15

SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) AND INCLUSION

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INTRODUCTION

This chapter will explore Special Educational Needs and Disability and consider how this fits with the Inclusion Agenda.

CHAPTER MAP

This chapter will include:

- What do we mean by Special Educational Needs and Disability including definitions and a brief overview of mainstream and special education
- Areas of need including the four broad areas of need identified in the SEND Code of Practice (Department for Education/Department of Health, 2015)
- What is inclusion? which includes an overview of the medical and social model of inclusion
- Case studies – including dyslexia, autism and Down syndrome

KEY WORDS

- Special Educational Needs (SEND), disability, code of practice, inclusion, neurodiversity, psychometric assessment, labels

LEARNING OBJECTIVES

In this chapter you will learn about :

- Definitions for Special Educational Needs and Disability (SEND)
- Broad areas of need to support identification and provision
- Medical and social models of inclusion and the arguments for and against the use of SEND labels
- The role of psychometric assessment for young people with SEND

WHAT DO WE MEAN BY SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND)?

DEFINITION OF SPECIAL EDUCATIONAL NEEDS (CODE OF PRACTICE, DFE/DOH, 2015: 15–16)

A child or young person has a Special Educational Need if they have a learning difficulty or disability which calls for special educational provision to be made for him or her.

A child of compulsory school age or a young person has a learning difficulty or disability if he or she:

- Has a significantly greater difficulty in learning than the majority of others of the same age, or
- Has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions,

DEFINITION OF DISABILITY (EQUALITY ACT, 2010)

You're disabled under the Equality Act 2010 if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities:

- 'Substantial' is more than minor or trivial, e.g. it takes much longer than it usually would to complete a daily task like getting dressed
- 'Long-term' means 12 months or more, e.g. a breathing condition that develops as a result of a lung infection

CRITICAL QUESTION

Take time to read through the definitions above carefully.

Do you think these definitions are clear for all to follow?
Note down any challenges you might have with these definitions.

There have always been those with additional needs in our society and for many years this marginalised group did not access school at all. In England, it wasn't until the 1970 Education (Handicapped Children) Act that discontinued 'the classification of handicapped children as unsuitable for education at school', and it took another 11 years, thanks to the significantly influential Warnock Report (1978), before it was stipulated in the Education Act (1981) that children should be educated in mainstream schools where possible. There was to be further international challenge with the World Conference on Special Education 1994 with the Salamanca Statement, a life changing document on inclusive practice. The statement's strong conclusion echoed across the world:

> Regular schools with [an] inclusive orientation are the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all; moreover, they provide an effective education to the majority of children and improve the efficiency and ultimately the cost-effectiveness of the entire education system. (United Nations Educational, Scientific and Cultural Organisation [UNESCO], 1994: 8)

CRITICAL QUESTION

Think about your own experience of school. Do you feel your school had an 'inclusive orientation'? If so, how do you feel this was achieved? If not, what were the barriers to this?

In England, there remain two routes in education for those young people with SEND:

- Special Education (where all children have their complex needs formalised in an Education, Health and Care Plan [EHCP] and receive top up funding from the local authority)
- Mainstream (where some children may have an EHCP but the majority are identified as needing SEN Support and funded directly from the school budget)

In England in 2020/21, 15.9% of school age young people were identified as having SEND, with 3.7% requiring an EHCP and those requiring SEN Support at 12.2% (Gov.UK, 2021) https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england)

SPECIAL EDUCATION

In these educational settings, which are often organised by area of need (see below), you will find a high ratio of adults to child, with a range of in-house specialists (e.g. speech and language therapists, occupational therapists, physiotherapists) and smaller class sizes. The curriculum can be tailored to meet the needs of the individual child and there is a strong focus on skills for life and preparing for adulthood.

MAINSTREAM EDUCATION

In these educational settings, the situation is quite different. With class sizes of 30+ students with one teacher and possibly a teaching assistant to support (more likely in primary than secondary schools) and very few in-house specialists, young people are educated alongside their peers. The curriculum may be tweaked but, essentially, children and young people in mainstream may access a similar package to the rest.

CRITICAL QUESTION

What are the strengths and weaknesses of each of these types of setting?

There is no such thing as a 'right school' or 'wrong school', but some schools certainly seem to suit an individual more than others. Read Miriam's story below.

CASE STUDY: MIRIAM

I have cerebral palsy, which was directly linked with complications at my birth. I went to my local, mainstream primary school and loved it. To be honest, I never knew any different. Since nursery, I was with the same group of children until the end of primary. I needed extra help in school and had a teaching assistant nearby for a lot of my time, but I had good friends and got invited to birthday parties! I managed OK at first at high school, but then some students started making comments about how I walk and talk. I was also getting much more tired as I had so far to walk around school and found the work was getting more and more difficult for me to do. I didn't have a teaching assistant with me all the time and those lessons were the worst. I began to hate school and became really unhappy. It was suggested at my Annual Review that I might prefer a move to another school. I was surprised that was an option but when I went to visit XX High [specialist school], it just felt right. I started there the next term and never looked back. I found I could do my work again – so much so that I was given more extension work than some in my class and made some great friends. We all had some kind of difficulty so nobody commented on mine. My confidence grew and I enjoyed it so much I stayed on at the Sixth Form!

CRITICAL QUESTIONS

- How did Miriam's primary setting successfully include her?
- What went wrong at high school?
- Why do you think the specialist setting suited Miriam more?

One of the challenges of mainstream schools can be a 'one size fits all' approach to provision. Here lies the tension as students like Miriam can be profoundly aware of their differences and feel like they simply don't fit in. It is also a challenge for educators as they are expected to try and teach the full National Curriculum (in England), at pace, to all. Unfortunately, not all children fit neatly into the current education system and the 'square peg/round hole' tensions continue.

Consequently, a lot of time and resources can be taken up trying to find appropriate ways for young people to access their education.

Where this is the case, not only the young person but the family can also be very frustrated with the situation. The Lamb Inquiry (2009: 2) focused on parents' views of children with SEN and reported an

> ... underlying culture where parents and carers of children with SEN can too readily be seen as the problem and as a result parents lose confidence in schools and professionals. As the system stands it often creates 'warrior parents' at odds with the school and feeling they have to fight for what should be their children's by right; conflict in place of trust.

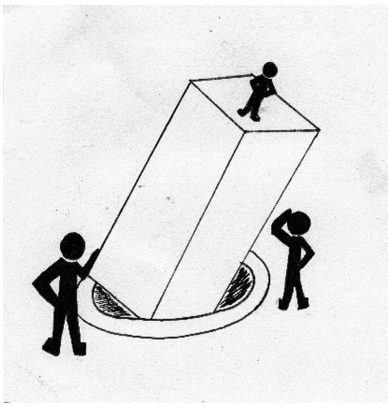

Figure 15.1 Square peg in round hole

Image created by Nia McSweeney for this chapter

CRITICAL QUESTION

Imagine if you were the parent of a child with a special educational need and/or disability. Why might you feel like a 'warrior parent'?

AREAS OF NEED

In England, the *Special Educational Needs and Disabilities: 0–25 Code of Practice* (DfE/DoH, 2015: 6.27, p. 97) refers to four 'broad areas of need [that] give an overview of the range of needs that should be planned for'. These areas are:

- Communication and interaction
- Cognition and learning
- Social, emotional and mental health difficulties
- Physical and/or sensory needs

COMMUNICATION AND INTERACTION

This area of need is currently the most prevalent in England, with a high number of children and young people identified as needing additional support in this area (Gov.UK, 2021). This category refers to needs that will affect speech, language and communication. Children who may need additional provision under this category are likely to struggle to

express their needs clearly through verbal language: for example, they may struggle with speech sounds/clarity of speech or have delayed language skills affecting their ability to communicate. These difficulties with expressive language can significantly impact on peer and adult interactions (Longfield, 2019). This area of need also considers groups of children who struggle to understand language (receptive language skills). These children can find school a real struggle as their difficulties can affect their ability to comprehend instructions/new concepts/texts. Those presenting with difficulties in both expressive and receptive language may have Developmental Language Disorder (DLD), which affects over 7% of children in our schools (Royal College of Speech and Language Therapists, 2021). Given their communication and interaction difficulties, children and young people with a diagnosis of autism are likely to be categorised under this area of need.

COGNITION AND LEARNING

This area of need refers to all difficulties related to learning. There are specific learning difficulties (SpLD) which are directly related to certain areas of learning, for example literacy (e.g. dyslexia) or numeracy (e.g. dyscalculia). Children with these specific difficulties require targeted support which is designed around a multi-sensory approach (Kelly and Phillips, 2016). For other children and young people, their learning difficulties are more generalised due to global developmental delay. These can be further categorised as general learning difficulties (GLD), moderate learning difficulties (MLD), severe learning difficulties (SLD) and profound and multiple learning difficulties (PMLD) depending on the severity of the difficulties. For many of these young people, they will need the curriculum to be significantly adjusted to ensure they can access the learning at their level.

SOCIAL, EMOTIONAL AND MENTAL HEALTH DIFFICULTIES

Children and young people who require additional support under this area of need find it difficult to manage their emotions, which impacts on their social skills and mental health. This may be linked to trauma, bereavement or a range of other environmental/genetic factors. For many children under this area of need, they find a full day in a busy classroom a real struggle and require targeted interventions to support them: for example, access to a calm space, handling emotions, resilience training and in some cases access to specialist support such as Child and Adolescent Mental Health Services (CAMHS). It is likely the children highlighted in this category are likely to implode (present as withdrawn, school refusers) or explode (challenging behaviour). A child with a diagnosis of attention deficit hyperactivity disorder (ADHD) will fall into this category. It is not uncommon for

children to present with these needs if they have an unmet learning need. For example, some children may increasingly feel stressed, agitated, frustrated with school if they are struggling to understand language or read effectively, which is why assessment and early identification are crucial (DfE/DoH, 2015).

PHYSICAL AND/OR SENSORY NEEDS

Young people with a physical disability which requires additional provision will fall under this category, for example, those with hearing or sight difficulties. The Code of Practice 6.11 (DfE/DoH, 2015: 94) clarifies that a medical or physical condition does not automatically lead to a child being placed on the SEN register. This would only be the case if the child requires provision that is 'different from or additional to' the quality universal offer for all children.

The Code of Practice 6.27 (DfE/DoH, 2015: 97) also clearly states that 'individual children or young people often have needs that cut across all these areas and their needs may change over time' so schools need to be careful not to over-simplify the identification of SEND and 'fit' a child into one category.

21ST CENTURY CHALLENGES

In recent years, there has been the increased awareness in schools of young people with 'new' complex learning difficulties and disabilities (CLDD) (Carpenter et al., 2011). These 21st century children struggle to access school for a variety of reasons.

INCREASE IN COMPLEX MEDICAL CONDITIONS

Due to medical advances, 8% of babies born in England are premature, that is before 37 weeks (NHS, 2019), with children born before 34 weeks being much more likely to have difficulties with cognition and learning (Wolke and Johnson, 2017). For every 47 births, one baby is diagnosed with a congenital anomaly (Public Health England, 2018).

ALCOHOL, DRUGS, SMOKING DURING PREGNANCY

It is estimated that 5% of pregnant women use one or more addictive substances (National Institute on Drug Abuse, 2020) and up to 17% of children in the UK could have foetal alcohol syndrome (FAS) (McQuire and Paronjothy, 2018)

MENTAL HEALTH

One in six children (aged 5–16) have a probable mental disorder (NHS, 2020).

It is unsurprising that that these statistics directly correlate with current observations seen in education, where children are presenting with such complex difficulties that affect their learning and behaviour.

> We have to equip teaching professionals to offer high quality education to these young people to prevent their disenfranchisement from the school system. (Carpenter et al., 2011: 4)

However, 10 years on from Carpenter's recommendation and many educational practitioners do not feel equipped to be able to meet the complex needs of these children. Consequently, there are challenges to successfully including all children and young people in the current education system and ensuring they have positive outcomes into adulthood.

CRITICAL QUESTION

Do you feel our schools are equipped to meet the needs of our 21st century children in mainstream and specialist settings?

What might some of the barriers be (a) for teachers? (b) for children with complex needs?

WHAT IS INCLUSION?

What do you think about when you hear the word 'inclusion'? Perhaps you reflect on your own school days when you met a wonderfully diverse group of young people who were all thriving in your setting? Perhaps you focus on one person you know personally, perhaps a wheelchair user or someone with a disability and you reflect on how they have full access to education and society as a whole? Perhaps that person is you? Or does the word 'inclusion' resonate as a notion of a more utopian society – something we dream of/aspire to?

CRITICAL QUESTION

What does 'inclusion' mean for you?

Consider inclusion within society as well as within education.

There are many definitions of inclusion out there, but this is the one we are going to use in this chapter:

> ... a framework within which all children – regardless of ability, gender, language, ethnic or cultural origin – can be valued equally, treated with respect and provided with real opportunities at school. (Thomas and Loxley, 2007: 124)

Put simply, education for all (Ainscow, 1995).

In any consideration of inclusion, it is important not to focus initially on exclusion: marginalised groups that are still not fully part of society. We hear all the time about groups of people – women, disabled, transgender, living in deprivation, non-white heritage for example – who feel they have been excluded for being a statistic. It's more helpful to think of inclusion as 'a process rather than a fixed state' (Bines and Lei, 2011: 421) and recognise there is still much to be done (Ainscow, 2020).

For the purpose of this book and chapter, we need to maintain a focus on inclusion in education. Remember, this refers to inclusion for ALL young people (see Thomas and Loxley's definition above) and therefore moves way beyond the parameters of special educational needs. However, it remains true that very often SEN and inclusion are linked together, and this is likely to be because the inclusion models discussed below stem from the notion of disability.

WHAT DO WE MEAN BY 'MODELS' OF INCLUSION?

We use the term 'models' to identify two very different perspectives of inclusion: the medical model (some refer to this as the psycho-medical model) and the social model (some refer to this as the socio-political model).

THE MEDICAL MODEL OF DISABILITY

The medical model is the traditional view of disability, which identifies deficits within a person. Historically, these deficits were disabilities and needed 'remedies' to 'cure' them. An 'expert' is required to 'diagnose' and 'fix' the person and it is assumed that anyone with such a 'deficit' requires special 'treatment'.

CRITICAL QUESTIONS

- How is the language used to describe the medical model of disability similar to that of medical science?
- What does this suggest about the views of professionals and the feelings of those in the disabled community? (Consider the sense of power/authority here.)

LET'S DISCUSS LABELS

Part of the role of this 'expert' would be to label some of these 'deficits'. For years, it has been commonplace for young people to be diagnosed with an 'impairment' or 'disorder' by a professional. For example, a child who has a deficit in reading or spelling may be given the label of dyslexic. A child who struggles to sit still and concentrate may be given the label of attention deficit and hyperactivity disorder (ADHD). (For more examples and explained acronyms search the internet 'Inside Government SEND abbreviations'.)

A diagnosis of need is still commonly given to many young people today. In the UK it is thought 10% of the population have dyslexia (NHS, 2018a) which equates to approximately 3 children in every classroom. ADHD is prevalent in 3–5% of UK children (NHS, 2018b) so it's likely most UK classrooms will have at least one child displaying ADHD.

Why we* like labels

**many young people/parents/educational professionals but not all*!

For many young people, being given a diagnosis helps them in many ways – it gives a name and credence to their difficulties and helps them understand themselves much better. Read Oscar's story below:

> Before I was diagnosed with dyslexia, I thought I was just stupid. So much in school was so hard for me. I just didn't seem to be able to learn like everyone else and did terribly in most of my exams. I loved PE and Food Technology and was really good at these but anything that involved reading and writing was a nightmare. It wasn't until I was about to sit my final exams that I was diagnosed. Suddenly it all made sense. I wasn't stupid after all but had a learning difference that meant I learned in a different way. I ended up getting extra time and a laptop for my final exams* and got the grades I deserved. I honestly think if I hadn't been diagnosed I would have gone into adult life feeling dumb.
>
> (*In England you don't need to have a diagnosis to get access to extra time/laptop for exam access arrangements.)

For so many like Oscar, such a diagnosis can significantly increase their self-esteem as deep down they know they're not stupid. So many of the rich and famous from days gone by and the contemporary world also have a story like Oscar's: Steve Jobs, Jamie Oliver, Richard Branson, Winston Churchill, Kiera Knightley, Walt Disney, Albert Einstein to name a few (search the internet 'Helen Arkell Famous Dyslexics' for more examples). It can be very helpful for those with a diagnosis to read about others who have become successful despite their difficulties

However, for many with dyslexia or other learning difficulties, school was a turbulent time where they felt misunderstood and struggled on a daily basis. Despite most UK classrooms

having young people with a diagnosis, there continues to be lack of training for teachers to implement the most appropriate teaching method to meet the needs of the student effectively.

For many young people and their families, having a diagnosis also opens up a wealth of services and support that are not available without one. In England, this is particularly the case for those with conditions such as autism. The waiting list for an Autism Diagnostic Observation Schedule (ADOS) which forms part of an assessment for autism is increasing (British Medical Association, 2019). Delays in diagnosis can put an additional burden on families.

Why we* don't like labels

**many young people, parents, educational professionals but not all*!

LABELLING THEORY The notion of labels was firmly challenged by sociologist Howard Becker in 1963. He challenged the concept of labels and deviance (across society, including the criminal justice system, not just in education) and introduced 'labelling theory'. His research found labels were a direct link to others' perceptions of 'normal' and those who 'share the label and the experience of being labelled [are seen] as outsiders' (Becker, 1963: 10). Therefore, labels and difference were a direct consequence of society and human perspectives rather than anything to do with individual deficits.

Another problem with labels is that very few children fit neatly (remember the square peg/round hole analogy from earlier) and it can sometimes be too easy to group children together to try and 'fix' their problem. They stop being individuals and instead it is the label that defines them.

> If you've met one person with autism, you've met one person with autism. (Shore, 2018)

CRITICAL QUESTION

Think about the above quote. What does it mean? What are the implications for those working in education?

Once you have made some notes, you can search the internet 'ibcces interview with Dr Stephen Shore' and read the author's response.

The other problem with labels is many children have more than one. The scientific name for this is comorbidity. In fact, some children can have so many labels that we can lose sight of the individual child.

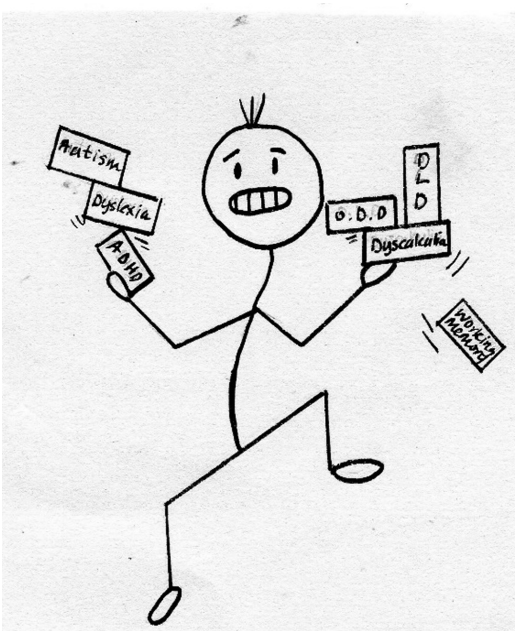

Figure 15.2 Juggling labels

Image created by Nia McSweeney for this chapter

Comorbidity can be a feature for many children with SEN. It wouldn't be uncommon in a UK school for a child to have a diagnosis of autism and ADHD alongside an anxiety disorder, sensory processing difficulty and motor skills difficulty. These labels all too easily define the child and each label seems to add more weight to their needs.

Griffiths (2017) uses the analogy of an 'SEN shoe box'. We pack the shoe box with diagnosis bricks, each one another 'problem' that needs 'fixing', adding weight and complexity with each block.

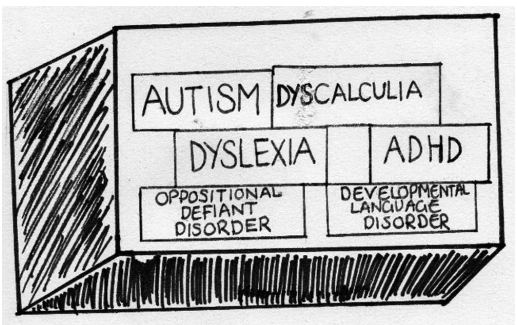

Figure 15.3 The SEN shoe box

Image created by Nia McSweeney for this chapter

CRITICAL QUESTION

Imagine you are a class teacher and have a child in your class with several 'labels'. What are the implications for you as a school educator? How might the child feel?*

(*If it helps, how might you feel if you were diagnosed with high blood pressure, diabetes, heart disease and a psychological disorder?)

There is a danger that once a child is presented as a list of deficits, not only do the adults around them need to try and fix them, but there can be a lower expectation of what the child can achieve. '[T]hese labels of SEN have perpetuated a culture of low expectations and have not led to the right support being put in place' (Ofsted, 2010: 9). Ironically, in some cases, the more labels, the less targeted support. The child is seen as complex with an array of difficulties and is likely to struggle in all aspects of education.

Or are they?

CRITICAL QUESTION

First of all, search the internet using these terms:

'How was school Zara Todd cotton wool'

'Teach us too Jonathan video'

How do Zara's and Jonathan's stories challenge the notion of labels/special education?

A final reason why labels may not always be helpful is that some children may use them as an excuse. 'I can't do this work, I've got dyslexia'; 'I can't behave on the school trip, I've got ADHD'. This 'can't do' approach is rarely helpful and can add even more barriers to learning. All children need to believe they CAN DO school and it's up to the educators to ensure this is the case.

IF NO SEN LABELS, THEN WHAT?

Could we not argue that all of us are 'special' with 'additional needs'? Nobody is 'average' or 'normal'; we are all unique and require different approaches/strategies depending on the task. This human variation is termed neurodiversity where there is 'no typical brain' (Armstrong, 2012; Griffiths, 2020). Originally named by sociologist Judy Singer in 1998, it is a term that is increasingly used now in education. The fundamental principles behind the notion of neurodiversity are to:

- Consider the whole child as unique
- Celebrate diversity of the brain function
- Focus on strengths as well as challenges

Let's take the shoe box analogy from earlier, with its layers of weighty bricks and labels and think about it in a different way. Imagine a box full of sugar paper confetti, an array of shapes, colours and sizes – 'a colourful tapestry' (Jackson, 2004: 42). Does this not help to summarise another way of viewing all our children?

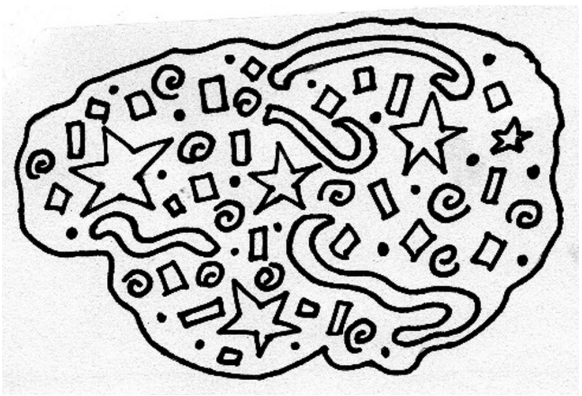

Figure 15.4 The confetti box

Image created by Nia McSweeney for this chapter

The conclusions of a recent study in England, also echo this:

> .... assigned labels are not the focus. Instead, it is more important to understand pupils as individuals with unique strengths, removing barriers to learning and providing support that meets needs and makes a positive difference. (Office for Standards in Education, Children's Services and Skills [Ofsted], 2021)

Educators should meet the individual needs of every child, with or without labels. Simple.

RESEARCH METHODS

This recent study (May 2021), *Supporting SEND*, was conducted by Ofsted, who based their research on a case study design of 21 pupils from seven different primary and secondary schools across two local authorities in England. These mainly took the form of interviews with the young person, family and school staff. The schools selected the young people/families they felt would respond well to working with unfamiliar adults.

What do you think are the strengths and limitations to this research method?

Search the internet 'Ofsted Supporting SEND' to see comments on the methodology and limitations near the start of the report.

ASSESSMENT IN CONTEXT – ASSESSMENT FOR EQUITY AND FOR LEARNING

Psychometric assessment

Fittingly under the medical model of inclusion, there needs to be a discussion around psychometric (taken from the Greek psycho = mental; metric = measurement) assessment. These assessments are used to measure a variety of skills – verbal, non-verbal, reading, spelling, maths, writing speed, concentration, etc. This form of assessment has been central to the work of psychologists, and more recently specialist teachers, focusing on the individual with the 'problem' and locating their 'deficit' (Barnes et al., 1999). Undoubtedly these assessments, still used today, decide what is 'average' and the child with special educational needs is usually placed within the 'below average plethora' – which draws on 'impairments' and 'deficits' (Macartney and Morton, 2011). Raw data can be provided to offer evidence of the 'impairment' and professionals can then draw assumptions and conclusions based on this. This form of assessment has prevailed in SEND provision for many years.

However, increasingly professionals are challenged that this form of assessment can lead to 'many a cul-de-sac' (Thomas and Loxley, 2007: 39) in its rigidity; arguably then, it does not meet the needs of the child.

CRITICAL QUESTION

How helpful is it to have standard average scores and what does this tell us about a young person?

Perhaps, more importantly the psychometric assessment can be seen to offer a window into a child working as independently as possible on a variety of tasks. The diagnostic assessments – observing how a child approaches a task, highlighting areas of strength as well as difficulty – all can play a significant part here.

Furthermore, many professionals would argue that whilst psychometric assessments form part of their assessment, this is only a small piece of the assessment jigsaw. Observations of the child in different environments, discussions with the young person/parents/teachers/other professionals also play a significant part; so perhaps such assessment does not fit so neatly under the psycho-medical model after all.

RESEARCH METHODS LINK

If you were undertaking a case study to better understand the needs of a particular child, what are the advantages and disadvantages of each of the methods above: psychometric assessment; observation; discussion with the relevant stakeholders?

SOCIAL MODEL OF DISABILITY

In contrast to the medical model, the social model of disability moves way beyond the needs of an individual and focuses on the environment – physical, organisational, attitudinal – environments that are often themselves disabling. It acknowledges that there will always be people in society with impairments, which is why all aspects of society need to plan and prepare for everyone. It is a liberating and powerful model to include all disabled people. (Search the internet 'Scope social model of disability video' where prominent disabled people explain what the social model of disability means to them.)

In terms of education, the social model of inclusion remains an arena of tension. Too often educational policies and procedures do not consider the neurodiversity of the school population and consequently schools must put in additional intervention and support to accommodate individual needs. This can be draining on resources and emotions and can lead to an increasing place of segregation and exclusion – the opposite of inclusion.

There is also a school of thought that suggests that the institution of education itself is a disabling factor (Dudley-Marling, 2004). Once upon a time, before the Industrial Revolution, our children mainly worked on the land with agriculture being their main subject of the day. One could ask if conditions such as dyslexia (did it matter if you couldn't read or write?) or ADHD (did it matter if you couldn't sit still and keep quiet?) were a concern in those days? The irony could well be that schools have actually created many more barriers for young people – again round peg, square holes.

ASSIGNMENT HELP: HOW MIGHT I USE THIS MATERIAL IN AN ASSIGNMENT?

Hopefully, this section should have helped you define inclusion as well as consider inclusion from the perspectives of both the medical and social model. You have also explored contrasting perspectives on the use of labels to identify young people with special educational needs. When writing an assignment on inclusion, it is important you also contemplate on your own observations and perspectives (linked to education and society as a whole) as well as consider the perspectives of the disabled community.

KEY RESOURCE

Watch this Ted Talk, *Education Paradigms*, delivered by Sir Ken Robinson, a British author who had a specific interest in education and the arts:

www.ted.com/talks/sir_ken_robinson_changing_education_paradigms

This goes way beyond special educational needs and disability and challenges the construct of formal education as a whole for 21st century young people.

CRITICAL QUESTION

In what ways might schools be considered to create barriers to inclusion?

Arguably, the exam system can be considered the most divisive, discriminatory and disabling feature of them all. The tension between inclusion and the standards agenda (Ainscow et al., 2006) continues in schools in England today. After all, the goal of the education system is to pass exams, isn't it? If so, many young people leave school having 'failed'.

EXCLUSIONS

Sadly, no chapter on SEND issues can omit those excluded from education, most of whom have social, emotional and mental heath (SEMH) needs. The statistics speak for themselves (Table 15.1).

Table 15.1 Permanent and fixed-period exclusions in England (2019/20)

	Permanent Exclusion (rate)	Suspension (rate)
With an EHCP	0.10	11.70
SEN Support	0.20	10.98
No SEN	0.04	2.43

* 2020 was the first year of school closures from March-July which affects this data from previous years

As the table shows, exclusion rates are higher among pupils with SEND (DfE, 2021).

CRITICAL QUESTION

Search the internet 'each other excluded' to hear the experiences of young people themselves, the best source of all.

What do you think needs to change in our education system to reduce the number of young people who are excluded from school?

Further reading on this area:

Timpson Review of School Exclusion (2019), Crown

Forgotten Children: alternative provision and the scandal of ever-increasing exclusions (House Of Commons, 2018)

Before ending this section on inclusion, it's also worth considering that, in defining Special Educational Needs as a separate group, therein lies the tension with wholly inclusive practice. The language of 'special' and 'needs' further blurs this concept. In England, the Code of Practice (DfE/DoH, 2015) stipulates that schools are expected to early identify 'needs', outline 'additional provision', identify a qualified teacher as the Special Educational Needs Coordinator (SENCO) to have 'day-to-day responsibility for the operation of SEN policy and co-ordination of specific provision made to support individual pupils' (DfE/DoH, 2015: 6.8.8, p. 108). One could challenge that current SEND policy in England is in itself a medical model approach and adds to the contradictions and confusions of inclusion.

CASE STUDY: ANIKA

Anika was identified whilst at nursery as struggling to follow nursery routines and was often involved in solitary play. She was unable to communicate her needs verbally and easily got distressed. School staff trialled a range of strategies to support her including the use of visual symbols. However, she continued to struggle to access the setting. Following a review meeting with family, it was agreed that school would refer to Speech and Language Therapy (SALT) for further advice and support. Although it took 18 weeks for this assessment to take place, Anika was given a personalised SALT programme. This was completed at home and school following training from the therapist. Over time Anika was able to communicate her needs responding to symbols and signs and then began to use words. Whilst Anika's verbal skills started to improve it was noted in Reception that she continued to struggle to follow classroom routines and remained socially isolated. In discussion with the family and SALT, it was decided that Anika was displaying several red flags for Social Communication needs and that school should complete a referral for an Autism Diagnostic Observation Schedule (ADOS). Anika was also displaying increasing sensory needs, finding the noise of the classroom particularly overwhelming. Anika started to wear ear defenders to reduce the background noise. By year 1, Anika had a diagnosis of autism and parents and school staff accessed training from the autism team to help understand Anika's needs further. This included understanding of Now and Next boards, visual time-table, social stories and an individual work station. Whilst these strategies and resources improved the school's offer for Anika, Anika continued to struggle to access the curriculum into year 2, with strategies such as phonics teaching not having any impact on her acquisition of literacy. In discussion with parents, it was agreed that school would seek further advice from an educational psychologist.

- In what ways has Anika's school evidenced ways to include Anika?
- What role have external agencies had to support Anika, her family and school?
- Do you feel a diagnosis was important for Anika/her family/school? Consider reasons for this.
- What autism-friendly approaches have you noted from this case study?
- What led to the school referring to educational psychology?
- What do you think is likely to happen to Anika's educational experience by the end of Y2? Y6? Y11? Post-16?

CASE STUDY: DANIEL

Daniel has thrived in his mainstream primary setting. He spends most of his time in his classroom, he has friends who invite him to birthday parties, he has a great personality and sense of humour. He loves music and drama and often performs in assembly. The whole school have a sign-along system where they use actions to support communication. Daniel has responded really well to this and is able to communicate with all staff and students using this method. Daniel's personalised curriculum includes life skills including taking him to the local shops. Daniel has Down syndrome.

- How has Daniel's primary school managed to break down barriers (social model of inclusion) and include him?
- What are your thoughts on Daniel's experience of teaching and learning? Who do you think was leading most of his personalised curriculum?
- Do you feel Daniel is likely to have the same experience when moving into high school? Why/why not?

To conclude, this chapter has considered the definitions of Special Educational Needs and Disability and explored the broad areas of need. We have also discussed the medical and social models of inclusion and considered how these link to the debate on labels and diagnosis. The voice of the young person, family and educational professionals has been part of this chapter to help view the landscape of SEND and inclusion from different perspectives.

CHECKLIST

Having read this chapter:

- I have clear definitions for Special Educational Needs and Disability (SEND)
- I know the broad areas of need to support identification and provision
- I understand some of the complexities contributing to 21st century children
- I have considered arguments for and against the use of SEND labels
- I understand the role of psychometric testing as part of an assessment for young people with SEND
- I have considered the viewpoint of the young person, family and educational professionals around SEND and inclusion

ANNOTATED BIBLIOGRAPHY

Education Endowment Foundation (EEF) *Special Educational Needs in Mainstream Schools*, (March 2020).

This report identifies five recommendations for mainstream schools.

Ainscow, M. (2020) Promoting inclusion and equity in education: lessons from international experiences. *Nordic Journal of Studies in Educational Policy, 6*(1), 7–16.

This journal explores the challenges and opportunities to promote inclusion acknowledging the barriers, 'within schools, between schools, beyond schools' (p. 15)

How Can We Achieve True Equality for Young People with SEND? With Simon Knight. Podcast by The Key (March 2021).

I am aware this chapter has very much focused on SEND and inclusion in mainstream schools. This podcast with Simon Knight reminds us of the value, strengths and challenges of educating young people in special school in England including during a global pandemic.