Special Educational Needs (SEN) - Quick Guide

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1. WHAT IS A STATEMENT of Special Educational Needs (SEN)?

A Statement is a document which sets out a child's SEN and any additional help that the child should receive. The aim of the Statement is to make sure that the child gets the right support to enable them to make progress in school. A Statement is normally made when all the educational provision required to meet a child's needs cannot reasonably be met by the resources within a child's school at School Action or School Action Plus.

Most children with SEN should have their needs met within a mainstream school. Before a Statement will be considered, additional help may be provided to the child at School Action. If the child still does not seem to be making enough progress then the school may seek advice from external professionals at School Action Plus. If this additional help is still not enough then the child's school or parents can apply to the LEA for a Statutory Assessment of the child's SEN in order to try and obtain a Statement of SEN.

WHAT IS A STATUTORY ASSESSMENT?

In order to get a Statement of SEN for a child, the LEA must first conduct a Statutory Assessment. A Statutory Assessment is a multi-disciplinary investigation to try and discover what the child's needs are and then determine what provision is needed to meet those needs.

The LEA will request "advice" from the child's parents, the child's school (or any other education settings or any other education professionals involved), a medical professional (usually a paediatrician), an Educational Psychologist, Social Services and any other relevant professional considered necessary such as a teacher for Hearing Impairment, a teacher for Visual Impairment, a Speech and Language Therapist etc. If after considering all of the evidence received the LEA decides that the child's needs cannot be met solely through school-based provision they may decide to issue a Statement of SEN.

A Statutory Assessment does not always result in a Statement and if the LEA decides not to issue one, they may issue a Note in Lieu, explaining why they have decided not to issue a Statement.

WHAT IS IN A STATEMENT?

The Statement should describe what the child's needs are, the objectives to be achieved, the provision required to meet those objectives, the monitoring arrangements, what school (or other placement) the child will attend and the child's non-educational needs and how these will be met.

A Statement is divided into six parts:

Part 1: Gives general information about the child
Part 2: Gives the description of the child's needs
Part 3: Describes all the special help to be given for the child's needs.
Part 4: Gives the name and type of school that the child should go to
Part 5: Describes any non-educational needs that the child has
Part 6: Describes how the child will get help to meet any non-educational needs

Parents are always sent a proposed (or draft) Statement to comment on before a final Statement is issued. At the proposed stages parents have the right to express a preference for the school they would like their child to go to and to be recorded in Part 4 of the Statement. Statements are reviewed yearly at an Annual Review, which the parents are invited to take part in, which will decide whether or not the Statement needs to be amended or ceased.

TIME SCALES

The whole process for getting a Statement aims to be completed within 26 weeks;

- An LEA has 6 weeks in which to respond to a request by a child's school or parents for a Statutory Assessment.
- The Statutory Assessment itself should take 10 weeks to complete (although the parents are normally only given 29 days to provide their advice) with a further two weeks for the LEA to reach a decision on whether or not to make a Statement.
- If making a Statement, the LEA will issue the proposed Statement to the parents who have 15 days in which to respond with their representations and preference for a school and the LEA then has 8 weeks (including these 15 days) to issue a final Statement.

DO PARENTS HAVE ANY RIGHT OF APPEAL?

If an LEA decides not to conduct a Statutory Assessment, issue a Statement, or if a parent is unhappy with the contents of either Parts 2, 3 and/or 4 of the Statement then they will have a right to appeal to the SEND Tribunal (Special Educational Needs and Disability Tribunal).

Where parents do not think that the provision set out is meeting their child's needs they can request a Statutory Reassessment. If this is declined or they disagree with any final new/amended Statement they can also appeal to the SEND Tribunal.

Parents also have a right to request the LEA to change the name of the school in Part 4 of the Statement and to appeal against any refusal (provided the school being requested is a maintained one). Parents also have a right to appeal against any decision by an LEA to cease to maintain a Statement. An appeal must be lodged with the SEND Tribunal within 2 months of the date of receipt of a decision letter from the LEA.

2. WHAT IS THE SEN CODE OF PRACTICE?

The SEN Code of Practice was last revised in 2001 and gives guidance on how to identify and assess children with SEN.

When dealing with children who have SEN all LEAs, early education settings and maintained schools (both primary and secondary) must take account of the Code as must the local Health Authority and Social Services when assisting LEAs. Schools must particularly consider what the Code says when they are preparing their policies to take account of children with SEN.

WHAT IS IN THE SEN CODE OF PRACTICE?

There are 10 chapters in the Code. Within each chapter there are various sub-headings, including but not limited to the information provided below.

Chapter 1: Principles and Policies

- Definitions of Special Educational Needs
- Fundamental Principles
- Role of LEA
- Roles and Responsibilities of Schools

Chapter 2: Working in Partnership with Parents

- Defining Parental Responsibility
- Supporting Parents During Statutory Assessment
- LEAs Working in Partnership with Parents
- Parent Partnership Services

Chapter 3: Pupil Participation

- Pupils and Parents
- Involving Pupils in Assessment and Decision Making
- LEA's Role in Pupil Participation

Chapter 4: Identification, Assessment and Provision in Early Education Settings

- Provision in the Early Years
- The Role of the SENCO
- Individual Records
- IEPs
- Early Years Action and Early Years Action Plus
- Request for Statutory Assessment
- Criteria for Statutory Assessment of Children under Compulsory School Age and Over Two.

Chapter 5: Identification, Assessment and Provision in the Primary Phase

- Provision in Primary Schools
- National Curriculum
- Record Keeping
- The Role of the SENCO
- Monitoring Progress
- IEPs

- School Action and School Action Plus
- School Request for a Statutory Assessment
- Annual Review

Chapter 6: Identification, Assessment and Provision in the Secondary Sector

- Provision in Secondary Schools
- National Curriculum
- Record Keeping
- The Role of the SENCO
- Monitoring Progress
- IEPs
- Request for Statutory Assessment
- Annual Review

Chapter 7: Statutory Assessment of SEN

- Routes for Referral
- Evidence to be Provided
- Notice that an LEA is Considering Whether to Make a Statutory Assessment
- Request by a Parent
- Communication and Interaction
- Cognition and Learning
- Behavioural, Emotional and Social Development
- Sensory and/or Physical needs
- Deciding that a Statutory Assessment is Necessary
- Time Limits for Making Assessments
- Views of Child

Chapter 8: Statements of SEN

- Criteria for Deciding to Draw Up a Statement
- Note in Lieu
- Writing a Statement
- Speech and Language Therapy
- Proposed Statement
- Naming a School
- Residential Placements
- Education Otherwise than at School
- Parental Representations about Proposed Statement
- Final Statement
- Maintenance of a Statement
- Ceasing to Maintain a Statement
- Amending an Existing Statement

Chapter 9: Annual Review

- Purpose of Annual Review
- Seeking Written Advice
- The Annual Review Meeting

- Conduct of Review Meeting
- Submitting the Report
- The Role of the LEA after Receiving the Review Report.
- Annual Review for Children with Statements Whose Education is Otherwise than at School
- A Change of School
- The Annual Review in Year 9
- The Transition Plan
- Students without Statements but with SEN

Chapter 10: Working in Partnership with Other Agencies

- Principles of Inter Agency Working for Children with SEN
- LEA Support Services
- The Connexions Service
- Learning and Skills Councils
- Child and Adolescent Mental Health Services (CAMHS)
- Social Services
- Looked After Children

3. WHAT IS AN Individual Education Plan (IEP)?

An IEP or Individual Education Plan is a plan or programme designed for children with SEN to help them to get the most out of their education. An IEP builds on the curriculum that a child with learning difficulties or disabilities is following and sets out the strategies being used to meet that child's specific needs.

An IEP is a teaching and learning plan and should set out targets and actions for the child that are different from or additional to those that are in place for the rest of the class. The IEP is not a legal document, which means that the LEA does not have to produce a plan or make sure that a child receives any support that is outlined in the plan.

WHAT IS THE PURPOSE OF AN IEP?

The purpose of an IEP is to inform the teacher and others working with the child of specific targets for the child and how these will be reached. The IEP allows schools and staff to plan for progression, monitor the effectiveness of teaching, monitor the provision for additional support needs within the school, collaborate with parents and other members of staff and help the child become more involved in their own learning and work towards specific targets.

WHAT IS IN AN IEP?

An IEP should contain "targets", "provisions" and "outcomes". It should note 3 or 4 short-term targets set for or by the child, the teaching strategies to be used to achieve those targets, the provision that will be put in place, say when the plan is to be reviewed and identify outcomes which show the child's progress against his/her previous targets.

Information that may be contained in an IEP may include:

- Any likes, dislikes or anxieties that the child may have
- Assessment information
- Details of any other educational plans the child may have.
- Details of how the IEP will be co-ordinated
- Details of the child's additional support needs
- Details of who will be providing the support.
- Home-based tasks and the parents' and child's comments
- Information and timescales for reviewing the IEP.
- Targets that the child is expected to achieve within a specified period of time.
- Parents and child's details

Targets set in the IEP should be "SMART", which stands for:

Specific, so that it is clear what the child should be working towards
Measurable, so that it is clear when the target has been achieved
Achievable, for the individual child
Relevant, to the child's needs and circumstances
Time-bound, so that the targets are to be achieved by a specified time

REVIEWING AN IEP

The IEP is a working document and should be reviewed regularly (usually two or three times a year) to ensure that it continues to meet the child's needs. When reviewing IEPs teachers need to consider both the parents' and the child's views, the progress made by the pupil, the effectiveness of the IEP, any specific

issues that impact on the child's progress and any changes to targets or strategies. After considering the child's current progress, new targets should be set to be achieved by the next IEP review.

4. WHAT IS AN EDUCATIONAL PSYCHOLOGIST (EP)?

An Educational Psychologist (EP) tackles problems encountered in a school environment by children who have learning difficulties and Behavioural, Emotional or Social difficulties (BESD). They work with individual children and also assist teachers, parents and other professionals involved with the child. EPs also help the teachers, parents and other professionals to understand the child's difficulties and support them in teaching and caring for the child. LEAs (Local Education Authority) usually employ many EPs working in schools, nurseries, special units and colleges but a growing number work as independent or private consultants.

WHAT DOES AN EP DO?

An EP will usually assess a child in one of two ways. The first way is through a direct assessment of the child; assessing the child's progress, observing them, interviewing them and using test materials.

The second way is through an indirect assessment which is usually conducted via consultations and discussions with the child's parents and teachers. EPs then write reports making recommendations for action to be taken including for Statements of SEN.

EPs can also provide training for teachers and other professionals on issues such as behavioural management, stress management, bullying and general assessments. Furthermore EPs can advise schools and LEAs about their policies on children with SEN as well as developing and supporting therapeutic and behavioural management programmes.

5. WHAT IS OCCUPATIONAL THERAPY (OT)?

Occupational Therapy (OT) is a treatment used to address a child's ability to perform activities of daily living such as walking, eating, drinking, dressing, toileting and bathing. The primary aim of OT is to maximise the child's potential to participate in activities of everyday life by minimising the impact of their disability through the use of purposeful activity or modifying the environment to better support participation.

Occupational therapy is practiced in a wide range of settings, including hospitals, health centres, homes, and schools. It can offer children with various needs positive, fun activities to improve their cognitive, physical and motor skills and enhance their self-esteem and sense of accomplishment.

WHAT DOES AN OCCUPATIONAL THERAPIST DO?

The occupational therapist (OT) is trained both in physical and mental health and can help with adaptations to changes in everyday life in order to overcome practical problems. The OT will assess the child's abilities and potential within the context of their family and physical environment, enable the child to maintain a balance and maximise their participation in daily activities including self-care, school related tasks and leisure time. They do this by providing advice, looking at ways in how everyday tasks can be done differently, recommending adaptations to the environment to maximise the child's ability to engage in activities and referring you on to other services that can help, for example speech and language therapy.

Therapists instruct those with permanent physical disabilities such as spinal cord injuries, cerebral palsy, or muscular dystrophy, in the use of adaptive equipment, including wheelchairs, orthotics and aids for eating and dressing. They also design or make special equipment needed at home or at work. Therapists develop computer-aided adaptive equipment and teach those with severe limitations how to use that equipment in order to communicate better. Also, physical exercises may be used to increase strength and dexterity, while other activities may be chosen to improve visual acuity and the ability to discern patterns. Occupational therapists often give children a series of daily activities to do at home, at school or both.

When dealing with children with Special Educational Needs (SEN), OTs also work on fine motor skills. This can help children to learn to grasp and release toys and other objects. Therapists also work on hand-eye coordination to improve skills such as hitting a ball, or copying from a blackboard. In addition they can help children with developmental delay learn basic tasks, such as bathing, getting dressed, brushing their teeth and feeding themselves; help children with behavioural disorders learn anger-management techniques; teach children with physical disabilities the coordination skills required to feed themselves or use a computer; and help children who have sensory and attention issues to improve focus and social skills.

WHERE DO OCCUPATIONAL THERAPISTS WORK?

Occupational therapists work in community centres, GP practices, hospitals, client's homes, residential and nursing homes, social services and council departments, schools, charities and voluntary agencies. In schools, for example, they evaluate children's abilities, recommend and provide therapy, modify classroom equipment, and help children participate as fully as possible in school programmes and activities. A therapist may work with children individually, lead small groups in the classroom or consult with a teacher.

WHO DOES OCCUPATIONAL THERAPY ASSIST?

Occupational therapists help children, teenagers and adults. For example an occupational therapist can evaluate a child's skills for play activities, school performance, and activities of daily living and compare them with what is developmentally appropriate for that age group. More specifically, occupational therapy can help those with:

Autism, Birth injuries, Brain injuries, Cerebral Palsy, Developmental Delay, Learning Disabilities, Mental health or behavioural problems, Multiple Sclerosis, Spina Bifida, Spinal Cord injuries

6. WHAT IS SPEECH AND LANGUAGE THERAPY (SaLT)?

'Speech and Language Therapy' is commonly used to help people with language or communication difficulties, although it can also be used to help individuals with difficulty swallowing, eating or drinking.

If the problem being experienced is related to another difficulty such as Autism this is called a 'secondary' impairment. If the problem does not stem from any other disorder, for example, if a child finds social interaction problematic, it is termed a 'primary' impairment. Whatever the cause a speech and language problem can present a considerable obstacle to a person's development.

Speech and Language Therapy Terms

Professionals may differentiate between the terms 'speech,' 'language' and 'communication' and so it is useful to define these terms. Speech relates to the ability to clearly enunciate the sounds necessary to speak; language concerns the comprehension of words and their utilisation to make sentences and; communication concerns the use of language in a constructive way, allowing for interaction with others.

WHAT DOES A SPEECH AND LANGUAGE THERAPIST DO?

The speech and language therapist is trained to assess and treat speech, language and communication problems in people of all ages to enable them to communicate to the best of their ability. They may also work with people who have eating and swallowing problems and work directly with the child and provide support to them and their carers.

Speech and Language Therapists will work with people who suffer the following problems: Stroke, learning disability, physical disability, neurological disorders, cancer of the mouth and throat, head injury, hearing loss and deafness, cleft palate, dementia and psychiatric disorders.

Speech and Language Therapists work in a variety of settings. These include hospitals (both inpatients and outpatients), community health centres, mainstream and special schools, assessment units and day centres and in clients homes.

HOW THE THERAPY WORKS

In a case where communication is the problem the aim of the therapist is to aid the child to communicate as best as they can. In order to do this the therapist first assesses the extent of their problem by considering factors such as how they produce sounds and whether they are able to comprehend spoken language. Once the therapist has made a diagnosis a programme of care is developed for the child in conjunction with their family, and other individuals such as teachers and social workers and other healthcare professionals.

SPEECH DISORDER AND SPEECH DELAY

It is to be noted that if a child is experiencing difficulties in speech it may not be that they have a 'Speech Disorder' but that they have a 'Speech Delay'. The former refers to unusual or abnormal development whereas the latter concerns children who are not developing as fast as they should be. However it is not always easy to determine which category a particular child falls into and professionals may not even make a rigid distinction between the two.

THE CATEGORIES OF IMPAIRMENT

In regards to communication a number of different forms of speech and language difficulties may be identified. These may affect the 'receptive language' of an individual (their ability to understand language) or

their ‘expressive language’ (their ability to form coherent sentences). For instance a person may be unable to control the muscles needed for speech or have a problem with semantics.

HOW DO I KNOW IF MY CHILD NEEDS SPEECH AND LANGUAGE THERAPY?

A number of factors may be identified in order to determine whether or not a particular child requires this form of therapy. For example in the case of a child between the ages of 1 and 2 the following factors would suggest that Speech and Language Therapy may need to be considered:

- There is no development of speech or only very slight progress in this regard
- They do not seem to understand what is said
- They have underdeveloped listening skills
- They are not playing as a child of that age usually would

7. WHAT IS ADHD?

'ADHD' stands for Attention Deficit Hyperactivity Disorder. It is also sometimes referred to as 'Hyperkinetic Disorder'. Until 1994 ADHD was known as 'ADD' (Attention Deficit Disorder) which did not refer to hyperactivity.

'ADHD' is a developmental and behavioural medical disorder, often caused by environmental or genetic factors that result in certain neurological differences. ADHD is often characterised by poor concentration, distractibility, hyperactivity, and impulsiveness which are considered inappropriate for the child's age.

ADHD is thought to be caused due to a lack of chemicals in the key areas in the brain which are responsible for organising thoughts. An estimated 1.7% of children in the UK have been diagnosed with ADHD (in the United States it is thought to be 8- 10 %) . It is more often found in males than females.

WHAT ARE THE SYMPTOMS OF ADHD?

The symptoms of ADHD are generally categorised in three ways as follows:-

Inattentive ADHD

This is where there is often an inability to pay attention to details or a tendency to make careless errors in work or other activities. Symptoms may include:-

- Difficulty with sustained attention in tasks or play activities;
- Apparent listening problems;
- Difficulty following instructions;
- Problems with organisation;
- Avoidance or dislike of tasks that require mental effort;
- Tendency to lose things;
- Distractibility;
- Forgetfulness in daily activities.

Hyperactive - Impulsive ADHD

This is where a child displays symptoms such as:

- Fidgeting or squirming;
- Difficulty remaining seated;
- Excessive activity;
- Difficulty playing quietly;
- Always seeming to be 'on the go';
- Excessive talking;
- Blurting out answers before hearing the full question;
- Difficulty waiting for a turn or in line;
- Problems with interrupting or intruding.

Combined inattentive ADHD and Hyperactive - Impulsive ADHD

This type involves a combination of the first two types of ADHD and is actually the most common form of ADHD. Symptoms are often present over a long period of time and occur in different settings, such as home and school. Often they will impair a child's ability to function socially, academically and domestically.

HOW IS ADHD DIAGNOSED?

ADHD needs to be diagnosed by a qualified healthcare practitioner. However, there can sometimes be difficulties in diagnosing ADHD for a number of reasons. For example there are no clear physical signs that accompany ADHD and there is currently no test that can determine the presence of ADHD. ADHD can only be identified by looking for certain characteristic behaviors which vary from person to person.

ADHD is also often found in conjunction with other disorders, such as:-

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)

Where children may display behavioural difficulties such as stubbornness, outbursts of temper and acts of defiance and rule breaking.

Mood Disorders (including depression)

Where children often feel isolated, inadequate to their peers, frustrated by school failures and social problems and also have low levels of self-esteem.

Anxiety Disorders

Where children may worry, panic excessively or be unduly fearful which in turn can lead to physical symptoms such as a racing heart, sweating, stomach pains, and diarrhoea.

ADHD and Learning Disabilities

Children with ADHD may also have other learning difficulties as a secondary condition such as Dyslexia where they may experience difficulties with reading and writing. Although ADHD is not categorized as a learning disability it can interfere with a child's concentration levels

Children with ADHD are often regulated by medication such as Ritalin (the generic form is called methylphenidate) . Ritalin increases the brain's ability to inhibit it self, allowing the brain to focus and not become distracted. Children prescribed Ritalin will often become more attentive to class work; activity levels can decline to within normal limits and impulsivity can be substantially reduced.

8. WHAT IS APRAXIA?

Apraxia is a motor disorder in which a child's ability to select and sequence movements is impaired. There are different types of Apraxia, such as Oral Apraxia, Verbal Apraxia and Ocular Motor Apraxia.

Apraxia affects the child's ability to use their muscles voluntarily. For example, a child with Verbal Apraxia may absent mindedly utter certain speech sounds (e.g. 'baba') but may find it difficult to produce them on demand.

WHAT ARE THE CAUSES OF APRAXIA?

Apraxia is caused when the area of the brain that tells the muscles how to move and what to do in order to perform a particular action, such as making a certain sound or series of sounds, is damaged or not fully developed. This makes it difficult to retrieve the 'motor plan' for that activity (e.g. how to co-ordinate the different parts of the mouth for saying something).

No one yet knows the precise nature of the brain impairment that leads to Apraxia. However, it is clear that muscle impairments are not the cause of Apraxia. The evidence for this is that children with Apraxia can use the same muscles for other activities. For example, whilst a child may be impaired in their ability to use their muscles for speech, they can use the same muscles for eating.

ORAL APRAXIA

In Oral Apraxia, the child has difficulty in using his mouth for non-speech purposes such as chewing, swallowing and coughing. Other symptoms that a child with Oral Apraxia may display include difficulty with sticking their tongue out and with blowing kisses.

VERBAL APRAXIA

In Verbal Apraxia the child has difficulty using their speech articulators (i.e. tongue, teeth and lips) and also has difficulty producing words and sentences. Their speech is characterised by them searching for the right word and by having several attempts before getting it right.

Some of the main characteristics of Verbal Apraxia are as follows:

- A young child may have limited speech sounds that they can use automatically, such that they may use a simple syllable (e.g. 'da') to mean almost everything.
- A child who can use several different consonants will show inconsistency in the way they use them. For example, they may be able to say a 'p' at the start of a word if it is followed by an 'o' but not if followed by an 'e'.
- A child may be able to say short words in isolation but will have difficulty using two or three words in a row.
- The longer the utterance, the worse the accuracy of the speech.

There are other problems which can be caused by Verbal Apraxia. For example, as well as having difficulties with forming words, children with Verbal Apraxia may also find it hard to find the words they want to say.

As a result of their frustration at not being able to communicate, young children with Apraxia may act aggressively towards their peers. Older children with Apraxia may become shy as a response to their inability to communicate with others.

Some children with Apraxia may actually speak quite fluently when talking about a given topic. However, when the topic is changed, they may become quiet and unsure of their ability to communicate. Others may have difficulty sequencing their ideas and this may also be reflected in their written language. Many children with Apraxia also have difficulties in learning to read and spell.

HOW IS VERBAL APRAXIA TREATED?

In order to gain fluency, a child with Verbal Apraxia must be referred to a speech and language therapist. Therapy is usually quite intensive and is started as soon as the child is ready for it (18-30 months). Therapy is likely to last at least two years and often lasts for even longer. In most cases children with Verbal Apraxia can become competent communicators as a result of therapy.

OCULAR MOTOR APRAXIA

Children with Ocular Motor Apraxia have difficulties controlling their horizontal eye movements. When they rotate their head to the side to look at an object, their eyes lag behind and then move in the opposite direction. To compensate, a child may jerk their head sharply past the object in order to bring their eyes into a position where they can view the object.

Ocular Motor Apraxia is a rare condition and little is known about what causes it. It usually begins to improve and may subsequently disappear after a child has reached the age of five.

Some of the symptoms of Ocular Motor Apraxia are as follows:

- A child may seem visually unresponsive from birth, behaving as if blind;
- A child may have difficulty with horizontal eye movements;
- A child may develop head jerks and blinking which helps them to break their focus and then realign it;
- A child may have low muscle tone;
- The child may also have a Developmental Delay, (i.e. they develop certain skills more slowly than their peers). This is because a lot of development is linked to vision;
- A child may fail hearing tests despite nothing being actually wrong with their hearing. This is because the hearing test may not account for the impact of visual impairment on the child's responses.

There are no known cures for Ocular Motor Apraxia. However, there are certain ways of relieving the effects of the condition. For example, a child can undergo physiotherapy if they have low muscle tone and there are toys and equipment designed especially for children with Ocular Motor Apraxia.

9. WHAT IS ASPERGER SYNDROME?

Asperger Syndrome ("Aspergers") is a form of Autism. It is also sometimes referred to as 'High Functioning' Autism but this is also sometimes said to be controversial.

Asperger Syndrome was named after an Austrian child psychiatrist called Hans Asperger who, in the 1940s, first identified a personality disorder affecting children, which he felt also came under the umbrella of Autism. Unfortunately, his work was not really taken notice of by the English-speaking world, although he had an influence over child psychiatry in Europe.

In the late 1970s Judith Gould and Lorna Wing conducted a study which concluded that Autism existed on a 'continuum' or 'spectrum'. In 1981, Lorna Wing first used the term Asperger Syndrome to describe a distinct sub-group of her patients with Autism. As a result, the term Asperger's became more widely used and is now often thought to be a more acceptable form of diagnosis for parents as it may not carry the same social stigma that is sometimes attached to the term Autism.

Some people with Asperger's may initially seem to have fewer problems with language and communication than those with Autism and are often of average or above average intelligence. However, children with Asperger's usually experience high level language and communication difficulties resulting in isolation, which can in turn lead to feelings of frustration, anger and a lack of self-esteem.

The following symptoms may exist in a child with Asperger's:

- Inability to read body language;
- Appearing self-centred and lacking in feeling for others;
- Using language which is often monotonous and repetitive;
- Problems with the 'three Rs' (i.e. reading, writing and arithmetic);
- Extreme sensitivity to smell, noise and light, often resulting in frustration and sudden outbursts;
- Obsessing about certain subjects sometimes leading to a deep knowledge of them;
- Usually having average to above average intelligence;
- Difficulty with understanding metaphors and sarcasm;
- Tending to take things literally;
- Impaired motor difficulties resulting in coordination problems and difficulties, for example, in sport;
- Unusual behaviour traits and mannerisms;
- Having little, or no, imagination and/or the ability to put themselves in another person 's situation;
- Inability to cope with unexpected situations ;
- Having an overwhelming need for organisation and structure.

THE MAIN DIFFICULTIES FOR PEOPLE WITH ASPERGERS

People with Aspergers have difficulties in three main areas: social communication, social interaction and social imagination.

Social Communication

A child who has a difficulty with social communication has difficulty expressing themselves emotionally and socially. For example they may have difficulty knowing where to start or end a sentence, difficulty understanding gestures and facial expressions and difficulty understanding sarcasm and metaphor. In order to help a child with Asperger's, who is struggling with social communication, sentences should be kept short, clear and concise.

Social Interaction

A child who has difficulty with social interaction has difficulty initiating and sustaining friendships. Children with Asperger's may want to be sociable but can find it difficult. This can lead them to feel anxious. A child with Asperger's can behave in what may seem an inappropriate manner, find other people confusing and unpredictable and seem withdrawn or aloof.

Social Imagination

A child who has difficulty with social imagination has difficulty imagining alternative outcomes and understanding subtle messages. Children with Asperger's can find it difficult to play imaginative games and often enjoy more logical, systematic subjects such as mathematics. A child with Asperger's may also find predicting what will happen next challenging and may struggle to interpret subtle messages that are usually conveyed through facial expression and body language.

Children with Asperger's can typically have difficulty with senses such as touch and can develop special interests to an obsessional degree. They may easily become angry, frustrated, depressed as a result of their condition and particularly the isolation which results. Most children with Asperger's also experience poor co-ordination and difficulties with fine motor control.

WHAT ARE THE CAUSES OF ASPERGERS?

The causes of Aspergers are still being investigated. There is strong evidence to suggest that Asperger's can be caused by a variety of physical factors, all of which affect brain development. There is also evidence to suggest that genetic factors are responsible for some forms of Asperger's.

CAN YOU HELP SOMEONE WITH ASPERGERS?

There is no known cure for Aspergers. The best approach is to provide an appropriate and structured environment, as people with Aspergers respond particularly well to organisation, order and routine.

10. WHAT IS AUTISM?

'Autism' literally means 'selfism'. It was first identified by a psychiatrist, Eugen Bleuler, in 1911 and he used the term to describe the social withdrawal which he saw as one of the key symptoms in patients of his with schizophrenia.

Autism is considered to be a disability which lies on a continuum (or 'spectrum'), with people being affected to different degrees of severity. There are approximately four times as many boys as girls with Autism.

Autism is a developmental disorder which affects a child's social and communication skills and impairs the natural instinct within them to relate to their fellow human beings. Children with Autism show little curiosity or imagination and frequently seem uninterested or indifferent. They also often have accompanying learning disabilities.

Asperger Syndrome is related to Autism at the more able end of the spectrum, and pupil's with Autism who have been integrated into mainstream provision are often those described as having Asperger Syndrome.

In some cases children with Autism may have an isolated area of ability, i.e. one or two skills in which they are markedly more advanced than in their general developmental level. This, however, is a rare occurrence, and certainly not typical of pupils with Autism.

WHAT IS AN AUTISTIC SPECTRUM DISORDER?

In recent years there has been an increase in the number of children and young people identified with Autistic Spectrum Disorders (ASDs). Autistic Spectrum Disorder is a relatively new term to denote the fact that there are a number of subgroups within the spectrum of Autism. These range from low-functioning/severe at one end to high-functioning (sometimes referred to as Asperger Syndrome) at the other end.

There are differences between the subgroups and further work is required on defining the criteria, but all children with an ASD share a triad of impairments in their ability to:

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

Some children with an ASD have a different perception of sounds, sights, smell, touch and taste, which affects their response to these sensations. They may also have unusual sleep and behaviour patterns and behavioural problems. Children of all levels of ability can have an ASD and it can co-occur with other disorders (for example, with sensory loss or Down's Syndrome).

Some experts on ASDs are beginning to view children with an ASD as having a different perspective and experience of the world. This view redirects the focus away from trying to change the child with an ASD. It encourages people to value the child's abilities and the child to develop their interests and activities.

This requires a balanced and empathetic approach. It may be necessary to adopt specific strategies in relation to particular areas of difficulty in order to assist a child to maximise their potential and preserve their dignity: from toilet training for a child who is profoundly affected to supported social skills guidance for a child who wishes to engage with his or her peers.

AREAS AFFECTED IN ASDs

There are several areas affected in ASDs including: non-verbal and verbal communication; social understanding and social behaviour; thinking and behaving flexibly according to the situation; and sensory perception and responses.

Non-verbal and verbal communication

Children and young people with an ASD have difficulty in understanding the communication and language of others and also in developing effective communication themselves. Many are delayed in learning to speak and some do not develop speech.

Many children with speech still have difficulties in using this to communicate effectively. It is likely that they will need to be taught the purpose of communication, a means to communicate (using pictures, photos, gestures, spoken or written words) and how to communicate.

Social understanding and social behaviour

A key characteristic of children with an ASD is their difficulty in understanding the social behaviour of others and in behaving in socially appropriate ways. Other children develop this understanding without being explicitly taught and do so fairly easily. Children with ASDs are very literal thinkers and interpreters of language, failing to understand its social context.

For the child with an ASD, other people's opinions may have little or no influence on their behaviour and the child may say and do exactly as they want. Children with an ASD often find it hard to play and communicate effectively with other children who may be confused by their behaviour and may avoid or tease them.

Adults who do not know the child or know about autism, may misunderstand the child's behaviour and view it as naughty, difficult or lazy, when in fact, the child did not understand the situation or task or did not read the adult's intentions or mood correctly.

Thinking and behaving flexibly according to the situation

Children with an ASD often do not play with toys in a conventional way, but instead spin or flap objects or watch moving parts of toys or machinery for long periods and with intense concentration. Their play tends to be isolated or alongside others rather than with others.

Some children develop a special interest in a topic or activity which may be followed to extreme lengths. Any new skills tend to be tied to the situation in which they were taught which means that children with an ASD will need specific help to generalise skills. They will also have difficulty adapting to new situations and often prefer routine to change.

Sensory perception and responses

It is evident that some children are over-sensitive or 'under-sensitive' to certain sounds, sights and textures. This has implications for the child's home and school environment and may explain their response to changing clothes or food and their response to noise.

In addition, the child may not make appropriate eye contact, looking too briefly or staring at others. In the past, there has been a focus on teaching the child to look when communicating but it may be that some children are unable to talk and look at the person at the same time

11. WHAT IS CONDUCT DISORDER?

Conduct Disorder is the term used to describe a pattern of repetitive behaviour where the rights of others or the current social norms are violated. Conduct disorder is a major public health problem because youths with conduct disorder not only inflict serious physical and psychological harm on others, but they are at a greatly increased risk for incarceration, injury, depression and substance abuse. After the age of 18 a conduct disorder may develop into antisocial personality disorder.

At one time or another most children and adolescents act out or do things that are destructive or troublesome for themselves or others. Only if this persists or continues to occur is it diagnosed by psychiatrists as conduct disorder. Conduct Disorder is much more common in boys than girls.

WHAT ARE THE SYMPTOMS OF CONDUCT DISORDER?

A pattern of repetitive behaviour as manifested by the presence of three (or more) of the following symptoms in the past 12 months with at least one present in the past 6 months:

- Aggression to people and animals: bullies, threatens or intimidates others; initiates physical fights; has been physically cruel to people or animals.
- Destruction of property: deliberately engaged in fire setting with the intention of causing serious damage; has deliberately destroyed others' property.
- Deceitfulness or theft: broken into someone else's house, building or car; lies to obtain goods or favours; stolen items of nontrivial value without confronting a victim
- Serious violation of rules: often stays out at night despite parental prohibitions (beginning before age 13); has run away from home overnight at least twice; is often truant at school (beginning before age 13)

HOW IS CONDUCT DISORDER TREATED?

The method of treatment selected for a child with Conduct Disorder will be determined by the child's age, symptoms, and tolerance for medications and/or therapies. The main approaches to treatment include cognitive behavioural therapy which helps to improve a child's problem-solving, communication, impulse control and anger management skills, family therapy/counselling and possibly medication to treat the symptoms of the disorder.

It is very important for a child diagnosed with Conduct Disorder to have a supportive family and home environment. Not only is this important for following whatever treatment programme is devised, but it helps the child realise that they are still loved and appreciated despite their behaviours. Notifying teachers of a diagnosis of Conduct Disorder is also important as it will help the child feel supported at school.

12. WHAT IS DYSLEXIA / Specific Learning Difficulty (SpLD)?

The word 'dyslexia' is originally Greek and means 'difficulty with words or language'. Up to 10 per cent of the UK population have dyslexia, with around 2 million people in the UK being severely affected. The condition is currently more common in males than females.

Dyslexia is a brain-based type of learning disability that specifically impairs a person's ability to read. These individuals typically read at levels significantly lower than expected despite having normal intelligence. They may also have trouble making the basic connection between letters and their sounds and have difficulty with spelling, writing, and speaking.

There is said to be an overlap with conditions such as Attention Deficit Hyperactivity Disorder (ADHD) of around 30-50%. The overlap with Dyspraxia appears to be even higher.

Frequent characteristics may include:-

- Confusing letters like b and d, either when reading or when writing, or sometimes reading (or writing) words like 'rat' for 'tar' or 'won' for 'now';
- 'Elisions', that is when a person sometimes reads or writes 'cat' when the word is actually 'cart';
- Reading very slowly and hesitantly, who reads without fluency, word by word, or constantly losing place, by leaving out whole chunks of texts or reading the same passage twice;
- Hesitant or slow reading and writing;
- Misreading, which makes understanding difficult;
- Putting letters and figures the wrong way round;
- Difficulty with sequences;
- Poor organisation or time management;
- Erratic spelling;
- Poor memory and concentration;
- Difficulty organising thoughts clearly;
- Poor self-image.

Associated features include problems in distinguishing left and right, poor sense of direction, difficulties with time and tense and subtle problems with both visual and auditory perception.

There are many types of Specific Learning Disability (SpLD) of which Dyslexia is only one. In some cases diagnosis can be difficult. Only a full psychological assessment will determine if any child or adult is Dyslexic. No two people with Dyslexia are exactly the same because Dyslexia ranges between mild, moderate, severe and profound.

Dyslexia is often identified whilst children are in primary school, and can become more evident as the need for written work arises.

However, children with Dyslexia also have many positive qualities in areas controlled by the right hemisphere of the brain, such as artistic skills, creative or global thinking, a strong athletic ability, good people skills, a vivid imagination, and 3-D visual-spatial skills.

13. WHAT IS DYSPRAXIA?

The word "dyspraxia" comes from the Greek word "dys" meaning "difficulty with" and the word "praxis", meaning "acting or doing".

Dyspraxia (also known as Developmental Dyspraxia) is an impairment or immaturity of the organisation of movement. Associated with this there may be problems of language, perception and thought.

Research indicates that up to one in 20 children suffer from the condition with boys identified four times more frequently than girls. It would therefore seem reasonable to suppose that there is at least one child in each class at school with Dyspraxia and in specialist provision for pupils with extreme emotional and behavioural difficulties the incidence is likely to be more than 50%.

Many people think of Dyspraxia as the 'Clumsy Child' Syndrome. Experts have described Developmental Dyspraxia as the difficulty in 'getting our bodies to do what we want when we want them to do it'. This difficulty can be considered significant when it interferes with the normal range of activities expected for a child of their age.

Gross and fine motor skills are hard to learn, difficult to retain and generalise, and hesitant and awkward in performance. Speech articulation may be immature or even unintelligible in early years. Language may be impaired or late to develop.

There can also be poor understanding of the messages that the senses convey and difficulty in relating those messages to actions. Dyspraxic children of normal intelligence may have great difficulty in planning and organising thoughts. Those with moderate learning difficulties may have these problems to a greater extent.

For most children there is no known cause, although Dyspraxia is thought to be an immaturity of neurone development in the brain rather than brain damage. Dyspraxic children usually have no clinical neurological abnormality to explain their condition.

Dyspraxia is part of a continuum of related disorders and may also be present in people with Autism, Dyslexia and Dyscalculia, among others.

14. WHAT IS 'EBD' (Emotional Behavioural Disorder)?

'EBD' stands for Emotional Behavioural Disorder (often referred to as 'Emotional and Behavioural Difficulties) and refers to a condition in which behaviour or emotional responses of an individual are so different from generally accepted norms, that they adversely affect that child's performance. The term EBD is a broad term often used to group a range of more specific difficulties such as behaviour which interferes with a child's own learning or the learning of their peers.

EBD is generally a specific diagnosis where the child displays persistent and severe behaviours. It can also be referred to as 'Social, Emotional and Behavioural Difficulties' (SEBD).

Due to the potential emotional difficulties or disturbance, children with EBD may refuse or unsuccessfully be able to utilise educational opportunities offered to them and are therefore potentially difficult or challenging to manage. Often due to the fact that the child's brain receives and processes information differently than a child who does not suffer from EBD.

WHAT ARE THE CHARACTERISTICS/ SYMPTOMS OF EBD ?

- Disruptive, anti-social and aggressive behaviour
- Poor peer and family relationships
- Hyperactivity, attention and concentration problems

TYPES OF EBD

A child with EBD will usually have their behaviour categorised into recognisable disorders, such as one of the following:-

- **Adjustment Disorders.** A child suffering from an Adjustment Disorder may have witnessed a stressful event or had a big change in their normal lifestyle. This could then have an adverse reaction on their behaviour and the child may become prone to truancy, vandalism, or fighting.
- **Anxiety Disorders.** A child suffering from an Anxiety Disorder may be prone to frequent panic attacks. Here the child may complain of physical symptoms such as headaches or stomach aches. The child may also display inappropriate emotional responses, such as outbursts of laughter or crying out of context
- **Obsessive-Compulsive Disorder ('OCD').** A child suffering from EBD may also have an Obsessive Compulsive Disorder (OCD). Here the child can display recurrent and persistent obsessions or compulsions. Behaviours may include repetitive hand washing, praying, counting, and repeating words silently.

Children with EBD need to be in environments which allow them to interact comfortably. They will often feel more comfortable in smaller groups with familiar peers, where extra support can be offered. Children will benefit from having structured and routine educational instructions. This can assist them in reaching their full academic potential.

15. WHAT ARE LEARNING DISABILITIES?

When children are slower than their peers at learning and understanding new things, they are often said to have Learning Disabilities. A range of different skills can be affected including speech and language skills, social skills and motor skills.

Causes include genetic factors (e.g. Down's Syndrome), infection before birth, brain injury at birth, brain infections or brain damage after birth. Often, the cause of the disability cannot be ascertained.

Some of the signs that a child has learning disabilities are as follows. The severity of these symptoms will often depend on how severe the Learning Disabilities are.

- Difficulty in learning new or complicated information;
- Difficulty in learning practical skills such as tying shoelaces and getting dressed;
- Difficulty in learning social skills such as holding a conversation;
- Difficulty in communicating;
- Low self-esteem caused by comparing themselves to other children;
- Poor memory;
- Poor attention span.

Learning Disabilities can often be a lifelong condition but it should be stressed that they can usually be managed successfully. Whilst some children with profound learning disabilities may always require 24-hour care, many children with less severe Learning Disabilities often go on to lead independent and fulfilling lives.

Learning Disabilities can often be categorised according to their severity. Levels include mild, moderate, severe and profound. The level of the disability is determined using IQ tests, behavioural competence tests and is assessed according to the child's need for special services.

MILD OR MODERATE LEARNING DISABILITIES (MLD)

Children with MLD tend to have an IQ between 50 and 70. It is often caused by a combination of restricted learning and social opportunities. There is sometimes a high rate of low-average intellectual ability and learning disability in close relatives.

SEVERE LEARNING DISABILITIES (SLD)

Children with SLD tend to have an IQ of below 50. SLD often has a specific biological cause.

WHAT CAN BE DONE TO HELP CHILDREN WITH LEARNING DISABILITIES?

Learning disabilities should be recognised as early as possible in a child's development so that the appropriate advice and support can be provided. Before the child is at school, it is normally up to a Health Visitor to notice that the child is developing slowly.

As the child gets older, though, a Child Development Team can be established to work with them. The team normally includes community paediatricians, nurses, psychologists, Speech and Language Therapists and psychiatrists.

16. WHAT ARE SOCIAL SKILLS?

Social skills are specific strategies used by an individual to perform social tasks effectively which will be judged socially competent. There are often two types: environmental social skills and social interaction skills.

Environmental Social Skills are essential to perform tasks in an educational setting and include skills such as listening and following instructions.

Social Interaction Skills are skills that facilitate any positive social interaction, such as starting and maintaining a conversation, complementing others and resolving conflict.

A child with limited social skills may display some of the following characteristics; -

- Having inability to remain calm and relaxed around others;
- Being particularly shy, introvert or aggressive;
- Not having many friends (due to the fact that they can find it difficult to build rapport with others and, in some instances, can find eye contact with other people very daunting);
- Finding it difficult to listen or to empathise with others.

It is common for children with limited social skills to also have a primary disability such as Autism which may impinge on their self-confidence and ability to integrate with others.

As a result children who have limited social skills can often display anxiety and depression and experience other social difficulties including social rejection and interpersonal relationship problems.

There is no known treatment for children with limited social skills, although counselling, skills training or direct instructions can be used to encourage a child to acknowledge and discuss problems which they are worried about. Children with limited social skills also benefit from being given positive feedback and praise as this can assist in developing their moral and self-confidence.

17. WHAT IS SPEECH AND LANGUAGE DISORDER?

A Speech and Language Disorder is where a child's speech and language develops more slowly than expected. Children experience difficulties with comprehension (understanding the language that is spoken to them), expression (using language to express what they want to say), using language (understanding the correct use of words and sentences) and speech sounds (the ability to select and/or pronounce the words). Children may experience difficulties in only one or two or these areas but they can experience them in all the areas mentioned.

THE MAIN DIFFICULTIES OF A SPEECH AND LANGUAGE DISORDER

Some of the main difficulties of having a Speech and Language Disorder are with:

Comprehension

There are various comprehension difficulties that can affect the ability of the child to understand what others are saying. For example, having a lot of ideas in one sentence or using a long sentence can make it harder for the child to comprehend. The child may also find it easier to use nouns which they can link to objects rather than verbs which are harder to explain. Using visual clues or gestures also often makes it easier for them to understand what is being said to them.

Expression

Expression difficulties are where the child may be able to form words but struggles to find the words they want, or put them into the correct order.

Using Language

Children may experience difficulties using language. Whilst they may not experience problems with the actual words and sentences they may find it hard be able to use them in different situations.

Using Speech Sounds

Children may also experience difficulties using speech sounds. This is where choosing the correct sounds needed to form words may be hard for the child and they may find it hard to produce the movements needed to create them.

HOW TO HELP A CHILD WITH A SPEECH AND LANGUAGE DISORDER?

Children with speech and language disorders need to be taught the speech and communication skills which other children learn naturally. Best results are achieved if extra help is introduced as early as possible. Often this is in the form of Speech and Language Therapy, either directly or indirectly.

18. WHAT IS TOURETTE'S SYNDROME?

Gilles de la Tourette Syndrome (or Tourette's Syndrome), is an inherited disorder. It is characterised by multiple involuntary tics which are brief, repetitive movements, which are either motor such as blinking or head jerking, or vocal such as throat clearing, grunting, snarling or similar outbursts. It is now known to affect up to 1 in every 100 school children.

Tourette's syndrome is often associated with over activity, learning difficulties, emotional disturbance and social problems. Obsessive - compulsive symptoms (OCD) are frequent in both the child and their family. Attention Deficit Hyperactivity Disorder (ADHD) has also been reported to be more common than in the general population. It is three times as common in males than females.

It usually begins between 5 and 11 and is likely to persist throughout life, though the degree of severity (from mild to socially debilitating) may differ between individuals and at different times in their lives. Symptoms can increase or decrease or even go into remission. It can also be suppressed so that it may appear different in one place (e.g. school). The condition usually improves after adolescence.

Although most children with Tourette's Syndrome are of normal intelligence, there can be a tendency for verbal abilities to be better developed than abilities which rely on manipulation of visual information. Some children may also have specific problems with organising work, memory and copying. Copying information quickly and accurately from the blackboard can be particularly difficult. Maths may cause special problems. There may also be difficulty understanding and remembering class work or homework.

19. WHAT IS OPPOSITIONAL DEFIANT DISORDER?

Oppositional Defiant Disorder (ODD) is a psychiatric disorder that is characterised by two different sets of problems. These are aggressiveness and a tendency to purposefully bother and irritate others. The main features observed are persistent disobedience and opposition to authority figures (such as parents, teachers or other adults). However the basic rights of others are still respected and age appropriate societal rules and behaviour are not violated. Before puberty the disorder is more frequently found in males than females, after puberty the ratio equals out.

Outward behaviour includes irritability, temper outbursts, frustration and intolerance. The child's self-esteem is usually low (although child may project an image of "toughness"). Additional symptoms of anxiety and depression are also common.

A pattern of negative, hostile, and defiant behaviour lasting at least six months during which five or more of the following are present:

- Child often loses temper.
- Child often argues with adults.
- Child often actively defies or refuses adult requests or rules (e.g. refuses to complete work).
- Child often deliberately does things intended to annoy others (e.g. flicks stationary at staff or pupils).
- Child often blames others for child's own mistakes.
- Child is often touchy or easily annoyed by others.
- Child often angry and resentful.
- Child is often spiteful or vindictive.
- Child often swears or uses obscene language.

WHAT ARE THE CAUSES OF ODD?

There's no clear cause underpinning oppositional defiant disorder. Contributing causes may include:

- The child's inherent temperament
- The family's response to the child's style
- A genetic component that when coupled with certain environmental conditions, such as lack of supervision, poor quality day care or family instability, increases the risk for ODD
- A biochemical or neurological factor
- The child's perception that he or she isn't getting enough of the parent's time and attention

IS IT POSSIBLE TO TREAT ODD?

Treatment of oppositional defiant disorder has poor outcomes. When the parents are overly restrictive, the child fights back more, resulting in a power struggle. Some individual therapies and family therapies have been successful, but not to a great extent.