vulnerable children – and long may it continue.

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2. The road to entitlement: An overview of Special Educational Needs in the early years

Just as elsewhere in the wider community, some children in an early years setting may have special needs associated with a physical or medical condition. Often, this will have no influence on their ability to learn, but if learning capacity should be impaired, then their education may fall within the remit of Special Educational Needs (SEN) legislation. Institutional responsibility for this sometimes poorly understood educational provision is usually delegated to a specific member of staff, whilst other colleagues, and most parents, may find its complex web of regulations bewildering and even a little intimidating. For those wishing to learn more, this chapter outlines the evolution of the SEN concept which informs the education of many of our children.

Out of the shadows

As in many other cultures, we have inherited our notions of disability and impairment from a medieval world of demons and punishment. Meighan (1981) believes this mix of history and myth is still echoed in our contemporary society via the ‘negative labelling of “special” or “handicapped” children’ often ‘cloistered away from the general public’. Centuries later, scientists from the Age of Enlightenment developed a more-informed understanding of many disabling conditions as medical science began to discover a range of relieving treatments and cures. Unfortunately, these celebrated advances were also accompanied by a tendency to map and classify the attributes of human ‘normality’, immediately stigmatising anyone unable to meet such specifications as ‘abnormal’. Even more importantly, the outcome of such pronouncements often condemned individuals to a dismal life of exclusion and segregation – a practice which was still relatively common during much of the 20th century.

SEN legislation



Figure 2.1 The pathway to inclusion

In the world of education, the SEN child’s journey from harsh segregation to integration and enlightened inclusion can be tracked via legislative reforms, as shown in the timeline of significant initiatives (Figure 2.2).

Though the first UK special school dates from 1791, and the 1834 Poor Law Amendment Act made special provision for children with disabilities, the Education Act (1944) was the first significant attempt to sketch a Special Needs landscape. This legislation introduced 11 classes of ‘disability of mind or body’ and endorsed separate special schools, whilst still declaring some children ‘educationally sub-normal’, or even ‘ineducable’.

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Prompted by the groundbreaking Warnock report of 1978, the 1981 Education Act switched the focus from group classification to individual needs, and established the principle that, wherever possible, children with special educational needs belonged in mainstream education. Then, under the Education Act (1996), every local education authority (LEA) was obligated to inform parents of children with SEN about the local services available.

More radical change in England was effected through The Children Act (2004) which advocated inter-agency working and, for example, ensured the integration of SEN provision in school- and early years settings. Whole-system reform became a priority, with transformative frameworks such as ‘Every Child Matters’ (DfES, 2004) detailing what the changes should look like. The consolidating Equality Act of 2010 then outlawed discrimination against any child with SEN – for example, making it unlawful for any early years setting to operate a discriminatory admissions policy.

The latest SEN reforms are incorporated within the 2014 Children and Families Act, which places children and parents at the core of the system: Inclusive Education Health and Care (EHC) Plans replace SEN Statements, the LEA and all other agencies must work collaboratively, early identification is paramount, and seamless SEN support is promoted from birth to age 25.

Year	Legislation	Focus
1791	First Special School	SEN provision
1834	Poor Law Amendment	Specific disability provision
SEGREGATION		
1944	Education Act	Attempt to detail special needs
1978	Warnock Report	SEN children brought into mainstream provision
INTEGRATION		
1981	Education Act	Introduced concept of individual needs
1996	Education Act	Proactive entitlement
INCLUSION		
2004	The Children Act	Integrated SEN provision for schools & early years
	Every Child Matters	Detailed transforming framework
2014	Children & Families Act	SEN support entitlement 0-25

Figure 2.2 Timeline of legislation with an SEN focus

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This statutory framework can be read as a welcome streamlining and development of contemporary SEN best practice. However, it will be clear to early years practitioners that the renewed emphasis on prompt action and multi-agency data sharing, plus the explicit reference to access and entitlement from birth, now places childcare professionals at the forefront of the process of detection and assessment of possible educational disadvantage, which may often trigger SEN intervention.

The disability debate

Those likely to encounter SEN contexts should be aware the concept of disability can be controversial. Early assumptions (and some SEN legislation), as Devarakonda (2013) and others have observed, cast disability as:

‘... a problem that was within the individual and had to be fixed or cured by therapy or special treatment. The focus was on the impairment of the child.’

This view is described as the ‘medical model’ (see Figure 2.3) and opponents argue it seeks to adapt those with a disability to conform to the needs of a non-disabled world, and prescribes segregation for those who cannot comply.

In contrast, a more recent view known as the ‘social model’ (see Figure 2.3) considers that, even though impairment and chronic illness are a difficult reality:

‘Disablement is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers.’

(Disabled Peoples’ International, 1981)



Figure 2.3 *Opposing interpretations of disability*

Frederickson and Cline (2009) note that, according to this perspective, ‘wheelchair users would not be seen as people with a mobility problem. Instead they would be seen as people whose mobility is often hampered by inappropriate building design.’

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Each view has its partisan adherents, but most modern legislation and educational best practice adopts an ‘interactional’ perspective (see Figure 2.4) which views SEN needs as ‘a complex interaction between the child’s strengths and weaknesses, the level of support available, and the appropriateness of the education ... provided.’

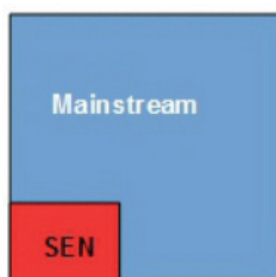


Figure 2.4 *Interactional perspective*

Integration or inclusion?

Modern SEN legislation anticipates the majority of all children with SEN will be educated in mainstream settings. Nevertheless, as Thomas & Loxley (2001) and many others insist, ‘inclusion is about more than merely the integration of children from special schools into mainstream school’. Ainscow (1995) characterises this essential difference by asserting that, with institutional integration, limited arrangements are made for a few children with SEN without changing much else, whereas inclusion implies more radical change and restructuring, thereby enabling an institution to embrace all children – as illustrated in Figure 2.

Integrated Provision



Inclusive Provision



Figure 2.5 *The difference between Integration and Inclusion*

In any truly inclusive educational setting, all students must feel accepted as ‘one of the family’. And as Savage (2015) points out, an early years facility can hardly claim to promote equal access if ‘a group of boys dominate the outdoor play area ... or a child with impaired sight tends to be marginalised at story time.’

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The implications of disability

The UK's SEN Code of Practice (Department for Education and Skills (2001a)) arranges SEN needs as outlined in the following table:

A	Cognition and Learning Needs	difficulties acquiring basic skills or understanding information
B	Behaviour, Emotional and Social Development Needs	difficulties making friends, relating to adults, behaving properly
C	Communication and Interaction Needs	difficulties affecting children's ability to express themselves, or to understand others
D	Sensory and/or Physical Needs	medical/health conditions which make it much harder for a child to learn

Table 2.1 SEN Code of Practice

All experienced academics and practitioners highlight the critical importance of early intervention. However, as Roffey (1999) cautions, childcare professionals must be aware families may not always offer their full support:

‘Their reluctance may stem from having experienced a lack of sensitivity and from feeling blamed or guilty as well as having to struggle to accept their child’s difficulties.’



Figure 2.6 The SEN burden for families

Such attitudes are not hard to understand if one considers the multiple extra burdens families are asked to cope with, as depicted in Figure 2.6:

- care for a child with SEN can be exhausting, impacting on the lives of parents and other siblings;
- bringing up a child with a disability is always more costly;
- negative community attitudes lead to social exclusion, and disability still carries a stigma in some cultures;
- a child with SEN needs is more likely to experience poverty, and poverty exacerbates impairment;
- a child’s longer-term future can be a particular worry for families.

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For childcare professionals with responsibility for children with SEN, a sensitive attitude is a must. Whilst (as regards disability) our wider society is often embarrassingly wedded to stereotypes and sensation – think of the silver screen portrayal of Dickens’ Tiny Tim, and news coverage of the trial of Oscar Pistorius – most children with a disability yearn to be accepted on par with their friends, and don’t wish to be defined by their impairment.

Beyond sensitivity, professionals must ensure they are aware of the basic implications of any condition or disability, otherwise, as Capel et al. note, they risk unforgivable errors:

‘... children who have obvious physical disabilities such as cerebral palsy often find they are treated as though their mental abilities match their physical abilities when this is not the case.’

(Capel et al., 1995)

The language of inclusion

Nowhere is acceptance more clearly offered, or withheld, than via the language society uses to communicate with, or about, those with disabilities. In an early years setting, professionals should use respectful language which acknowledges that children with SEN, just like their classmates, are active individuals who have the same right to grow and take control of their own lives.

For example:

- Wheelchair users don’t think of being ‘confined to’ a wheelchair – it’s a mobility aid.
- Avoid negative medical labelling: ‘suffers from’ implies a patient in constant pain and despair. Use ‘has epilepsy’ (etc. as appropriate) instead.

Watch your language!

Don't say ...	When you could say ...
✗ able-bodied	✓ non-disabled
✗ mentally handicapped	✓ with a learning disability
✗ the blind	✓ people with visual impairment
✗ the deaf	✓ people with a hearing impairment
✗ a diabetic (etc.)	✓ a person who has diabetes
✗ fits, spells, attacks	✓ seizures

Table 2.2 Inclusive language

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And finally ...

The best way to gain the confidence of a child with SEN is to use a normal tone of voice while speaking directly to the child – even if they have an interpreter. Also, never finish the child’s sentences – just give them plenty of time to respond. For those unfamiliar with SEN environments, there can seem lots to remember, but with a little background work it’s more about attitude than anything else.

So don’t worry endlessly about political correctness; if you can relax and speak to a child with SEN using the everyday language you would use with any other child, you’ll find the visually impaired will be very happy to ‘see’ you, and wheelchair users will be simply queuing up to ‘go for a walk’ with you!



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3. Language acquisition: A key learning tool

For every learner, the use of language is also a critical component which lies at the heart of learning in its broadest sense. It is essential to human thought, communication and social interaction, allowing the transmission of ideas, concepts and understandings, and also serving as the principal means by which individuals order their own social experience and conduct their social relationship with others. Furthermore, as Meighan (1981) notes, children developing their own language skills soon begin to notice the detail of how others communicate:

‘... the linguistic rules they seem to obey, the styles to which they appear to conform, and the particular symbols they employ to describe the world,’

and use these observations to shape their own speech.

The diagram in Figure 3.1 below outlines the basic elements of a communication encounter:

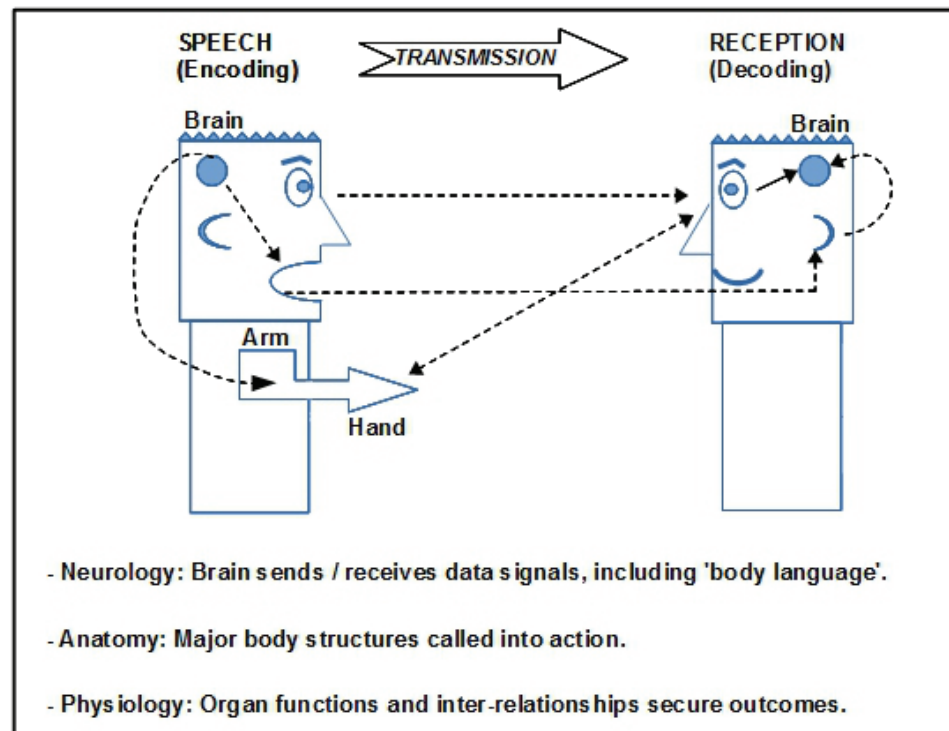


Figure 3.1 The communication process

(Developed from Crystal and Varley, 1998)

For a broad range of reasons, children with SEN may not have managed to acquire sufficient competence to control every aspect of this complex communication chain. Frederickson & Cline list the five key language competences which effective communication demands as:

- Phonology and syntax – how words sound and fit together;
- Semantics – the meanings of words;
- Pragmatics – the social conventions which apply;

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- Conversational competence – the ability to customise speech to the needs of each listener;
- Sociolinguistic competence – understanding how social and cultural contexts impact upon language conventions.

(Frederickson & Cline, 2009)

The role of assessment

Individual assessment is essential to explore and understand the possible implications of any impairment. For example, a young child blind from birth may learn a new object word, such as ‘towel’, quickly enough but seem to have much greater difficulty than his classmates in grasping how the word can be extended (e.g. its transferable use in multiple contexts: from the kitchen to the bathroom and beach, paper towels etc.). Although linguistic experts may disagree about why this may happen, most accept that the lack of visual feedback plays an important part.

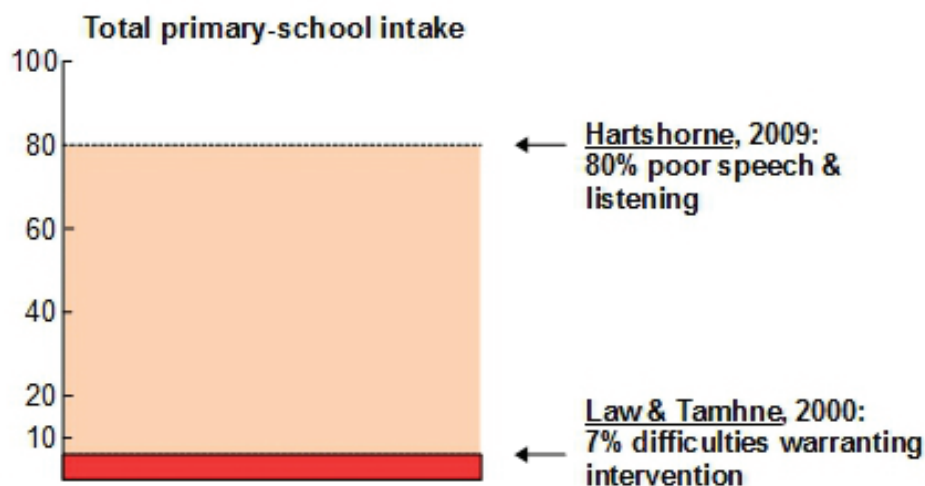


Figure 3.2 Primary school intake: estimated language issues

Surveys adopting different research criteria have tended to mask the extent of early childhood language difficulties, though experts accept the incidence of problems is comparatively high among preschool children. Two such investigations are summarised in Figure 3.2, where Hartshorne (2009) suggests up to 80 per cent of children enter primary school with ‘impoverished speech and poor listening skills’, whilst Law and Tamhne (2000) conclude that ‘studies suggest that as many as 7 per cent of children may have difficulties which warrant attention’ – statistically equivalent to one child in every average-size nursery group.

Though Law and Tamhne agree many children displaying early speech and language difficulties resolve them without resort to specialist intervention, they caution that early delays constitute ‘a risk factor both for subsequent speech and language difficulties and for other schooling and social problems’.

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Language impairment: Principal areas of concern

The following diagram (Figure 3.3) illustrates the specific obstacles a child with speech and language difficulties may face:

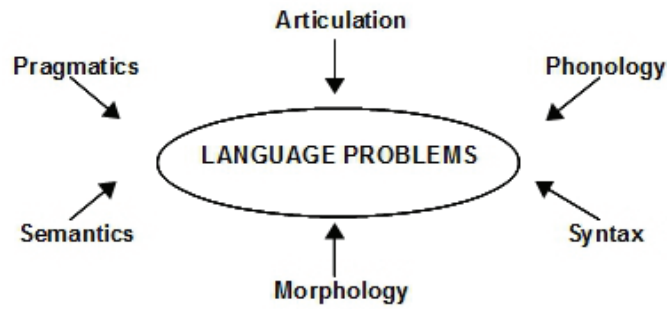


Figure 3.3 *Language difficulties*

Using the above functional descriptions, Crutchley et al. detailed the problems encountered by children undergoing typical speech and language therapy as:

- Articulation – pronunciation problems attributed to physical difficulties.
- Phonology – pronunciation problems attributed to non-physical difficulties.
- Syntax – problems assembling words into multi-word sentences or understanding complex sentences.
- Morphology – problems deriving new words from existing words, or from the use of inflexions.
- Semantics – difficulties with the meaning of words.
- Pragmatics – difficulties with the use of language in social contexts.

(Crutchley et al., 1997b)

This discussion considers three important contexts in which speech and language difficulties can occur:

- difficulties arising alongside other disabilities;
- specific language impairment;
- communication problems attributed to emotional and social difficulties.

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Language - acquisition problems occurring alongside other disabilities

Infants naturally acquire communication competence through close human contact in multi-sensory settings where, as Whitehead (1999) records, pre-verbal experiences pave the way for language development. Access to such natural influences can be restricted or denied if, for example:

- circumstances of neglect and deprivation severely limit language input;
- audio and/or visual input is unavailable due to impairments;
- severe physical difficulties prevent the functioning of speech mechanisms.

Adapting other mechanisms to compensate for deficits is a characteristic of human development, thus it is common to find that a child with significant visual impairment will often develop acute hearing to maximise acoustic inputs. Where difficulties cannot be supported or overcome by such means – as in cases where motor control is insufficient to allow speech development – it is very important to use Augmentative and Alternative Communication (AAC) methods and technologies to ensure such children can still develop into active communicators.

Specific language impairment

Where children show satisfactory development in other domains, but not in speech and language, this is regarded as a specific language impairment (SLI). Modern thinking no longer chooses to diagnose SLI by systematically excluding all other factors. Thomas, for example, comments that SLI suggests ‘an atypical learning process’ in which ‘impaired behaviour is the outcome of development working under other constraints’ (Thomas, 2006). The definition offered by Lees and Urwin, summarised in the table below, reflects a more-contemporary inclusive assessment:

Language disorder: a language profile which <i>may</i> be associated with hearing / learning / environmental / and emotional problems – though not attributable to these alone, and which is characterised by one or more of the following:	
1	A family history of specific difficulty in language development.
2	Neurological signs, or presence, of cerebral dysfunction.
3	Developmental discrepancy between language subsystems and other cognitive developments.
4	An inability to recover ground via 'generalised' language support.

Table 3.1 Defining Language Disorder (SLI) by inclusion

(Adapted from Lees and Urwin, 1997)

Early-years children with SLI require the support of a speech and language therapist who will liaise with teachers and other professionals to devise and deliver appropriate remedial interventions.

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Communication problems attributed to emotional and social difficulties

The frustration of SLI can cause the emergence of secondary difficulties affecting a young child's behaviour and ability to form peer relationships. Occasionally, a child acquires language skills yet cannot use them due to the influence of emotional and social difficulties. This can give rise to the phenomenon of selective mutism where a child is verbal in some settings, but non-verbal in others. Though comparatively rare, this behaviour seems to affect children in the 3-5 age group and also appears to coincide with transitions, such as moving into a nursery or similar childcare facility.

Given that a selectively mute child can and will speak in certain contexts, conventional language therapy is mostly ineffective. However, behavioural methods involving sensitive staged acclimatisation to the new environment have been shown to work.

The impact of intervention

As Pritchard and Brodie (2015) remind us, early years practitioners are uniquely placed to observe the specifics of language problems, and thus may often be called upon to note the precise nature of a language difficulty. This helps to ensure that any professional intervention is optimally targeted to achieve the best possible outcomes.

If proof was ever needed that such efforts are always worthwhile, Whitehead supplies it in her account of American author and lecturer Helen Keller's compassionate and 'inspired teacher' who:

'placed the hands of the blind and deaf Helen Keller under a gushing water pump and constantly wrote the letter signs w-a-t-e-r on the child's palms as the water poured over them.'



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4. Accommodating unpredictability: The challenge of autistic spectrum disorders

Whilst language issues have tended to remain low-profile, society’s fascination with the talents of autistic-savants has been selectively influential in raising awareness about autistic spectrum disorders (ASD). Pioneering Cornish physician John Langdon Down was the first to use the term ‘savant’ in 1887 to describe persons with mental disabilities possessing exceptional but ultra-specific skills. Much later, the 1988 film-drama *Rain Man* with its portrayal of real-life American ‘mega-savant’ Kim Peek, played by actor Dustin Hoffman, similarly highlighted Peek’s stunning feats of memory whilst also exposing some of the neglect and severe isolation experienced by many with autism and related conditions. In altogether milder form, TV’s *Doc Martin*, as played by actor Martin Clunes, exhibits eccentricities and social inhibitions also common to ASD.

Theory of mind

Though sharing autistic traits, savants are by no means representative of the majority of those with autistic spectrum disorder. The defining feature of this group of ASD conditions is a crippling social withdrawal which Baron-Cohen et al. (1985) consider stems from the fundamental lack of a Theory of Mind. According to Eysenck & Flanagan (2001), this critical faculty is an essential prerequisite for the ability to recognise that ‘others’ thoughts and emotions ... are different from one’s own’, and is also the mechanism used to ‘make predictions of how others will behave’. Describing the impact of such impairment on autistic children, Wellman (1994) concludes it ‘robs them of the ability to understand others’ feelings, desires, and beliefs. As a result, people can seem like any other object ...’

Based on present understandings about the roots of ASD in biological toxins and problems surrounding birth which compromise brain development, Figure 4.1 summarises the life-changing effects ASD can produce:

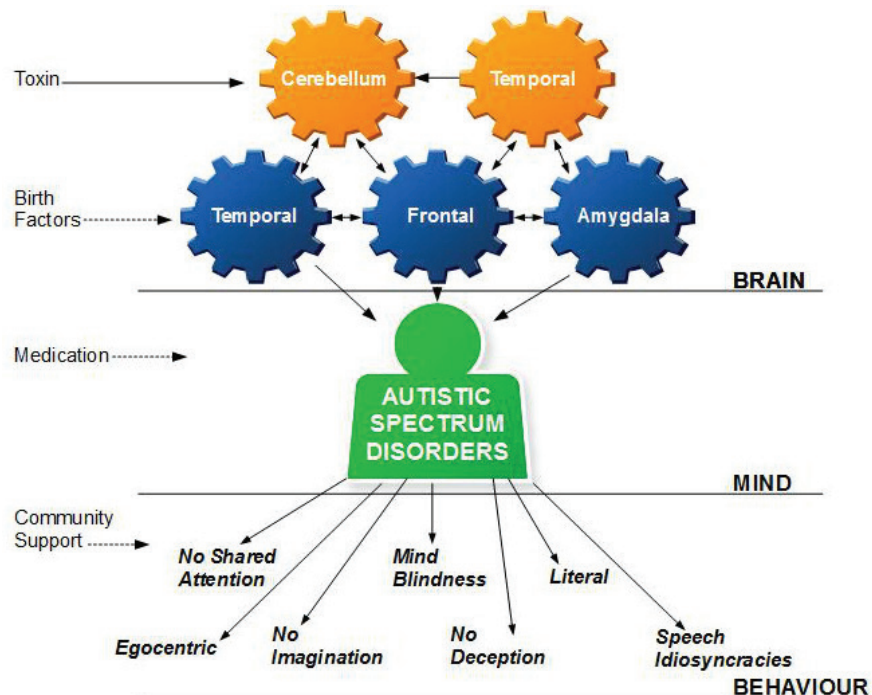


Figure 4.1 A causal framework for ASD (Inspired by Frith, 2005)

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Just a glance through the above behavioural outcomes will show the difficulties children with ASD are bound to experience when they encounter typical early years educational provision. Here, teaching and learning primarily occurs as a social encounter which builds upon a pattern of developmental learning experiences reassuringly familiar to most children from their earliest days. However, those whose impairments fall within the autistic spectrum are simply not ‘wired’ to respond to such methods, and thus, as the following anecdotal reports illustrate, are more likely to exhibit unusual and altogether more unpredictable conduct within an early years setting:



Figure 4.2 Anecdotal ASD behaviours in early years settings
(Sources: Frederickson & Cline, 2009 [a, b, c] Glenn et al., 2005 [d])

The triad of impairments

Only as a result of groundbreaking work by Kanner (1943) and Asperger (1944) in the 1940s, leading to a reassessment of autism in the 1960s, has it become clear that ASD is not an emotional disorder but a physical one. Identifying this paradigm shift, Wing comments on the implications:

‘the behaviour of children with autism made sense if viewed as due to disorders of aspects of development starting from birth or the early years of childhood.’

(Wing, 1996)

Modern thinking recognises that the behaviour of all children with autism and its spectrum of related conditions is constrained by a shared triad of impairments as depicted below:



Figure 4.3 The triad of impairments

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whilst Frederickson & Cline report that a consensus of contemporary opinion defines the disabling effects of this devastating trinity (for children) as an inability to:

- understand social behaviour, which affects their ability to interact with children and adults;
- understand and use non-verbal and verbal communication;
- think and behave flexibly, which may be shown in restricted, obsessional or repetitive activities.

Childcare professionals should be aware that the degree of impairment each child may suffer, and the type and severity of consequent behaviours which emerge, is so varied that individual assessment is essential. Though the tripartite symptoms are ever present, the balance of these features will determine the specific ASD profile which will be encountered: an (older) child with Asperger’s syndrome may superficially appear to be a high-achiever on some measures, whilst Wing notes that, sadly, ‘perhaps one in four or five of all those with autistic spectrum disorders, never speak, but remain mute all their lives.’

Assessment and early intervention

ASD is often difficult to categorically diagnose and is very unlikely to be established below two years of age. Once a health-based assessment has determined there are ASD issues, behavioural programmes often form the basis of early attempts to improve targeted features of a child’s social, communicative and cognitive impairments. The procedure which may be used in an educational setting, for example to minimise screaming or aggressive behaviour which a child may pursue to achieve certain goals, is outlined in the diagram below:

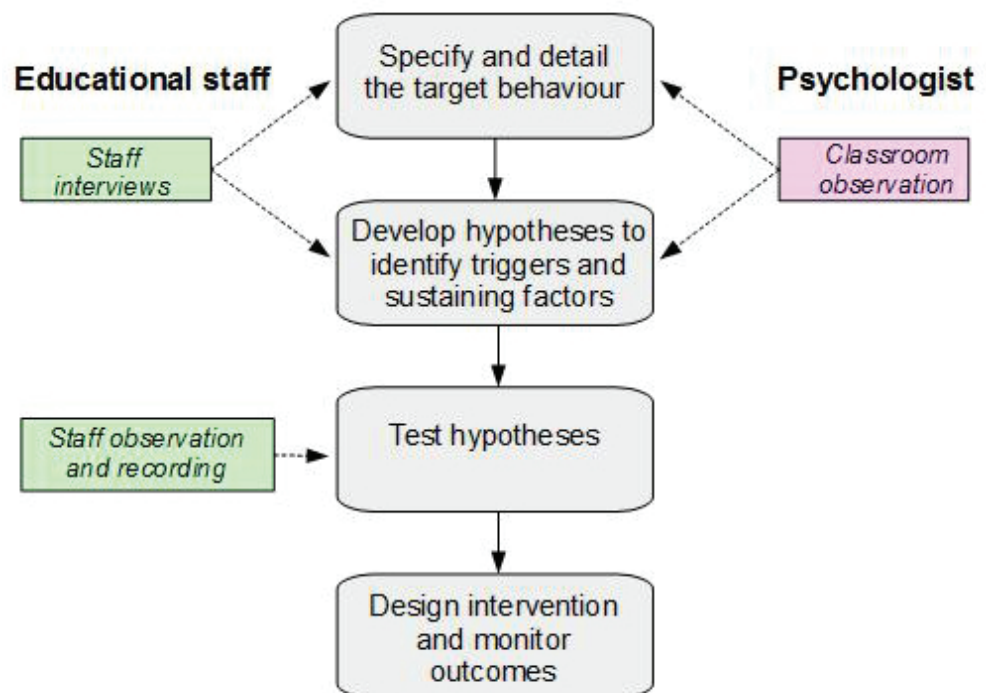


Figure 4.4 Functional behavioural assessment and management
(Inspired by Frederickson & Cline, 2009)

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Siegel (2003) characterises the strategies driving such interventions as a series of questions:

- How do we rewire around the weakness and utilise relative strengths as best we can?
- How do we come to understand this profile of weaknesses and strengths – autistic learning disabilities and autistic learning styles?
- How can information about how the profile is different for each child be used to individualise treatment plans?

Echolalic intervention

Those who care for children with ASD will probably have heard many examples of echolalia: an inappropriate echoing of a learned phrase which nevertheless serves a useful function. For instance, a child told to leave a door handle alone may immediately say: ‘Don’t turn the lights off!’ – which makes sense only if it is recalled that he was earlier told not to flick the light switch. Such phrases can get ‘stuck’, and even when inappropriate, come to be repetitively used as an attempt to communicate.

Howlin (1998) recounts how, following an initial period of observation and assessment, an intervention was used to reduce the occurrence of specific inappropriately formed echolalic phrases (‘Do you want to go out?’, ‘Would you like to go to the swings now?’). These were replaced with the more practical phrases ‘Can I go out?’ and ‘I want to go on the swing’. Data from the exercise is shown in the chart below to indicate the level of progress such intervention was able to achieve in just a few weeks:

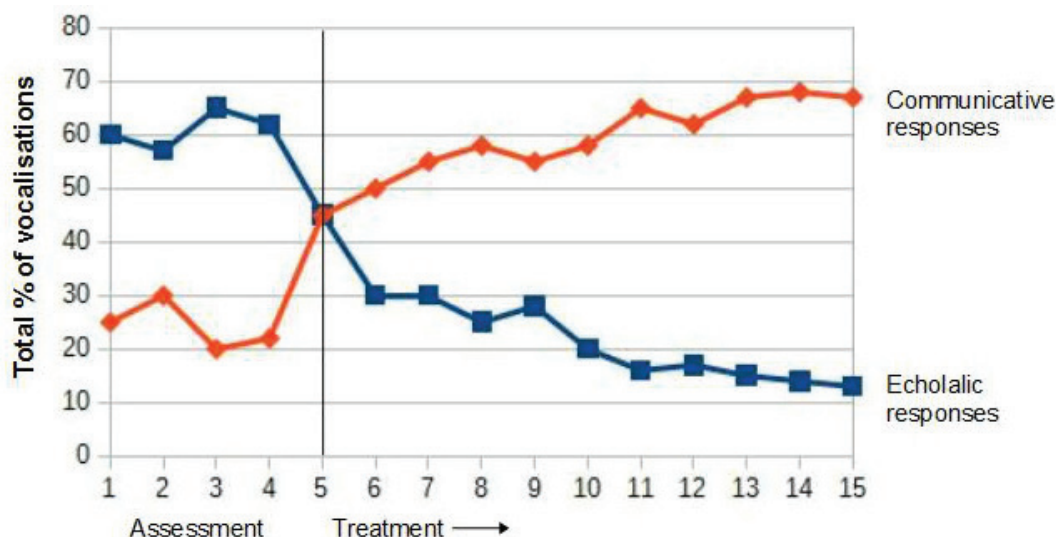


Figure 4.5 Intervention to modify echolalic responses

(Howlin and Rutter, 1987a)

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The value of early years experiences

Siegel, Wing, and many others highlight the benefits children with ASD gain from attending some form of pre-school unit and Wing believes that:

‘At this pre-school stage, mixing with children without disabilities often works well. There is no pressure to engage in tasks beyond the child’s capacity and very young children have not yet developed the strong group feeling that can at a later age lead to rejection of those who are different.’

Given that ASD behaviours only start to become apparent around the age that early years provision begins, it is clearly of paramount importance that all centres in both private and maintained sectors have secure systems in place to ensure no child showing early signs of ASD is ever overlooked.



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5. Understanding learning difficulties

At this juncture, the discussion will focus upon learning difficulties in a broad sense, leaving dyslexia – classified as a specific learning difficulty (SpLD) – to be explored in the following chapter. The notion that a child may have ‘a significantly greater difficulty in learning than the majority of children of his age’ (DfEE, 1996) is a defining concept which successive SEN legislation has sought to address via different forms of special educational provision. Access to additional support implies that certain criteria have been met, and some measurement of a child’s ability to learn is a key component of any process leading to a diagnosis of learning difficulties. This assessment itself has also proved enduringly controversial.

Intelligence

During much of the twentieth century, the ‘standard’ educational method used to determine a person’s learning proficiency was an IQ rating. This was calculated using a varied series of tests with the resultant scores then aggregated to produce an ‘Intelligence Quotient’. Central to this assessment is the idea that a ‘normal’ score of 100 would be gained by a majority of the population; most of the rest would cluster either side of the 100 ‘norm’; and only a few would score at a significantly higher, or lower, level. In statistical terms this produces a graph with a characteristic bell curve, as shown in Figure 5.1 below:

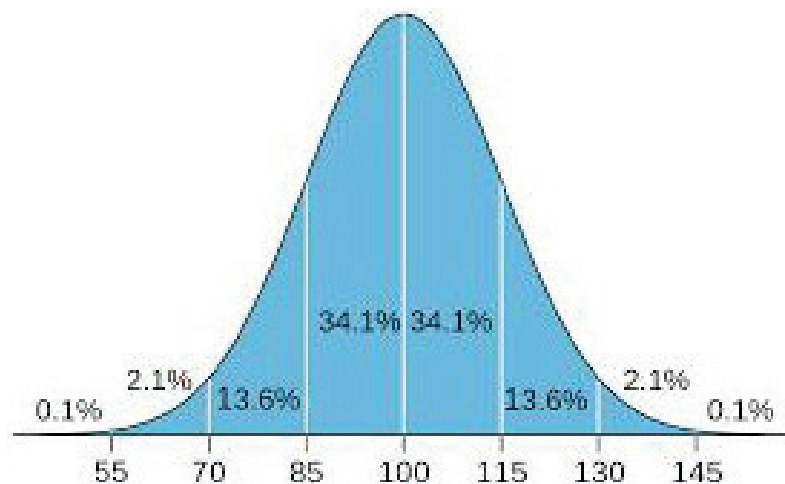


Figure 5.1 IQ bell curve

Though long used to measure intelligence and learning capacity, and firmly fixed in public consciousness as an indicator of ‘cleverness’, IQ tests have also had their detractors. Some noted that a single score culled from a series of tests created an illusion of scientific precision, whilst others argued that a test designed for one socio-cultural group should never be used to determine the relative intelligence of entirely different groups.

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LINGUISTIC



LOGICAL-MATHEMATICAL



BODILY-KINESTHETIC



INTRAPERSONAL



SPATIAL



MUSICAL



INTERPERSONAL



Figure 5.2 Gardner's theory of multiple intelligences (Gardner, 1983)

Whilst IQ scores reinforced the idea that intelligence is a relatively fixed, quantifiable feature, Gardner's theory of multiple intelligences, as depicted in Figure 5.2, took the opposite view that an array of distinct mental abilities, where absolute correlations were rare, was a truer reflection of the distribution of intelligence throughout a population. Gardner believed there was no 'single irrefutable and universally accepted list of intelligences', but this has not prevented the core idea of his theory strongly influencing the educational curriculum, and contributing substantially to the concept of personalised learning.

Cognitive styles

Dominant or preferred modes of learning have been described in a variety of ways – visual, auditory or kinesthetic (Barbe et al., 1979); left-brain / right-brain; reasoning and memory vs. perception; accommodator, converger, diverger or assimilator (Kolb, 1984); and many more. These concepts all imply there is no best method suiting all learners in all contexts, and many have gone on to argue too that a gross mismatch between learners and learning styles can be an often-overlooked reason for some degree of learning difficulty. Whilst cognitive/learning-styles theory has brought a more democratic and personal feel to educational learning, critics have warned that such well-intentioned labelling of a student as one fixed type of learner has the potential to cause, as well as solve, a number of problems in relation to an individual's educational development.

Socioeconomic perspectives

Though they were initially barred from the formal education system until 1970 reforms, the inclusion of children with severe learning difficulties (SLD) actually helped to focus attention on facilities for learners classified as having moderate learning difficulties (MLD). A growing volume of research (e.g. Lindsay et al., 2006) demonstrates that MLD special schools, when compared with mainstream schools and special schools offering other types of SEN provision, contain students from certain social groups persistently over-represented in this type of institution, as shown below:

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Figure 5.3 Social ecology of a typical MLD school (Inspired by Tomlinson, 1988)

According to many observers, such statistical evidence leads to the uncomfortable conclusion that MLD has become a classification too-easily attaching to children from particular socioeconomic backgrounds. This criticism echoes the decades-old critique of IQ tests devised for white middle-class children and then used to determine the educational life chances of children from ethnic groups and similar. Whilst the seemingly inequitable MLD population mix is obviously hard to miss, it's even harder to explain. As evidenced by the diagram in Figure 5.4 below – Why can't Jonny read? – inspired by Thompson (1988), any explanations attempting to shed light on MLD issues will tend to reflect the particular focus, concerns and familiar experience of the commentator, with teachers and psychologists therefore homing in on a variety of personal and contextual elements, whilst sociologists offer a contrasting view via the citing of macro-level injustices and inequalities.

	Teachers & Psychologists		Critical Theorists
	Personal	Environmental	Structural
Interpersonal	He lacks intelligence He can't concentrate He does n't like his teacher		
Institutional		He has a disadvantaged background He's an inner-city child His school lacks the right staff/resources /teaching methods	
Societal			He's black and working class Schools help to reproduce cultural, social and economic inequalities

Figure 5.4 Why can't Jonny read?

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Assessment of intelligence: dynamism vs. inertia

A debate with continuing relevance for the assessment of learning difficulties is the extent to which intelligence is a largely fixed and static attribute, or a pliable and adaptable quality. Advocates of the former view tend to be seen as traditionalists with reduced ‘linear’ expectations for those with learning difficulties, whilst those favouring dynamic assessment appear to accept Vygotsky’s view of learning (Vygotsky, 1978) as a primarily social construct with the child as an apprentice-learner. Vygotsky described the initial learning stage as an adult-led encounter with appropriate ‘scaffolding’ to support and encourage the learner. This would lead on, Vygotsky believed, to a later phase where the child internalised the learned concept. Furthermore, Vygotsky’s idea of a ‘zone of proximal development’, where a child feels confident enough to push boundaries and transcend the limits of his present learning, is entirely consistent with contemporary accounts of dynamic assessment more sympathetic to the notion of progression. Budoff’s work on learner classification to inform special education decisions (Budoff, 1987) is a good example of modern dynamic assessment principles. The appraisal incorporated a learner-coaching element and helped to maximise every limited-ability child’s potential via the adoption of three compassionately devised categories. Oozing encouragement, the category descriptors identified:

- high performers, who can achieve without assistance and make modest gains from coaching;
- gainers, who don’t succeed at first but make gains when coached;
- non-gainers, who don’t perform well and make marginal gains from coaching.

Learning difficulties: implications for educators

Whilst it is clear that children with SLD will require support, early intervention and perhaps special arrangements, from the outset, the appropriate educational options and menu of interventions for those with MLD are less easy to formulate. There is a contemporary view that MLD expectations have been too limited in the past, and the dialogue is now leaning more towards entitlement for learners with MLD. Frederickson and Cline (2009) sum up a powerful prevailing view thus:

‘... learning difficulty is partly determined by the learning context and cannot solely be understood as a fixed characteristic of the learner. For some commentators this has led to the rejection of the term learning difficulties altogether.’

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Summarising the gains which learners can be supported to achieve via the enlightened deployment of these modern dynamic teaching methods, Watson (2000) relates the stimulating learning experiences which can be anticipated:

- ‘the learner is active;
- the teacher is responsive to pupil’s interests and existing understanding;
- educational talk, focusing on the task in hand, is emphasised;
- social experiences are integral to learning and highly valued;
- teachers build on and extend pupils’ thinking;
- through scaffolding and mediation, teachers encourage cognitive restructuring;
- pupils’ awareness of their own learning is assisted;
- (learning) transfer is facilitated;
- challenging tasks indicate that teacher expectations are high;
- pupils are gradually helped to become self-directed, self-aware learners, who are in control of their own learning;
- confidence and self-esteem are raised.’

The simple message for all educators would seem to be: premium teaching methods will always produce premium results for all learners – and the incremental improvements gained by a child with MLD are just as important and critical to his life chances as they are to all other children right across the attainment spectrum.



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6. Decrypting dyslexia: A review of progress

Dyslexia is one of the most significant barriers to literacy, causing distress and confusion to significant numbers of young children. Should anyone doubt the full educational implications, Walker's summary covers some of the main points:

'... the child may be branded "careless" or "lazy" ... Yet he may make a valuable oral contribution, showing insight and a clear grasp of the concepts ... He may be able to explain in graphic detail that he has just made a model aircraft carrier describing the guns, the flight deck, the radar scanning equipment but when asked to write, he is unable to express all this and so merely writes, "I made a bote." Besides reading and spelling very badly, ... he will have difficulties in ... short term memory, organisation and sequencing ... he is unable to recite the days of the week.'

(Walker, 1989)

Graphic designer Daniel Britton, who also suffers from dyslexia, designed his own font to simulate the frustrating experience for those trying to read, in order to better inform those unaffected, explaining:

'For most people with dyslexia, the letters and numbers do not jump around on the page and the colours remain the same ... You can see the information, you can see each letter perfectly but there is something in your mind that is stopping or slowing the process of information.'

(Britton, 2015)



(Dyslexic font shown in red)

Figure 6.1 Recreated Dyslexia Alphabet (Britton, 2015)

The British Dyslexia Association estimates that mild dyslexia affects around 10% of the population, whilst around 4% are severely afflicted. For childcare professionals, this translates as 2 in every group of 20 children showing some significant reading problems, with almost 1 in every 25 having a severe difficulty – reason enough to become broadly acquainted with this rather enigmatic condition.

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Historical perspectives

The timeline at Figure 6.2 below traces the evolution of dyslexia knowledge and the emergence of different ways of conceptualising the disorder, and/or its effects on individuals:

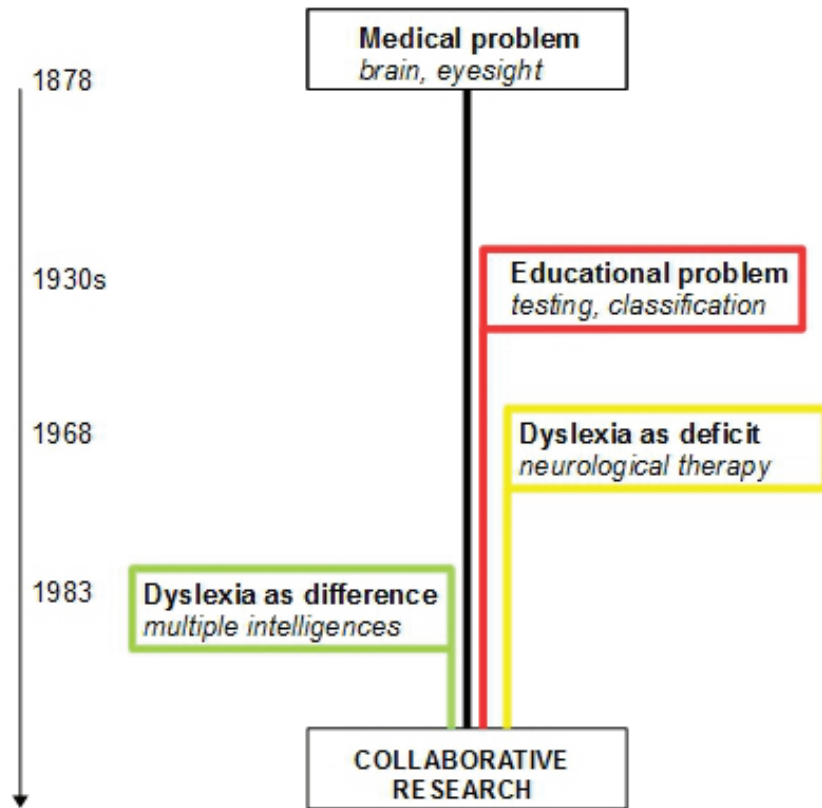


Figure 6.2 Dyslexia timeline

As Lawrence (2008) observes, dyslexia ‘is only one of many terms that have been used over the years to describe children with literacy difficulties’, and the publication of the DfEE Code of Practice (1994) marked the first legislative acknowledgement of the condition. Though Galton’s analysis of individual difference in children’s academic performance (1869) raised awareness, it was not until 1878 that the neurologist Kussmaul first explored reading difficulties in the context of neurological impairment. Then, in 1887, ophthalmologist Berlin coined the term ‘dyslexia’, replacing the earlier description of ‘word blindness’. Writing in an 1891 edition of *The Lancet*, Dr Dejerne linked these same reading difficulties to the after effects of brain injury, a line of enquiry soon followed by many others. The work of Hinshelwood (1900), a Scottish eye-surgeon, implicated congenital brain defects which impaired eyesight, and the American neurologist Orton (1925) noted the tendency for those exhibiting word blindness to reverse letters – for instance, turning ‘won’ into ‘now’ – using the term ‘strephosymbolia’ to describe this specific phenomena, and classifying children’s reading difficulties as ‘alexia’.

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The input of educationalists

Reading difficulties were still overwhelmingly seen in medical terms during the 1930s, but at least educationalists began to discuss the matter and also published new teaching approaches suggesting how the problem might be addressed educationally. A growing body of academic literature indicated teachers and educational psychologists were taking ownership of the issue, but it was to remain the preserve of school medical officers to rule upon dyslexia and other learning difficulties right up to the 1970s.

New learning strategies

A notable and effective teaching method to support children with dyslexic reading problems was designed by Gillingham and Stillman in 1936. Based on phonics (language sounds), this multi-sensory reading initiative coached children who first spoke the word aloud, before being guided to write it down, taught how to listen and pick out the word being spoken, and then invited to model it in clay.

Inspired by the notion that dyslexia was associated with neurological deficits in the brain, Doman and Delacato (1986) devised a series of exercises which mimicked early child developmental events like crawling, stretching and balancing. Their premise was that a child with dyslexia was ‘learning-disabled’, meaning that certain essential developmental stages had not been satisfactorily accomplished, resulting in impaired physical mobility and thus ultimately restricting access to language and communication. After a prolonged period of physical exercise, Doman and Delacato believed a child’s natural hemispherical dominance would be reset and ‘neurological organization’ restored. Despite much academic controversy, the concept of revitalising neural pathways is still considered a viable approach to tackling learning difficulties, as exemplified by the work on neural deficits carried out by Dennison (1981) and Dore (2006).

Work by the British Psychological Society (BPS, 1999) has drawn the various strands of deficit-hypothesis thinking together in diagrammatic form, and a simplified version of this is illustrated in Figure 6.3:

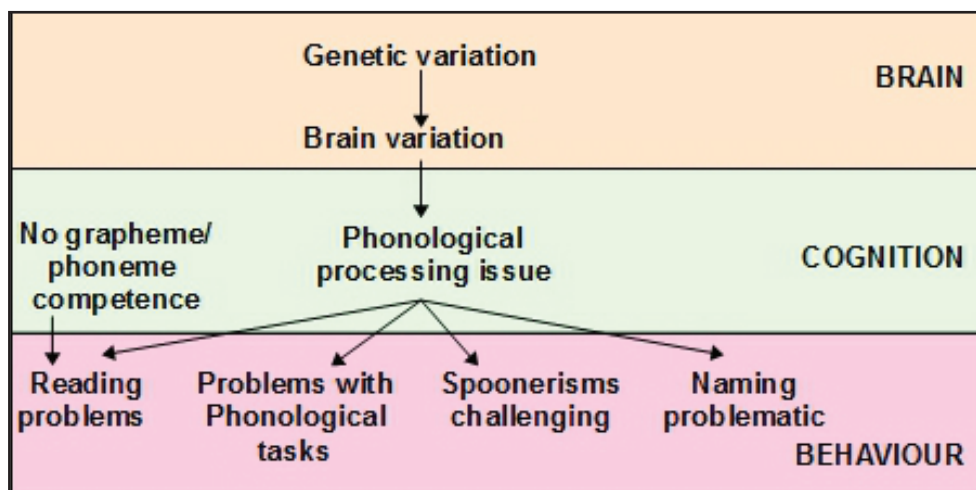


Figure 6.3 Phonological delay/deficit hypothesis (Adapted from BPS, 1999)

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Dyslexia as difference

Gardner's theory of multiple intelligences, published in 1983, was instrumental in persuading researchers to consider the proposition that not all children would necessarily develop linguistic competence – that attribute being just one of a suite of human intelligences. In 1994, Galaburda's adult autopsies (Galaburda, 1994) provided supporting evidence for this view by showing that those with dyslexia also exhibited enhanced development of the brain's right hemisphere. Given that the right brain is the area known to be associated with creativity and visual processing, this evidence implied those with dyslexia somehow compensated for possible left-brain limitations by increased right-brain activity. Researchers, and much populist opinion, have often concluded that such re-routing of thought processes can help produce distinctively talented individuals whose impairment may even have contributed to their special output. The diagram below offers a sample illustration of those entrepreneurs, creative thinkers, scientists, and artist belonging to this category:

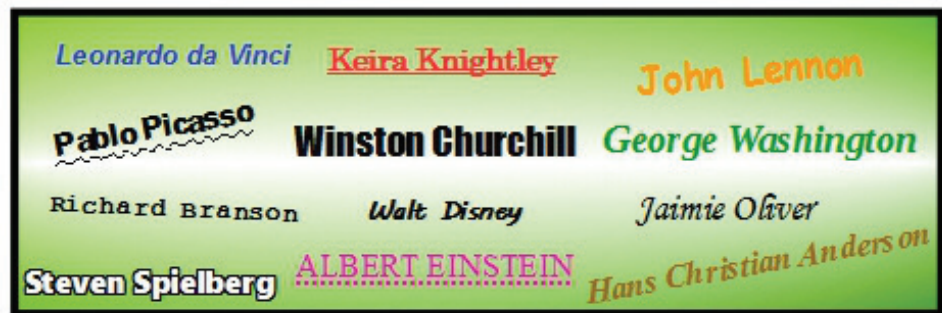


Figure 6.4 Creative individuals with dyslexia

Building on the presumption dyslexia is not a deficit but a different way of learning, Silverman (2002) and Freed (1997), among others, have successfully proposed the idea that many children with dyslexia will learn best through methods employing visual learning styles.

Modern inter-disciplinary research

The route to an advanced understanding of dyslexia has many fine examples of inter-disciplinary working. For instance, the advent of safe and reliable brain-scanning techniques has now revealed the parts of the brain typically employed by dyslexic and non-dyslexic readers, as depicted below:

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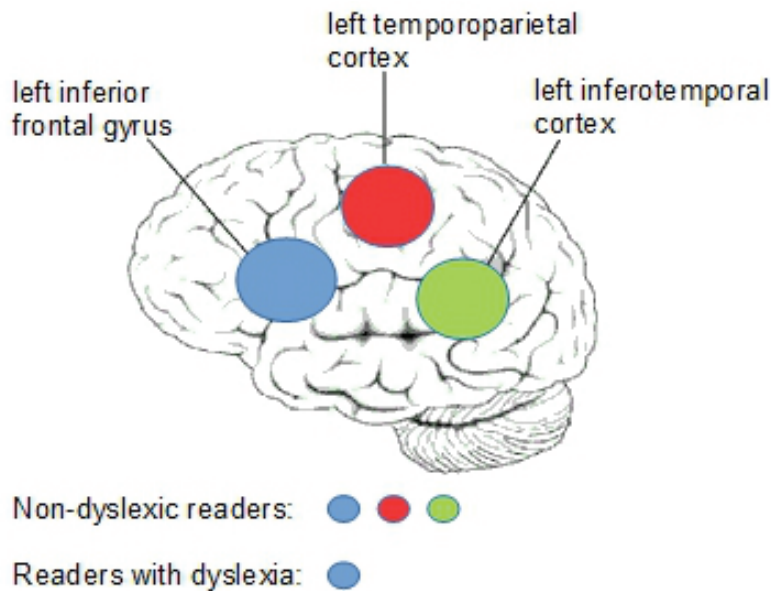


Figure 6.5 Brain regions deployed in reading

(Inspired by Goswami, 2006)

For the first time, this information clearly shows the neurological differences which occur between the two types of reader – validating the inferences made by many earlier pioneers.

Elsewhere, as the list below illustrates, the BPS have analysed 10 prominent modern theories of dyslexia to show that six still implicate some type of phonological deficit (i.e. a difficulty in processing the range of sounds which make up words and language) as a cause of learning difficulties (including dyslexia):

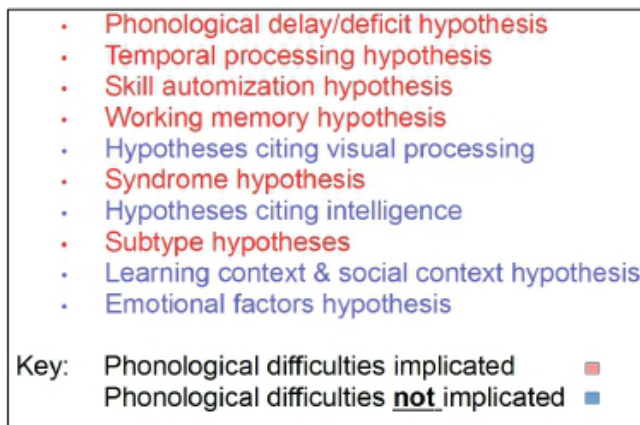


Figure 6.6 Comparison of 10 dyslexia-related theories *(Adapted from BPS, 1999)*

Another landmark outcome of the comprehensive BPS review of research was an updated and widely agreed definition of dyslexia. Reversing decades of negative ‘ruling out’ of all other causes before reaching dyslexia at the bottom of the list – an unforgivable approach which prevented early treatment and diagnosis. The new wording is much quicker and simpler to apply:

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‘Dyslexia is evident when accurate and fluent word reading and/or spelling develops very incompletely or with great difficulty. This focuses on literacy at the ‘word level’ and implies that the problem is severe and persistent despite appropriate learning opportunities.’

(BPS, 1999)

Interactive research and dialogue is ongoing, and as controversial as ever: a 2015 study tracking 14,000 children looked at issues of visual impairment, finding that children with dyslexia had precisely the same incidence of eye problems as the general population (Creavin et al., 2015). In addition, many children identified as dyslexic were also classified as having ‘perfect vision’.

Commenting on the outcomes, lead author and paediatric ophthalmologist, Cathy Williams said: ‘Some practitioners feel that vision impairments may be associated with dyslexia and should be treated. However, our study results show that the majority of dyslexic children have entirely normal vision on the tests we used.’

Whatever contributions future biological and neurological research discoveries may bring to dyslexia, it is almost certain the remedial help and practical support children with dyslexia receive will continue to be delivered by professionals in the educational domain.



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7. Some perspectives on behavioural, emotional and social difficulties

As SEN provision has evolved, social attitudes and the descriptive language used to describe conditions have likewise been adjusted and updated.

Unfortunately, this is rarely a linear process and as the 2013 BMA Board of Science report ‘Growing up in the UK’ acknowledges, different agencies will explain the difficulties of children with SEN in markedly different ways:

‘Psychiatrists ... distinguish between normal and abnormal groups of children, and think of the abnormal group as having disorders ... produced by an interaction of biology and environment.

Teachers ... tend to use an undifferentiated category of ‘emotional and behavioural problems’ ... primarily caused by adverse environmental factors, in particular problems in the family context, (and) essentially amenable to improvement through education.

Social workers ... regard labelling children as a stigmatising process which is best avoided, and prefer to explain children’s problems in social terms.’

(BMA, 2013)

Though this diversity of emphasis can ‘breed misunderstanding and inhibit communication’, modern thinking tends to view behavioural, emotional and social difficulties (BESD) as part of a mental-health continuum which, as the diagram below (based on DfE guidance) indicates, begins with an essentially childish non-compliance which falls within the boundaries of normal development:

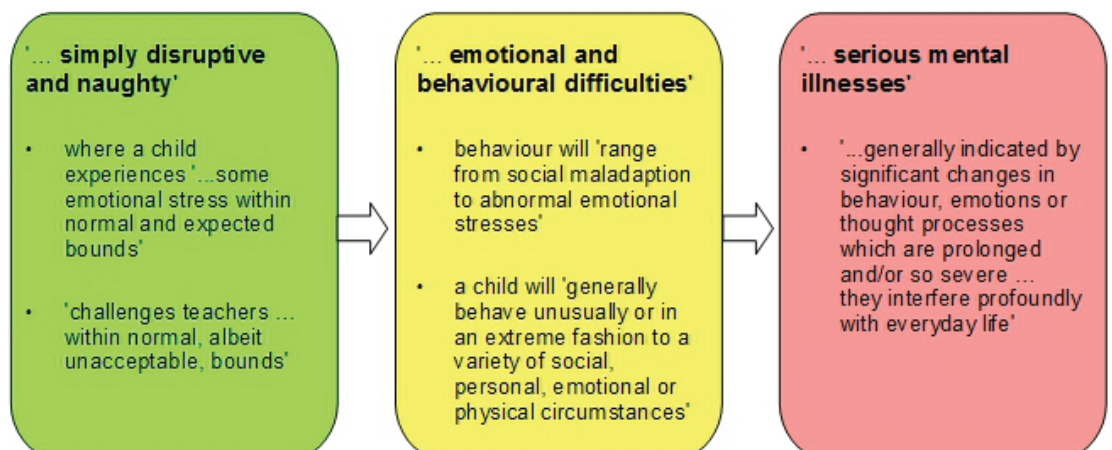


Figure 7.1 Problem behaviour conceptualised as a continuum

(from Department for Education, 1994c: 7)

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Frequency of BESD and mental health problems

Published statistics on BESD rely on school figures, and DfE estimates for 2013 show BESD as the 'primary need' for 24.5% of the total number of 5-16 year olds identified at School Action Plus level. As regards mental health for school-age students, the latest government figures available (Office for National Statistics, 2005) were actually collected back in 2004. The diagram featured in Figure 7.2 below charts these statistics as data percentages for the most commonly occurring conditions, split between boys and girls.

A glance through the display data reveals that boys feature strongly across almost every category. And though girls score highest on depressive and anxiety disorders, boys also have a significant presence. As the SEN literature would predict, boys are heavily over-represented in the areas of ASD, ADHD, and general conduct/behaviour problems.

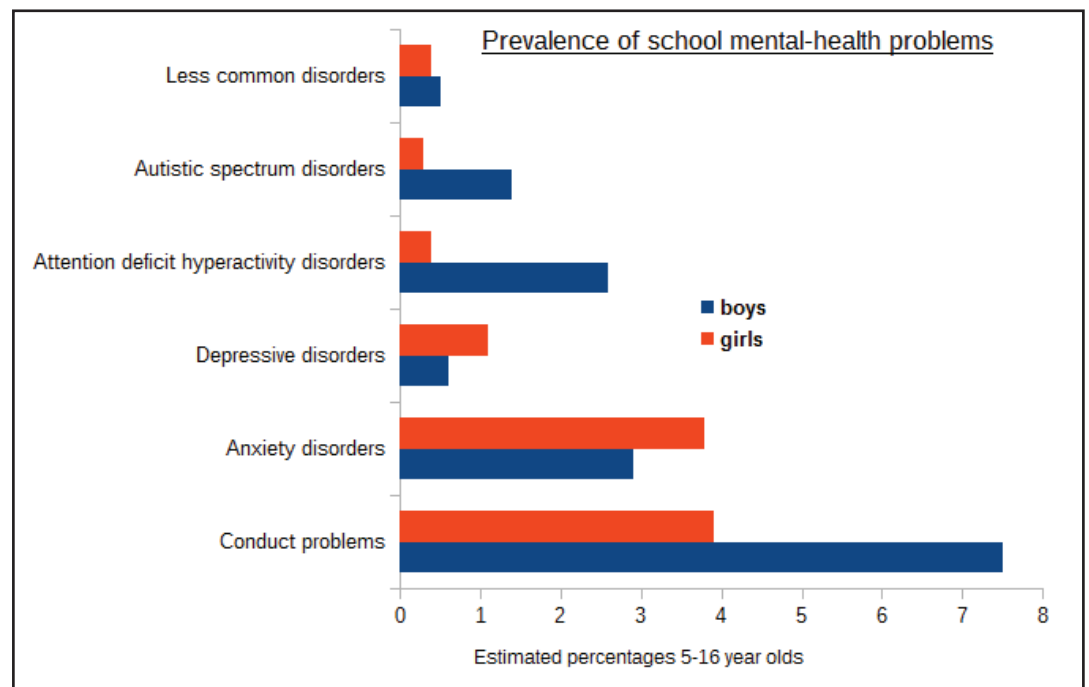


Figure 7.2 Mental health issues for students in the 5-16 age range

The concept of BESD

Attempts to understand BESD at a theoretical level and to prescribe interventions have used a variety of approaches, but three primary domain pathways have emerged as the most productive ways to explain and conceptualise BESD problems:

- Biological approaches which examine brain data alongside vision, hearing and other sensory activity.
- Cognitive approaches which explore affective factors and assess a child's intra-personal state.
- Behavioural approaches which focus on any behaviours which can be observed.

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In practice, those working with children with BESD mostly tend to use a combination of these methods. In addition, some practitioners have found it helpful to think of BESD in terms of systems theory which accepts the complexity of BESD and therefore specifically sets out to explore the interactive nature of all elements within the environment of the individual child.

Biological issues

Looking at BESD from a scientific perspective, Bauer & Shea (1999) report that many researchers believe there is a 'significant relationship' between physical illness and mental health. Similarly, genetic predispositions, malnutrition, and allergies have also been implicated as influencing BESD. Furthermore, advances in medical technologies have pinpointed some reduced blood flows within the brain, and have also resulted in the development of drug treatments to correct chemical imbalances. Such drug therapies have been used with some success notably to alleviate attention deficit hyperactivity disorders (ADHD), leading many to cite subsequent improved functioning as evidence of a biological basis for BESD.

Cognitive perspectives

Cognitive theories believe thought processes influence how a child perceives and interacts with the world. As the following examples demonstrate, each theorist will emphasise different aspects of cognitive functions:

- Rogers' work on children with low self-esteem (Rogers, 1959) found that a child with a poor self-concept was not 'fully functioning' because their 'ideal self' – how they wished to be – was not in balance with their 'actual behaviour' – how they really behaved.
- Heider's work on attribution theory (Heider, 1958) explained how a child may attribute the actions of others to internal factors – such as personality traits – whilst making external attributions – for example, blaming the environment – to account for his own actions. Kelly's Covariation Model (1967) develops this idea, offering insights on how children can be influenced by constant exposure to the opinions and attitudes of significant others.
- Festinger's theory of cognitive dissonance (Festinger, 1957) explains how children look for consistent models to establish their beliefs and attitudes. According to Festinger, a powerful need to reconcile conflicts in this area can sometimes result in irrational and maladaptive behaviours.

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Behavioural perspectives

Behavioural theory adopts the standpoint that observed BESD behaviours have been learned by the child, and that the success of any subsequent interventions can be gauged by observed changes. Once again, theorists have offered nuanced versions of behaviourism, with some of the major theories listed below:

- Pavlov's early animal experiments (Pavlov, 1897) showed how easily 'behavioural conditioning' could occur in humans.
- Skinner's work on 'operant conditioning' (Skinner, 1938) demonstrated the principle of 'reinforcement' – the idea that any behaviour which gets rewarded will tend to be repeated by the child, whilst unrewarded behaviours will wither away.
- Bandura's social learning theory (Bandura, 1977) explained how a child's behaviour is learned via his environment through a process of observational learning.

Psychodynamic approaches

Following Freud's doctrines, the psychodynamic approach to BESD holds that the reasons for dominant behaviours are grounded in the unconscious, and that childhood is the time when these are in the process of formation. Furthermore, the unconscious mind is also believed to be where conflicts occur. For example, the conflict which can occur where a child feels a teacher – the temporary, in-school 'parent' – is proposing views entirely contrary to those of a home parent or caregiver.

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BESD intervention strategies

Behaviourist BESD strategies are very common in educational settings with positive reinforcement to encourage desirable behaviours, and the ignoring of undesirable responses to 'extinguish' them, by far the most common approaches overall. Continually disruptive pupils are given 'time out' to starve them of the positive reinforcement of classmates, and punishments are used to remind misbehavers about the consequences of their actions.

One problem with behaviourist approaches can be that much of the focus is on what not to do. This can be redressed by whole-class work which models and reinforces required behaviours. In addition, a child with BESD will often receive individual support where specific behaviours are targeted in order to accordingly promote or reduce the identified behaviour.

Cognitive strategies involve counselling approaches like anger management and problem-based interventions. This work will usually have a personal-development focus with the aim of raising self-esteem, though care must be taken to only offer justifiable praise in recognition of desirable improvements and achievements. Frederickson & Cline (2009) note just how difficult this can be in some institutions:

'Attempting to boost self-esteem at an individual level through positive, affirming feedback might be unlikely to have a long-term impact on a pupil who has SEN in a school context where recognition and rewards focus on the highest level of achievement, with effort or relative improvement being recognised in a more marginal or tokenistic way.'

Psychodynamic approaches include small 'nurture groups' with younger children, led by a trusted teacher and other adult figures. These aim to model and incorporate positive elements of home and school experience, offering:

'... food, comfort, consistent care and support, and close physical contact seen in cradling, rocking, sensory exploration and communication by touch' (Bennathan and Boxall, 2000).

Parenting

The common message with BESD treatments and interventions is that they should not be considered in isolation, and that the child's parents must always be kept fully informed, and fully involved. Thus intervention strategies may include support for the development of parenting skills which research confirms can make such a positive contribution to a child's well-being.

Maccoby and Martin's work on parenting styles (Maccoby and Martin, 1983) distinguished four main approaches to parenting found to influence a child's future mental health. This method considers the likely impact, and future teenage outcomes, of different blends of the twin components of demand/control and warmth/acceptance, as represented in the following diagram:

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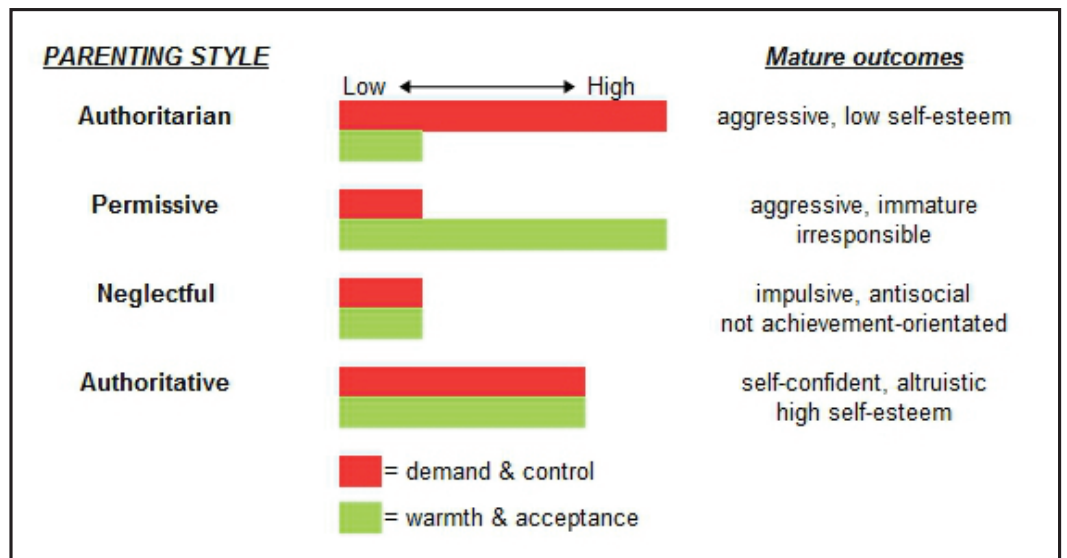


Figure 7.3 Parenting styles (Inspired by Maccoby and Martin, 1983)

It would be unfair to suggest family relationships depend solely on parenting styles, and it cannot be denied that the child with a relaxed temperament will be the easiest to parent in ‘authoritative’ fashion. Nevertheless, as the BMA report warns, any ‘stressful circumstances’ in which ‘parenting is almost inevitably disrupted’ must be taken into account in the context of a truly meaningful remedial intervention:

‘There is plenty of evidence, ... that parents who are warm and affectionate, in the context of clear, firm limit-setting, will have a positive impact on their children’s mental health, and that authoritative parenting can mitigate the adverse effects of other stressors. These general principles are the basis for a wide variety of parent education initiatives.’

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8. Developing emotional and social competence and well-being

‘... the whining schoolboy, with his satchel
And shining morning face, creeping like snail
Unwillingly to school.’

William Shakespeare, ‘As You Like It’ (1600)

The importance of education, Shakespeare’s 17th-century wisdom implies, is such that it overrides ‘minor’ considerations like a child’s personal happiness. And as with similar aspects of natural parenting, the practical cruel-to-be-kind measures this scholar endures may turn out to be the best medicine after all. Sadly, over four hundred years later, the current reality is that our rolling media news still makes it hard to miss images of children who may be lost to education for ever, and some whose sole remaining aspiration is to stay alive.

Basic needs

Realistically, there are vastly different degrees of ‘school unwillingness’, lack of engagement, poor behaviour and more, and many obvious – though regrettable – reasons why. However, most parents and childcare professionals well understand any child’s emotional and social competence and well-being must at least be on track before even the most basic educational development can be anticipated. Maslow made this same point back in 1943, and his well-known ‘hierarchy of needs’ diagram – shown below – is a stark reminder why government SEN policy in the modern age now considers it essential to equip all children with essential social, emotional and behavioural skills.

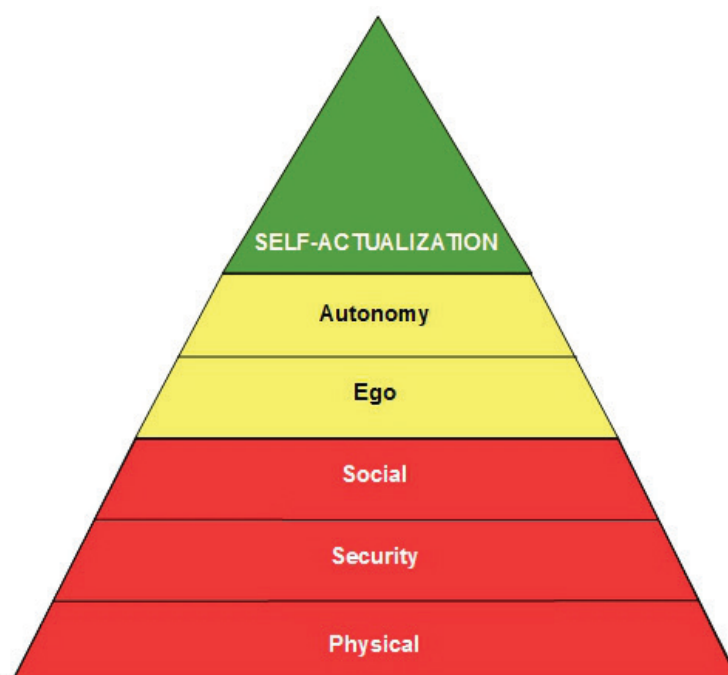


Figure 8.1 Maslow's hierarchy of needs (1943)

(Adapted from Fontana, 1981)

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Maslow later developed far more elaborate versions of this diagram to support his basic premise that, before the intellectual developments leading to autonomy and ultimate self-actualization can ever take place, the most basic needs associated with human survival must be fulfilled. Nevertheless, the image suffices to highlight the pathway to personal growth, whilst also reminding us that this route to emotional health and well-being is non-negotiable because every single child matters – a theme now enshrined in educational legislation.

Every Child Matters

This landmark initiative further addressed by The Children Act 2004 (DfES, 2004) and at least partially prompted by the Laming report (Laming, 2003) investigating the tragic death of Victoria Climbié, sets out the minimum levels of support each child is entitled to expect. In diagram form, when similarly formatted as below, the five key ‘Every Child Matters’ principles (DfES, 2003b) show a certain family resemblance to Maslow’s hierarchy. But much more importantly, as Frederickson & Cline (2009) note, they act as a safeguarding framework designed to address ‘the negative consequences of deficiencies in social and emotional competence and well being’.



Figure 8.2 Every Child Matters: five key principles

This legislation acknowledges that, whilst some children require extra support for a variety of reasons, accepting the need for broad-based institution-wide interventions will serve to significantly reduce the numbers who require more-specific, or even individual interventions to prevent a slide towards deteriorating mental health. The diagram below outlines how positive early-intervention measures to improve the social and emotional environment for all signal a policy shift towards using psychology to enhance children’s life chances rather than just to fix emerging problems.

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Figure 8.3 Types of explicit intervention strategies

(Adapted from DfES, 2005d)

Peer groups and friendships

Direct adult observations of child interactions in a classroom or similar setting can yield accurate and perceptive survey data on many aspects of the prevailing social climate. Unfortunately, what is known to researchers as the Hawthorne effect (Mayo, 1949) – where the subjects behave differently just because they are being observed – tends to skew research outcomes to a marked extent. More informal assessments fare better by comparison but still tend to miss crucial subtleties which often only come to light over time.

Work with younger children is essential, and overarching peer group assessments are often quickly and simply achieved via some form of rating scale. For pre-school children this must be easy to understand, so the use of images as in the example below helps to set the scene:

Andrew					
Becky					
Kofi					

Figure 8.4 Social Inclusion Survey

(Inspired by Frederickson and Graham, 1999)

During a survey, children might be asked how much they like to play with each classmate in their group. Smiling, neutral and frowning faces offer a choice of response, with a question mark used where the respondent cannot place an occasional individual. Photos of each child can help to jog memories and keep down erroneous replies. It can be revealing to rerun the survey on another day, this time asking how much the children like to work with each member of the class, because a change of activity and context will often produce a varied outcome. Periodic social data collection can help track the natural dynamics and fluctuations of friendship groupings, but can also provide an early warning about children vulnerable to social isolation, or worse.

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Interventions at institutional level

DfES guidance stresses that the development of social and emotional competence is an ongoing process which is necessarily linked to, and part of, child development. Thus Bruner's 'spiral curriculum' (Bruner, 1960), which returns to topics again and again, each time recasting them in the light of a child's increasing maturity, is the most relevant learning model. As the DfES document explains:

'... children's capacity to manage the feelings involved, and the range of strategies at their disposal, will be very different in the early years than, for example, their experience at the age of 11. We cannot therefore 'teach' these skills as a one-off. There is a need to revisit and develop the concepts, understanding and skills over time, building on what has been learned previously.'

(DfES, 2005d)

Highlighting another key feature, the advice points out 'there are also differences in the ways that emotions may be valued, experienced and displayed across cultures'.

The DfES guidance conceptualises the social and emotional aspects of learning (SEAL) across seven key themes as follows:

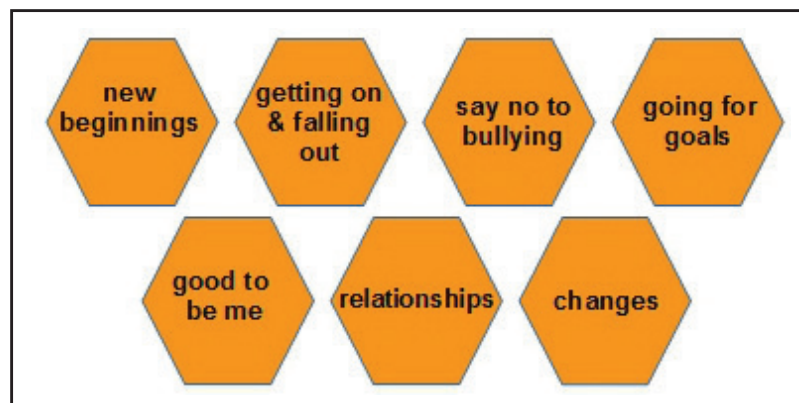


Figure 8.5 SEAL themes (Adapted from DfES, 2005d)

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These themes, the DfES recommend, should be regularly approached in institutional settings through the medium of five personal and/or intrapersonal socio-emotional skills, each of which is shown below accompanied by its symbolic image:

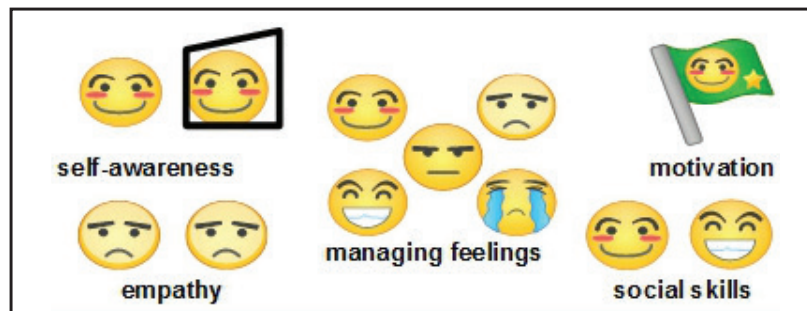


Figure 8.6 DfES social & emotional aspects of learning (DfES, 2005d)

Interventions for at-risk groups

The role of parents in child development is universally acknowledged. For instance, Nutbrown et. Al (2013) note that Every Child Matters legislation makes the parental contribution ‘explicit in helping to achieve ... outcomes’ – especially the first three, which ‘apply more obviously to the youngest children’:

1. Be Healthy ... parents, carers and families promote healthy choices...
2. Stay Safe ... parents, carers and families provide safe homes and stability...
3. Enjoy & Share ... parents, carers and families support learning...

Thus intervention programmes target parents first, and include both voluntary groups and arrangements set up under compulsory parenting orders. Experience reported by the Social Care Institute for Excellence (SCIE), the National Institute for Clinical Excellence (NICE), and others suggests: practical advice strongly underpinned by theory has been effective, aggressive child behaviour was positively influenced, families with younger children fared best, and recruitment was better where the course descriptor avoided the term ‘parenting programme’.

Small ‘child social skills’ groups tend to operate in discrete clinic settings on school premises. These are generally seen as effective, with some feedback noting that child social-problem solving skills were positively enhanced, children from families under particular pressure also improved, and the programmes were also of practical benefit to children with ADHD.

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Individual interventions

Individual initiatives for children with major difficulties are invariably multi-agency responses and tend to involve safe and secure settings where boys, children from deprived backgrounds, children with SEN, and those from cultural and other minorities are generally over-represented. One-to-one contact allows a full range of strategies to be employed and tailored to the needs of each child. Sessions will often focus on a specific social skill, or a group of 'can do' skills, and use a combination of modelling, reinforcing, scaffolding strategies, and coaching skills to promote positive social behaviours and responses. Children with sensory impairments will have, or must be taught, specific ways of recognising and interpreting emotions in others. In addition, cultural knowledge and sensitivity is demanded when interacting with children from other cultures whose background may, for example, have taught them to use and respond to gesture and gaze in different, culture-specific ways.

Early years childcare professionals have a major responsibility to do all they can to break the link between socio-economic disadvantage and consequent educational under-performance. Far from being no more than a thankless task, promoting emotional literacy in an environment which positively affirms that every child really does matter sends out a constant message of hope which will enhance the lives, experience and prospects of all children who attend – no matter how 'unwillingly' they may at first 'creep to school'.



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9. The implications of sensory impairments

Children with sensory impairments affecting hearing or vision must never be treated as if they had learning difficulties, and learning expectations for this group of learners should be the same as for any other child. However, these impairments naturally mean that learning will prove a much greater challenge than for most other children – unless educational providers are prepared to make enabling technologies available and learning resources accessible. To facilitate this, the Equality Act 2010 requires ‘reasonable adjustments’ to be made for those with such additional needs. Importantly, as the Equality and Human Rights Commission (2015) point out, these arrangements must be ‘anticipatory’: thus for institutions, the absence of children with sensory impairments will not excuse the lack of adequate facilities.

Hearing loss

Hearing loss, otherwise known as deafness, has implications for learning. As the National Deaf Children’s Society (NDCS) and others point out, it can vary both in ‘degree and nature’. This means a child’s hearing loss could be:

- ‘mild, moderate, severe or profound;
- fluctuating (glue ear) or permanent;
- affecting one or both ears.’ (NDCS,2012)

The two methods used to identify and describe levels of deafness are shown in the table below:

1. Descriptions of level of deafness	2. Hearing level in decibels = loudness
Mild	20-40
Moderate	41-70
Severe	71-95
Profound	95+

Table 9.1 Levels of deafness (NDCS)

Thus, for example, a child who cannot hear sounds rated below 20 dB – such as a whisper – would be described as having a ‘mild’ hearing loss.

The everyday implications of these different degrees of hearing loss are mapped in the diagram shown in Figure 9.1 which outlines the relative sound levels of some common audio events.

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Implications for learning

As Table 9.1 conveys, each child’s hearing impairment may well be different as regards the frequencies they can sense and/or how loud the sound signal must be before they can hear anything at all. Whilst loudness is a relatively straightforward concept, the DfE Early Support information explains how the subtle impact of frequency levels can be easily overlooked:

‘Speech is made up of a range of frequencies, so it is important to consider frequency when thinking about a child’s ability to hear speech sounds. A good example of this is the word “moose”. ‘M’ is a low-frequency sound, ‘oo’ is a middle-frequency sound and ‘s’ is a high-frequency sound. To hear the word completely, a child must have appropriate levels of hearing at low, middle and high frequencies.’ (DfE, 2011)

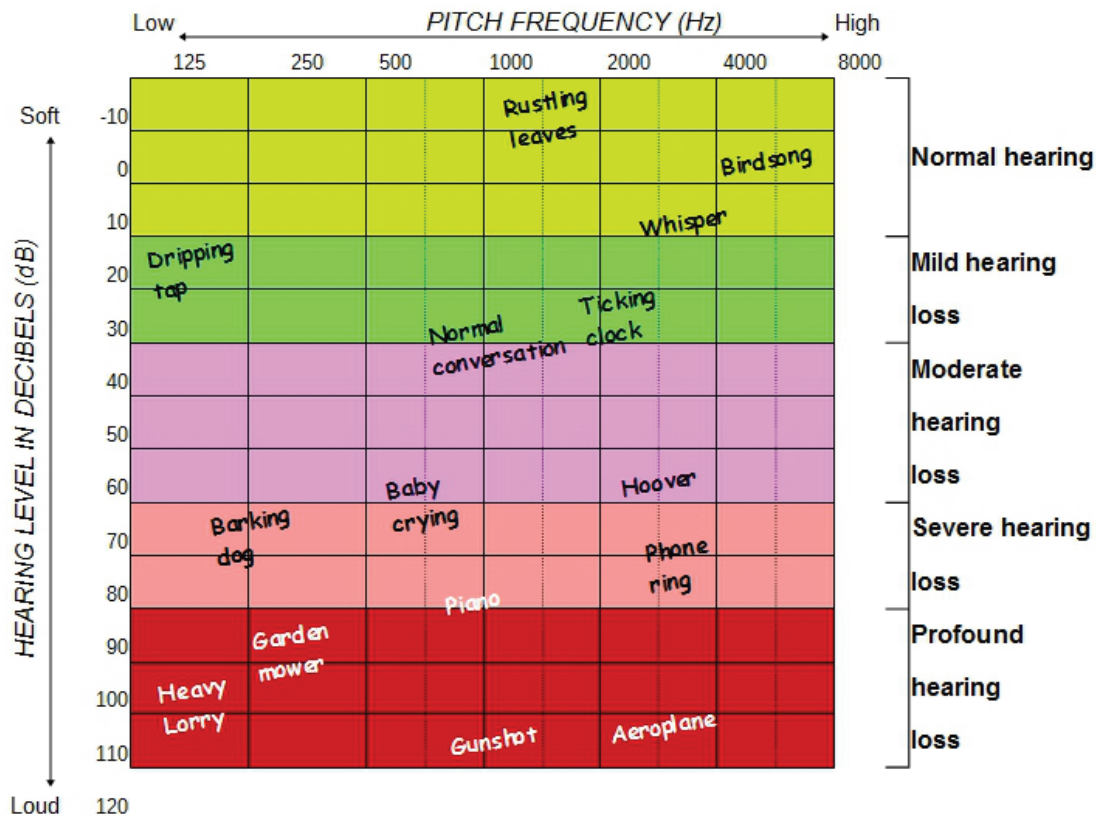


Figure 9.1 Audiogram of everyday sounds (Inspired by NDCS, 2012)

Though any hearing loss imposes limits on a child’s experience, problems in the 20-60 dB range seriously affect the reception and understanding of conversational speech. This, of course, makes it considerably more difficult for children with hearing impairments to acquire, and benefit from, formal and informal educational exchanges, as occur, for example, in the classroom and at home, or through play, friendships and similar social experiences. To illustrate this, the diagram in Figure 9.2 shows where some of the most common language sounds and syllables lie within the frequency spectrum of everyday speech.

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Just how problematic this kind of deprivation can be is addressed in a 2015 report by The Ear Foundation which states that ‘children with mild hearing loss (up to 40 decibels) can miss between 25 - 50 per cent of what the teacher says in class ... In comparison, children with moderate hearing loss (up to 70 decibels), miss over 50 per cent of speech.’

All mild/moderate hearing loss will naturally also impact upon a child’s ability to ‘overhear’ and pick up aspects of language informally. In the classroom, dynamic learning situations commonly involve not only whole-class, direct instruction from the teacher, but also ‘within-earshot’ discussions between learners as well as individual teacher/learner discussions. It is likely that a child with mild/moderate hearing loss will therefore miss out on these valuable enhanced forms of indirect learning.

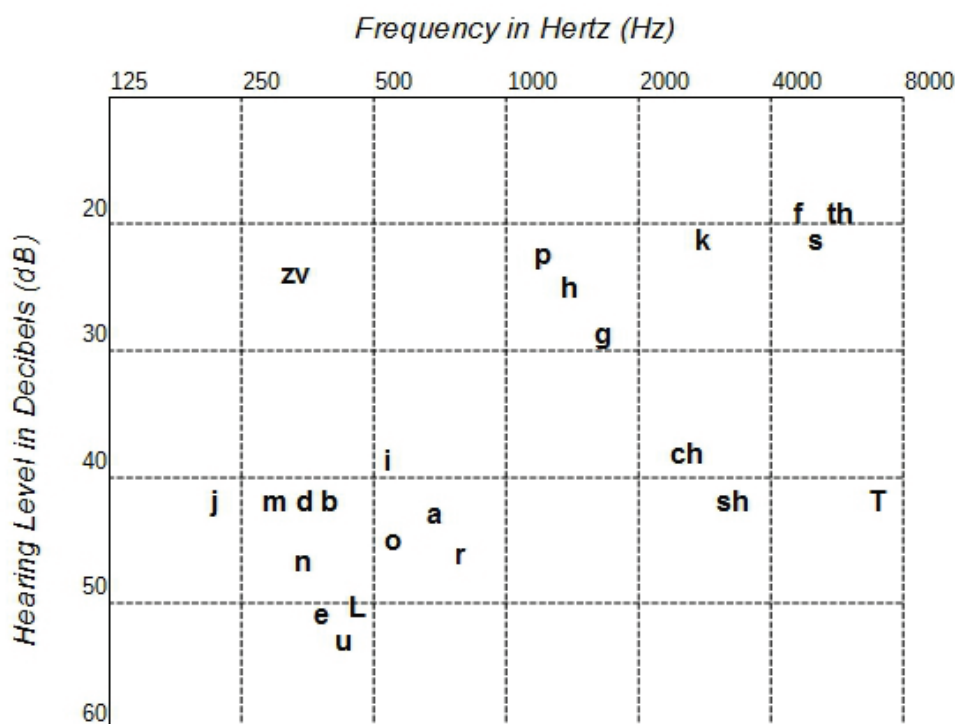


Figure 9.2 Frequency range of conversational speech
(Inspired by NDCS, 2012)

Prevalence of hearing loss

A survey conducted by Fortnum et al. in 2002 explored the prevalence of hearing loss among the UK school population. Those children described as having a significant hearing loss (above 40 decibels) were distributed across moderate/ severe/ and profound categories in the following proportions:

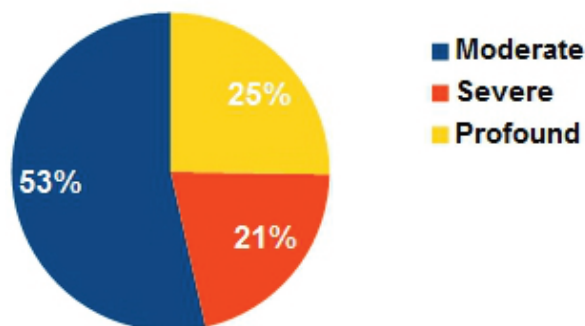


Figure 9.3 Prevalence of hearing loss: UK school population
(Fortnum et al., 2002)

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Communication

Where hearing is seriously impaired, the natural tendency to use other senses to compensate has been harnessed in several different ways to produce a range of different communication systems. Some of those listed by the NDCS and others as often used to facilitate children's education are described below:

British Sign Language: this visual language has its own grammar & uses signs, gestures & finger spelling. A child whose parents are deaf may develop early BSL skills.

Speech reading / lipreading : Though children under four will not be skilled lipreaders, they will be primed to watch a speaker for visual clues. This skill supports other communication systems.

Cued speech: different hand positions used in conjunction with speech to add clarity and assist lipreading.

Finger spelling: each letter of the English alphabet assigned one of 26 different hand shapes. These are employed to slowly spell out English words.

Signed English: based on British Sign Language, plus additional markers. Used in conjunction with speech to overcome ambiguities.

Sign-supported English: as with Signed English, used together with speech, but without the use of additional markers.

Figure 9.4 Communication systems

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Unidentified hearing loss: cause for concern

Early years childcare professionals will understand that early intervention is the paramount consideration in cases where a hearing impairment is suspected. Collating the work of others, Frederickson and Cline (2009) have comprehensively listed classroom signs of potential hearing loss which, though many may have alternative explanations, nevertheless require careful investigation if a child:

- reacts slowly to instructions, or repeatedly asks what to do;
- watches others, then copies what they do;
- constantly asks others to repeat what they have said;
- hears, but only intermittently;
- misinterprets information and questions, or responds to just part of what was said;
- can't locate a speaker, or sound source (especially in noisy conditions);
- daydreams or shows poor concentration e.g. in discussions or at story-time;
- comments inappropriately, as if conversation topics are not followed;
- has delayed language development;
- has difficulty repeating words/sounds or remembering people/places;
- shouts without realising they are being noisy;
- makes speech errors;
- confuses similar-sounding words (e.g. that, fat, vat);
- watches speakers as though lip-reading;
- tends to be disruptive when expected to listen;
- has reading/spelling/writing difficulties;
- suffers frequent coughs and cold.

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Visual impairments

Even though, according to the DfE, children with visual impairments account for a relatively modest 1.8 per cent of those with SEN statements (DfE, 2011), education professionals should not underestimate the sometimes complex nature of their varied requirements. For example, the graphic below quantifies the typical range and variety of impairments among children served by specialist local authority services:

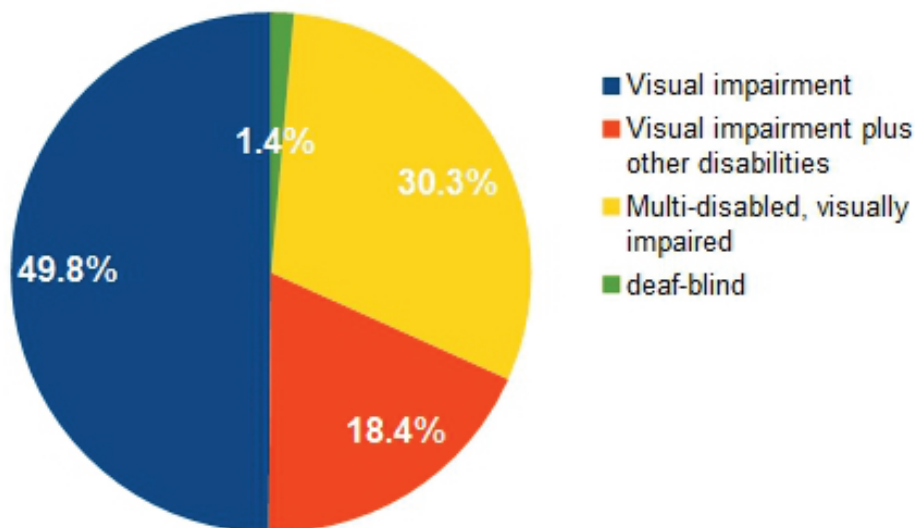


Figure 9.5 Range of visual impairment: UK school population

(Data from Keil and Clunies-Ross, 2003)

Clearly, the presence of other disabilities renders assessment more complex, and sometimes results in substantial visual needs losing priority, or perhaps being overlooked altogether. From an educational standpoint, an assessment of a child's functional vision is an essential prerequisite to the planning of suitable provision – a process which can be significantly enhanced by input from other SEN professionals such as a qualified teacher of children with visual impairment.

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Key considerations

The RNIB (Royal National Institute of Blind People) document 'Focus on Foundation' provides a checklist of key points to guide and inform best practice for early years providers supporting children who are visually impaired:

- Support and advice should be obtained from the local authority Visual Impairment Service.
- The child is first and foremost a child whose development will be individual no matter what level of vision impairment.
- Vision is the major source of information, stimulating curiosity, integrating information and inviting exploration.
- Higher skills in the use of the other senses do not automatically develop to compensate for the lack of sight, but develop through experience, practice and supported learning.
- Learning through senses other than vision can be slower and may be incomplete; it cannot always provide all the necessary information in order to ensure an accurate understanding of people, places and objects in the child's environment.
- Lack of sight can have a profound effect on the child's ability to interact socially. Social clues such as body language, gesture, eye contact, or facial expressions may be missed or misunderstood, and alternative ways of reading other people's feelings and non-verbal communication need to be actively taught.
- A child's confidence is influenced by their ability to be independent in both their learning and everyday routines. (RNIB, 2012)

Extended curriculum

Amplifying the RNIB guidance, Frederickson and Cline (2009) note that curriculum requirements for children with visual impairments 'will extend beyond the National Curriculum and encompass extra learning tasks around mobility, independence and access.' And, as the DfE's Early Support8 document advises (DfE, 2011), such additional requirements will usually include essential enabling skills like learning to read via Braille or Moon systems, and developing fluent ICT skills as early as possible.

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Socio-cultural perspectives

As with other SEN issues, those with hearing and/or visual impairments will not necessarily see themselves primarily as ‘impaired’ – a perspective actively supported by the UN Convention on the Rights of Persons with Disabilities, which determines that:

‘Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.’

(UN, 2006)

High-profile Deaf and Blind role models and cultural groups – often habitually adopting these capitalised descriptors – have ensured that the ‘medical model’, which characterises these major impairments as a ‘deficit’, is counterbalanced by a ‘social model’ which recognises these conditions alone neither define nor diminish a person’s social worth. Accompanied by an understandably robust advocacy, these movements have already given fresh impetus to enabling technologies and assured widespread appreciation that, given equality of access, those with hearing and visual impairment can achieve to precisely the same degree as ‘normal’ hearing and sighted populations.



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10. Equitable demands: Physical needs and inclusion

Throughout history, many social and cultural majorities have tended to reject, isolate, and exclude those with different physical needs. The Greeks and Romans would habitually abandon, or murder, children who did not ‘fit in’; the Tudors could find no value in the ‘helpless poor’; and the Victorians allowed many children with disfigurements to become circus exhibits. More enlightened and inclusive practices can certainly be found in 21st-century educational settings, but change has rarely kept pace with aspirations.

Diverse physical needs

Though an individual’s needs will always be specific and personal, Frederickson and Cline (2009) propose three useful categories of physical needs which mainstream educators may find helpful when thinking about aspects of their own provision:

- Severe physical disabilities: which include motor impairments associated with medical conditions such as cerebral palsy. These in turn can further influence many other aspects of child development.
- Dyspraxia and development coordination disorder (DCD): can cause impaired motor coordination even when there is no underlying medical condition. Developmental delays are common – a feature which has broad implications for social development and educational advances.
- Chronic and severe illness: because medical needs are prioritised, educational attendance and progress are disturbed. In addition, a child’s symptoms may impose limits on what can be achieved in a classroom setting.

Disability and education: the historical perspective

For children with physical needs, the journey towards inclusion has been a hard road – for example, the first UK educational provision for those with disabilities came into being little more than one hundred years ago. The timeline given in Figure 10.1 will help to track the progress of this reform by noting some relevant milestones.

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Redefining disability

According to the 'World Report on Disability' (World Health Organization, 2011), disability is 'an evolving concept', and the most significant driver in terms of equal status for those with disabilities has been the transition from defining disability exclusively in medical terms towards an awareness of the social dimension as it impacts upon individuals. As a consequence, many living with impairments refuse to acknowledge the notion of 'disability', pointing out that their exclusion – from educational institutions, for example – is solely the result of society's barriers to access. Recent disability legislation has begun to acknowledge this 'social model' of disability. For instance, the 2005 Disability Discrimination Act imposes 'general' duties on public bodies, which include the following:

- To promote equality of opportunity between disabled people and other people;
- To eliminate harassment of disabled people that is related to their disability;
- To promote positive attitudes towards disabled people;
- To ... take account of disabled people's disabilities, even where that involves treating a disabled person more favourably ...

In addition, the Act also requires the execution of 'specific' duties, including:

- Developing and publishing a Disability Equality Scheme ...
- Publishing an Annual Report on progress and activities;
- ... involving disabled people in all aspects of the Scheme's development and implementation.

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Year	Event	Notes
1899	Special schools for physically impaired	Teachers paid by results - to detriment of students with SEN
1902	Education Act	Each Local Authority must devise Education Plan – medical professionals required to judge who was suitable for mainstream attendance
1944	Education Act	Advocated alternative provision for children with 'disability of mind or body'. Educational segregation defined in medical terms. Some deemed 'ineducable'
1971	Education Act (Handicapped Children)	Ineducable descriptor removed. Both those with learning difficulties and physical disabilities entitled to education
1978	Warnock Report	Set out ground rules for modern SEN provision: introduced statementing, advised that majority of all children should be taught in mainstream
1981	Education Act	Implements Warnock: defines special needs, specifies school's responsibilities and parent's rights
1988	Education Reform Act	Introduced National Curriculum for all. Focus on staff performance brought return of payment by results – leading to neglect of SEN provision
1993	Education Act	Introduces SEN Code of Practice applicable to all schools
1997	Excellence for All Children	DfEE policy document advocates use of new technologies for special needs learners
2001	Special Educational Needs & Disability Regulations	Schools required to anticipate and adjust to meet needs of students with disabilities. Now bans discrimination
2014	Special Educational Needs & Disability Act	Unified statutory provision 0-25 years and inclusive Education Health and Care (EHC) Plans replace SEN Statements

Figure 10.1 Disability and education timeline of reforms

Attitudes in transition

Disability awareness has, of course, influenced attitudes and practices in the educational world too. Devarakonda (2013), for instance, reports that many research findings confirm 'teachers' attitudes change from negative to positive as a result of their experiences with children with disabilities'. This can be tracked via research initiatives, such as the survey information below adapted from Frederickson and Cline. This data traces the development of the teaching profession's attitudes towards educational provision for children with physical disabilities:

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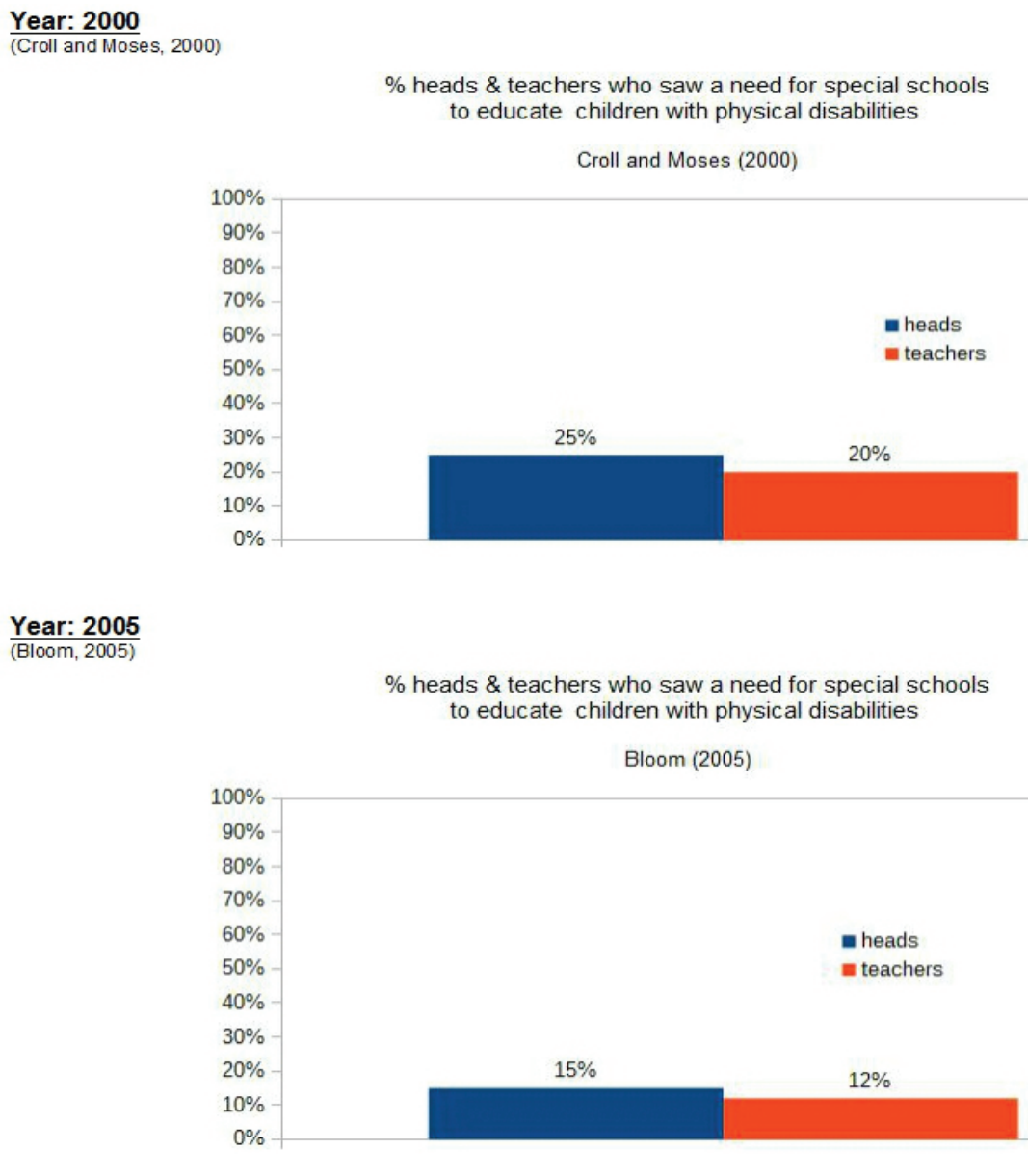


Figure 10.2 Teaching profession's attitudes to disability
(Adapted from Frederickson and Cline, 2009)

As regards the issue of educational segregation, Fontana (1981) has identified precisely why this initiative consistently failed to achieve its primary aims:

‘One of the problems of special schools, no matter how good, is that children become labelled, in their own eyes as well as in those of adults and other children, as being “different” ... in an undesirable way. This kind of stigma places additional burdens upon children and their parents.’

He also points out the underlying irony, adding, ‘the purpose of such education after all is to enhance children and not to handicap them further.’

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Thankfully, as the data above confirms, the tide is now turning, and Devarakonda has noted research listing several specific areas of improvement, such as:

- newly qualified and younger teachers show positive attitudes towards inclusion...
- teachers who are satisfied with the support available, and the development and training they have undergone, develop a positive attitude towards inclusion;
- teachers from mainstream schools perceived that inclusion resulted in a positive impact on the children without disabilities.

Mainstream inclusive practice

When considering the prospect of making children with physical needs feel welcome in mainstream settings, four principal areas are consistently mentioned:

1. Access to the educational institution

Apart from physical access to buildings, classrooms and facilities, other issues such as appropriate pain relief, and ensuring that each teacher's mode of delivery does not disadvantage those with impairments, must all be carefully evaluated.

2. Keeping staff informed of children's needs

Teachers may not always readily appreciate the nature and consequences of a physical disability. Keeping staff informed about a child's impairment is a courtesy which helps them: liaise with parents and other professionals, better assess the impact and benefits of educational initiatives, and better understand the burden of impairment for the child.

3. Delivering a broad and balanced curriculum for all

For children with disabilities, one of the perceived advantages of mainstream settings is better access to a broad and balanced curriculum. However, it is still too common to find that this is just not the case. The worst forms of tokenism once had children copying, developing handwriting, and making craft items as a pale substitute for educational advancement. Whilst accepting progress has been made, Science, PE and Games perhaps still have some ground to make up in this respect.

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However, some PE and Games initiatives have sought to boost the move towards greater inclusion. For example, though the age disparities prevent an absolute comparison, the Sport England data on a whole range of school sports shows not only the difference between the preferences of young people with disabilities and those of total school populations, but also some useful points of correlation such as the mutual popularity of swimming, gym and football – as depicted in the extracts below which shows the 1 to 5 rankings and percentages for the most-favoured activities:

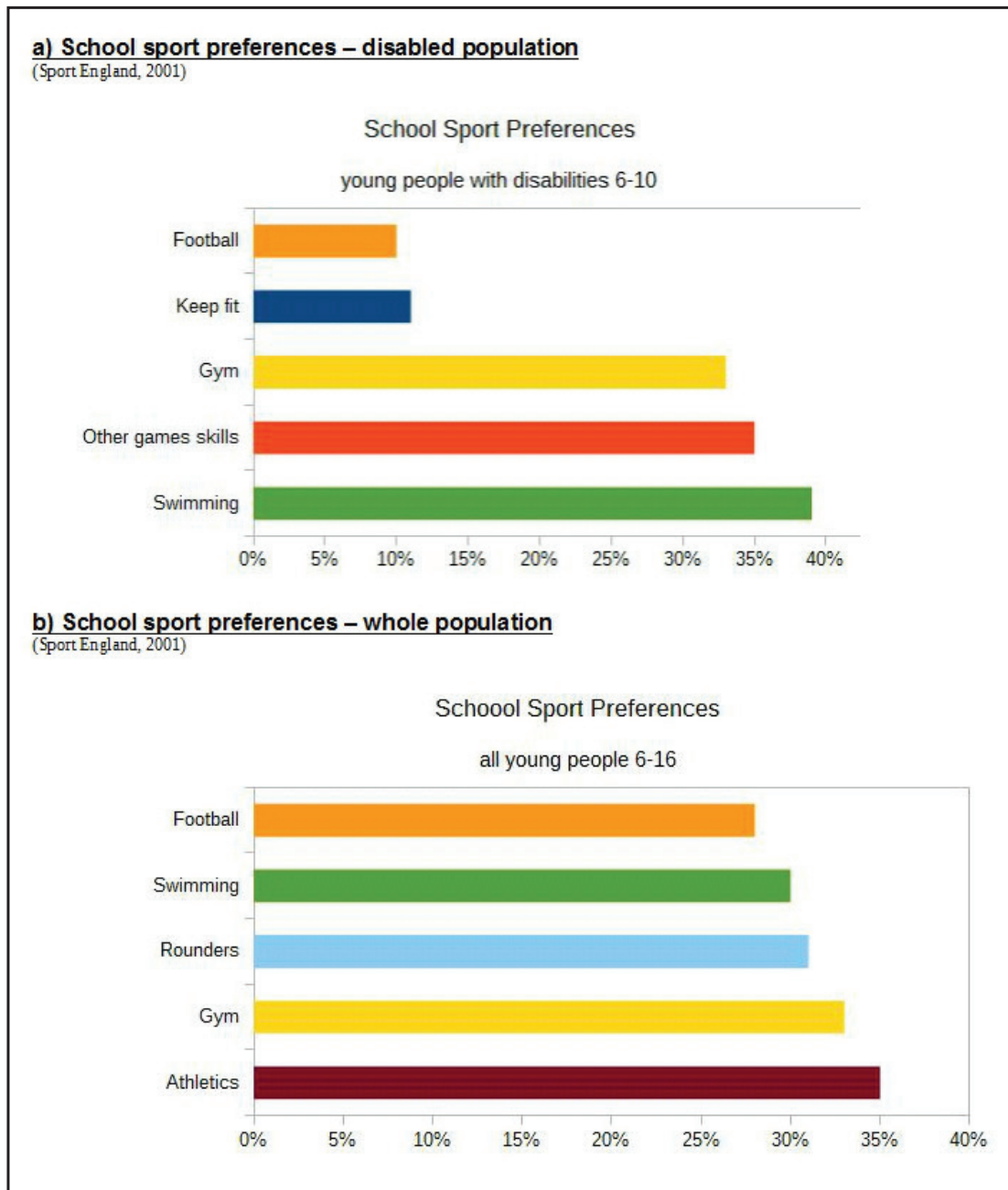


Figure 10.3 School sport preferences disabled/ whole population
(Sport England, 2001)

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4. Accommodating illness and medical needs

Some children could attend a mainstream setting if only their medical needs (e.g. treatment and/or medication) could be properly met. Even though schools have historically contributed enormously to overall child health and well-being, the differentiated support needed to transform the life chances of individuals has too often lagged behind. Similarly, when a child has to cope with longer-term illness and the resultant planned and unplanned absences, institutions can sometimes find it very difficult to provide adequate and effective support – a failing which can only be addressed at strategic level.

Mapping an inclusive future

Many SEN commentators mention the Italian Reggio Emilia preschools as aspirational models of best practice. Here, according to many, the pedagogy of an inclusive community seems to accept Reid and Valle's observation that differing physical needs should be seen as 'human variation rather than pathology'. (Reid and Valle, 2004)

A few of Nurse's observations about Reggio Emilia (in 2001) are quoted in conclusion. These remarks clearly identify some areas where this Italian facility offers a highly nuanced benchmark of exemplary inclusive practice:

'... the preschools minimise the effects of disability and a slower rate of learning because the learning environment matches the developmental and social needs of the individual child ... A difference between the system in the UK and the Reggio response is the commitment to children learning as a group, from each other ... Reggio Emilia is a stable, prosperous and cohesive community. The preschools are a highly regarded part of that community which in turn values the group experience they offer to young children. Provision is local so the children are not placed in distant centres which isolate them and their families from their own community.'

(Nurse, 2001)



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