St. Mary's Grammar School, Belfast

SPECIAL EDUCATIONAL NEEDS (SEN) POLICY

December 2017

Edmund Rice Schools Trust

Aims

In keeping with our school ethos, we are committed to meeting the Special Educational Needs (SEN) of our students. We wish to enable SEN pupils to achieve the greatest possible individual richness, to learn to express this richness in ways acceptable to the society in which the child lives and to ensure that he is capable of achieving the highest possible degree of educational, economic and social competence compatible with his aptitudes and abilities. This is achieved by nurturing the whole person: academic, physical and spiritual and by exposing them to a broad and balanced curriculum.

Objectives

- To enable the school to identify, assess and diagnose an individual student's 'Special Educational Needs' within its current population.
- To enable the school to identify, assess and diagnose any 'Special Educational Needs' of new admissions.
- To facilitate the dissemination of the above information to all relevant staff.
- To ensure that these identified needs are met by appropriate means within the mainstream curriculum.
- To enable close consultation and partnership between parents of children and SEN and the school.
- To enable the provision of an advisory service to the school's SMT on the needs of individual children.
- To raise awareness of Heads of Faculty/Department on specific needs within their curricular areas.
- To facilitate an effective liaison with all relevant external support agencies.
- To enable the school to fulfil any statutory obligations required by current legislation.

Identification

- St. Mary's recognises and values the knowledge and experiences of the feeder schools in the identification of SEN.
- St. Mary's will attempt to foster close links with the teachers of pupils who are about to transfer to the secondary phase.
- St. Mary's will respond to the request of parent(s) for an educational assessment of a son subject to the availability of a referral under our priority procedure
- St. Mary's will act in the best interests of pupils as identified by the C.A.T. tests

Role of SENCO

SENCO is a designated teacher responsible for:

- operating the SEN policy on a day-to-day basis
- responding to requests for advice from other teachers
- co-ordinating all SEN provision
- producing pupil I.E.Ps (Individual Educational Plans) (**see Appendix 1 Page 42**)
- liaising with the various teachers teaching the pupils with SEN
- making available all relevant information to teachers and appropriate guidance
- maintaining a SEN register
- liaising with parents of SEN children
- establishing SEN inset training for staff
- liaising with external support e.g. our school nurse
- liaising with internal support e.g. our Literacy & Numeracy Co-ordinators and Health Co-ordinator
- maintaining a dialogue with SMT through the Pastoral Vice-Principal

What is SEN (Special Educational Needs)?

The term **'special educational needs'** is defined in the 'Code of Practice for the Early Identification and Assessment of Special Educational Needs (1998)' as **'a learning difficulty which calls for special educational provision to be made'.**

'Learning difficulty' means that:

a) the child has significantly greater difficulty in learning than the majority of children of his/her age;

b) the child has a disability which hinders his/her use of everyday educational facilities.

It must be remembered that very often children identified as having special educational needs exhibit a **'range of difficulties'** some temporary and some more permanent. It is important therefore that we as teachers try to understand the possible causes and range of their 'learning difficulties' and how we can offer the quality of teaching which will enhance their learning environment.

Possible Causes of Learning Difficulties

Biological:	ante-natal post-natal sensory defects
Home Factors:	socio-economic status family values / attitudes / traumas physical conditions in the home general health
Emotional & Behavioural Factors:	low self esteem / self-confidence lack of motivation / concentration anti-social behaviour bullying : depression : eating disorders : social phobia
School Factors:	inappropriate teaching methods ineffective teachers teacher expectations school policy curriculum challenges
Ability to learn:	neurological defect and / or general or specific learning difficulties affecting: • auditory skills • visual skills • motor skills • language processing skills

Range of Possible Disabilities /Difficulties

Auditory Skills:

- deafness, either profound or temporary (eg: glue ear)
- poor auditory memory (ie: ability to listen and remember instructions, sequences etc)
- poor auditory discrimination - (ability to blend series of sounds into recognisable words).

Visual Skills:

- poor sight
- visual perception problems eg: photophobics - see only bits of words
- visual motor skills - may see things piecemeal
- visual discrimination problems – poor sequencing
- poor visual sequential memory
- peripheral vision - swirls, edges, too much chemical energy to the brain - shimmering effects.

Motor Skills: (Gross & Fine)

- balance, posture, running etc.
- speech
- handwriting, art and craft
- visual tracking
- poor grasp
- reversals
- directional/orientional problems.

Language Skills:

- receptive and expressive language
- damage to the front of the brain
- Broca's area - may cause difficulty with expression
- speech delay - linked to auditory problems.

These disabilities may be accentuated by:

Consequence of poor health in early years;
Development delay;
Physical disability;
Emotional/Psychiatric disturbances;
Brain injury or trauma;
Effects of epilepsy;
Poor social skills;
Socio-economic background;
General intelligence level.

Special Educational Needs/Learning Difficulties can be classified into:

1. **Learning Difficulties:**
   - Slow learners
   - Specific learning difficulties - dyslexia, dyspraxia.

2. **Emotional and Behavioural Difficulties:**
   - Attention Deficit Disorder (ADD)
   - Attention Deficit and Hyperactivity Disorder (ADHD).

3. **Speech and Language Difficulties:**
   - Delayed and disordered development
   - Autistic Spectrum Disorders

4. **Sensory Impairments & Physical Disabilities:**
   - Hearing loss
   - Visual impairment
   - Physical disabilities.

Children with SEN – Whose responsibility?

In school, children with a SEN are the responsibility of all members of staff involved in the education and welfare of the child. St Mary's CBGS follow the five stage approach from the Code of Practice. (1998).

Stage 1	A need is recognised by Subject/Form teacher	• Form/Subject teacher creates an action plan and makes all other teachers involved with child of their concern and course of action with set review date • Each department should have policy/structures in place to cope • Inform SENCO to allow for registration on register.
Stage 2	SENCO devises a suitable I.E.P.	• SENCO circulates I.E.P. to Subject Teachers to amend for subject-specificity • SENCO keeps record of I.E.P. and informs parents • A review date is set.
Stage 3	SENCO devises a suitable I.E.P.	• SENCO contacts outside agencies for assistance - e.g. Educational Psychologist, Peripatetic Service • Parents informed.
Stage 4	SENCO devises a suitable I.E.P as at stage 3	• SENCO refers child for statutory assessment • All information from stage 1 to 3 collated for referral • Educational Psychologist Service perform assessment.
Stage 5	A statement of special educational need is produced and is a legal entitlement to provision	• An I.E.P. is produced as at stage 3 using advise from the statement • SENCO conducts annual review with the parents and relevant teachers and bodies.

All teaching staff have a responsibility to inform themselves of a pupil's circumstances. School records for each class are readily available. At the beginning of each school year, the SENCO will ensure the availability of a SEN register with individual pupil details. Staff have the responsibility of identifying pupils in their classes from this register. The SENCO will directly approach teachers if a new intake during the school year has special needs. Substitute teachers will be briefed individually by the SENCO.

Teachers must sign the Information Recording Sheet affirming their awareness of a special needs pupil in their class. (**see Appendix 2 Pages 43 & 44**). All Classroom assistants for pupils with statements are directed in their duties by and liaise with the SENCO and the Pastoral Vice-Principal.

Assessment

SENCO, in tandem with the Literacy and Numeracy Coordinators, work and use a number of strategies and tests to assess pupils for difficulties:

- The English Department use the Vernon Graded Spelling Test on all classes, Years 8 to 12, and pass on the scores to SENCO.
- SENCO uses the Vernon Graded Spelling Test, to assess the need to apply for extra time in GCSE and AS/A2 examinations.
- SENCO uses the 10 minute writing test is also used to assess pupils for extra time.
- SENCO uses the Cognitive Ability Test 3 (CAT3) on the Year 8 pupils and the Year 10 pupils to have standardised, objective assessment of the pupils to assist in the diagnosis and assessment of any educational need.
- SENCO uses a Dyslexia Screening Test on pupils if a teacher of parent is concerned with the progress of a pupil and would like to rule this out as a source of the difficulty.
- SENCO and the Numeracy Coordinator use an Arithmetic/Mathematics Test to assess a Mathematics age to identify pupils at induction time who may experience difficulty with Mathematics.
- SENCO engages pupils in setting and reviewing their personal targets.
- SENCO has an involvement with the school's recovery programme in English & Mathematics

Guidelines

Staff are offered clear guidelines to assist them with behavioural issues although, in making judgements and decisions about pupils, we recognise the uniqueness of each individual circumstance as it arises.

These guidelines will be reviewed annually by our SENCO and our Pastoral Committee and amended or added to as judged appropriate:

Guidelines for dealing with Vision Impairment (Page 9)

Guidelines for dealing with Autism / Asperger's Syndrome / Autistic Spectrum Disorder A.S.D. (Page 10)

Guidelines for dealing with A.D.H.D./ A.D.D. (Page 17)

Guidelines for dealing with Dyspraxia (Page 30)

Guidelines for dealing with Dyslexia (Page 33)

Guidelines for internet research (Page 40)

Guidelines for dealing with Vision Impairment

The extent of visual impairment depends upon the physical sensory impairment of the student's eyes, the age of the student at the onset of vision impairment, and the way in which that impairment occurred. Vision also may fluctuate or may be influenced by factors such as inappropriate lighting, light glare, or fatigue. Hence, there is no "typical" vision impaired student.

The major challenge facing visually impaired students in the science educational environment is the overwhelming mass of visual material to which they are continually exposed to textbooks, chalk/whiteboard writing.

In addition, the increase in the use of films, videotapes, computers, DVD/CDs, and television adds to the volume of visual material to which they have only limited access. To assist in overcoming a students' visual limitation requires unique and individual strategies.

Some general points:

- Call the student with vision impairment by name if you want his attention.
- Seat the student away from glaring lights (e.g. by the window) and preferably at the front of the class.
- Use descriptive words such as straight, forward, left, etc. in relation to the student's body orientation. Be specific in directions and avoid the use of vague terms with unusable information, such as "over there", "here", "this", etc.
- Describe, in detail, pertinent visual occurrences of the learning activities.
- Give verbal notice of room changes or assignments.
- Offer to read written information for a person with a visual impairment, when appropriate.
- If a student with a visual impairment is in class, routinely check the instructions are being followed.
- Try to use an auditory or tactile signal where a visual signal is normally used.
- It is not necessary to speak loudly to people with visual impairments.
- Always notify changes of class schedule in advance.

Guidelines for dealing with Autism / Asperger Syndrome / Autistic Spectrum Disorder A.S.D.

It has been said that understanding **Autism** and **Asperger Syndrome** is like trying to grasp mercury – you think you have it but end up having to chase lots of smaller pieces. Each child is affected in a different way and because of this there are as many definitions of the condition as there are specialists.

Asperger Syndrome (AS) is named for Hans Asperger, a Viennese paediatrician who first described the condition in the 1940s. Although it was "officially" recognised for the first time in 1994, AS is still often undiagnosed or misdiagnosed.

Asperger Syndrome (AS) is a pervasive developmental disorder characterized by abnormalities in social interaction and communication. It belongs to the **autistic spectrum of disorders** (ASD) and shares several features with **autism,** but is regarded as a separate clinical entity.

The most important starting point in helping a AS pupil to function effectively in school is for the staff to realise that the child has an inherent developmental disorder which causes him to behave and respond in a different way from other students.

Asperger Syndrome is NOT –

- **The result of poor parenting**
- **A mental illness**
- **The result of an emotional disorder**
- **Easy to diagnose**
- **Curable**

Listed below are the three main areas of impairment and some of the common characteristics which AS pupils may display.

The AS pupil may have an inability to see the BIG picture, may focus on detail and ignore the WHOLE, be unable to make sense of things in context and have difficulty with problem solving.

Organisation problems are major as the pupil has no executive function. This impacts on books, equipment, homework, coursework, study skills and revision skills

1. **Communication:** Language impairment across all modes of communication – speech, intonation, gesture, facial expression, two-way conversation and other body language. For example:
    a. The pupil has a superficially perfect spoken language, which may seem formal and pedantic.
    b. Their voice may lack expression
    c. When listening to others the pupil understands the words rather than the meaning, this is often the case when reading (known as "hyerlexia")
    d. The pupil may understand others in a literal way without understanding the implications of what has been said

    (e.g. the response to a statement such as –"*That scarf is not part of school uniform*" - may be –"*I know that*"- rather than what was implied i.e. *"Take it off.")*

    e. The pupil is limited in their use of non-verbal communication and often cannot make sense of the gestures, facial expressions and body language of others.

2. **Socialisation:** Knowing what to do when they are with other people. Difficulties with social relationships, poor social timing, lack of social empathy, rejection of normal body contact, inappropriate eye contact. Some examples are:

    a. The pupil may be socially isolated amongst his peer group (but may not be worried about it) or may wish to join in with his peers but cannot and becomes upset and concerned about it, lacking the strategies to develop and sustain friendship.
    b. The pupil may feel tense if others approach him and make social demands. He may be unable to maintain a conversation often giving mono-syllabic answers.
    c. The pupil may behave or use language in a socially inappropriate way e.g. when speaking to teachers.
    d. The pupil may fail to pick up social cues and unwritten rules. This makes him prone to teasing and ridicule.
    e. The pupil may be unable to

        - understand cause & effect,
        - deception – intentional or "spoof"
        - read or understand other's emotions,
        - differentiate fact from fiction

Our codes of conduct are shaped by how our behaviour affects the thoughts, opinions and feelings of others - generally one strives not to offend. AS pupils, on the other hand are unable to understand that others have thoughts and feelings and their inability to "mind read" or to make accurate guesses about what other people are thinking create a social minefield.

3. **Imagination:** Rigidity and inflexibility of thought process – resistance to change, obsessional and ritualistic behaviour. Some examples are:
    a. The pupil may have an all-absorbing interest which peers find unusual.

b. The pupil may insist on the adherence to certain routines
c. The development of the ability to think and play creatively will be limited
d. The pupil will have difficulties in generalising skills from one setting to another so skills learnt in one classroom setting will not be carried through to another class setting.

In addition AS pupils will have difficulty in the following areas:

4. **Poor motor coordination**
    a. The pupil may appear gauche in their movements – attracting ridicule from their peers
    b. The pupils presentation of work may be poor and tasks are often unfinished
    c. The pupil may have difficulty with self-organisation e.g. packing school bag, finding way round school.
    d. The pupil may have difficulties with handwriting and in some cases they may be dyspraxic
    e. The pupils difficulties may be severe enough to warrant the label of dyspraxia

5. **Sensory perceptual differences**
    a. Over or under sensitive to smell, taste, touch, sight and sound
    b. Over or under sensitivity to heat and pain
    c. Inability to filter out extraneous noise/stimuli and focus on the salient information/speaker
    d. Unusual visual perception, may have difficulties picking out the foreground/background of a picture
    e. Perseveration on one detail in a picture despite its relevance to the subject.

Strategies

The following suggestions are offered as a series of "tips" that have been gathered from parents, teachers and support staff.

The most important starting point in helping a student with AS to function effectively in school is for the staff to realise that the child has an **inherent developmental disorder** which causes him to behave and respond in a different way from other students.

Communication

- Specifically engage attention visually, verbally or physically
- Slow down the pace
- Give the pupil time to respond – often an AS pupil will wait until you finish talking before he starts to process the information given.
- Simplify your language
- Be concrete and specific
- Keep facial expressions and gestures clear
- Give one instruction at a time, not a sequence
- Avoid using vague terms such as – later, maybe next week…
- If necessary break down tasks into smaller steps
- Give a clear indication of the amount of work required, teach what finished means and what to do next.
- Use additional visual (or written) clues to aid the pupil's understanding
- Be sensitive to the pupil's attempts to communicate
- Teach the pupil how to ask for or refuse help and how to indicate that he needs a break
- Set up situations which will encourage the pupil to communicate
- Don't assume that because the pupil has repeated an instruction that he has necessarily understood
- Explain
    - Metaphors e.g. "frog in your throat"
    - Idioms e.g. "save your breath"
    - Double meanings
    - Sarcasm e.g. "that was clever" when someone makes a mistake
    - Nicknames
    - Cute names e.g. "pal", "wise guy"

- Remember that facial expressions and gestures used in regulating classes – the raised eyebrow or the arms folded while ominously waiting for quiet - and other social clues or indicators may not work
- Provide accurate, prior information about change
- Provide accurate prior information about expectations
- Don't rely on emotional appeals
- Don't give options if there are no options – e.g. don't say things like "that's the homework, you can chose to do it or not but you know what will happen if you don't."
- Remember an increase in unusual responses probably indicates an increase in stress
- If the pupil becomes agitated understand that the usual strategies for calming a pupil (e.g. physical comfort, verbal reasoning) may have the opposite effect and make the situation worse.
- For a pupil who has an obsession – don't try to stop it. Make it manageable, limit it and try to use it positively.
- Allow modifications as needed to deal with under or over sensitively to environmental stimuli e.g. it's too cold next to the window.
- Avoid pressure to be "good" or other abstract expectations
- Avoid punitive measures that lower self-esteem, increase anxiety and are not understood.
- Offer alternative method for recording activities e.g. photocopy notes rather than rely on dictation or copying from the board/overhead.
- Use labels/diagrams/maps to increase the pupils awareness and understanding of his physical environment
- If necessary use a sequence of pictures/instructions to develop organisation of materials and activities

Disciplinary action should never be contingent upon behaviours that are part of the child's disability e.g.

- Avoidance of eye contact
- Talking to self
- Slow response time
- Lack of respect for others
- Repeating words or phrases
- Upset with crowd or with noise
- Anxiety
- Persevering on topics of interest
- Upset caused by change

AUTISM – Explanations for peers/teens

What Is Autism?

Autism is a developmental disorder that some people are born with — it is not something you can catch or pass along to someone else. It affects the brain and makes communicating and interacting with other people difficult. People who have autism often have delayed language development, prefer to spend time alone, and show less interest in making friends. Another characteristic of autism is what some people describe as "sensory overload": Sounds seem louder, lights brighter, or smells stronger. Although many people with autism also have mental retardation, some are of average or high intelligence.

Not everybody with autism has the exact same symptoms. Some people may have autism that is mild, whereas others may have autism that is more severe. Because it affects people differently, autism is known as a **spectrum disorder**. Two people with the same spectrum disorder may not act alike or have the same skills.

As many as 1 in 500 people have autism, and it's four times more common in guys than in girls. Although doctors do not know exactly what causes it, researchers believe autism is linked to differences in brain chemicals (**neurotransmitters**). These differences may be caused by something in our genes — families who have one child with autism have a higher risk of having another child with autism or a similar disorder. Research suggests that it's probably a combination of genes that causes the disorder, not a single autism gene.

Sometimes you may hear other developmental disorders mentioned in the same way as autism, such as Asperger syndrome, Rett syndrome, and childhood disintegrative disorder. These disorders, along with autism, are all considered **pervasive developmental disorders**. People diagnosed with any of these disabilities have problems with social skills and communication.

What Do Doctors Do?

Autism is usually diagnosed at a very young age, when a child is 1 1/2 to 4 years old. There are no medical tests to determine whether someone has autism, although doctors may run various tests to rule out other causes of the child's symptoms. The best way to identify autism is to watch how a child behaves and communicates. Parents can help by telling the doctor how the child acts at home. Then a team of specialists — which may include a psychologist, a neurologist, a psychiatrist, a speech therapist, and a developmental paediatrician — will evaluate the child and compare levels of development and behaviour to those of other children the same age. Together, they will decide whether the child has autism or something else.

How Is Autism Treated?

Autism is not treated with surgery or medicine (although some people with autism may take medicine to improve certain symptoms, like aggressive behaviour or attention problems). Instead, people who have autism are taught skills that will help them do the things that are difficult for them. The best results are usually seen with children who begin treatment when they are very young, as soon as they are diagnosed.

Special education programs that are tailored to the child's individual needs are usually the most effective form of treatment. These programs work on breaking down barriers by teaching the child to communicate (sometimes by pointing or using pictures or sign language) and to interact with others. Basic living skills, like how to cross a street safely or ask for directions, are also emphasized. A treatment program might also include any of the following: speech therapy, physical therapy, music therapy, changes in diet, medication, occupational therapy, and hearing or vision therapy. The same specialists who helped diagnose the condition usually work together to come up with the best combination of therapies to use in addition to the educational program.

By the time they are teens, people with autism may be taking regular classes, attending special classes at the high school level, or attending a special school because of ongoing behavioural problems.

What Are Teens With Autism Like?

Because their brains process information differently, teens with autism may not act like other people you know (or each other, because the severity of symptoms of autism varies from person to person). They can have trouble talking and sometimes communicate with gestures instead of words. Some spend a lot of time alone, don't make friends easily (and may not act like they want to), and don't react to social cues like someone smiling or scowling at them. They often do not make eye contact when you are talking to them. They also find it hard to join in a game or activity with other people. If they are sensitive to sensory stimuli, they might draw back when hugged or startle easily when they hear a sudden noise, even if it's not very loud.

Some teens with autism are passive and withdrawn, whereas others are overactive and may have tantrums or act aggressively when they are frustrated; it's important to realize that this is part of the disorder. Many teens with autism also continue to have intellectual limitations and learning problems. Because they don't have the ability to express emotions like anger and frustration in more acceptable ways, teens with autism may express themselves in ways that seem inappropriate. Many have difficulty coping with change and get anxious if their daily routine is altered. In more severe cases, a teen might fixate on different objects or ideas or display repetitive motions like rocking or hand flapping.

One common misconception is that people with autism don't feel or show emotion. Although they can feel affection, they often don't express it the same way others do. To an outsider, this can come across as being cold or unemotional.

Living With Autism

Perhaps the most difficult part of coping with autism is interacting with other people every day. Because the brain of a teen with autism works a little differently, learning to communicate can be like learning a foreign language. This can make it hard for people with autism to express themselves or for other people to understand them, so just talking with a classmate becomes stressful and frustrating.

When even a casual conversation requires so much effort, it's hard to make friends. Teens with autism may have to think constantly about how other people will perceive their actions and make a conscious effort to pay attention to social cues the rest of us handle without even thinking. Basically, it takes a lot of work for a person with autism to do what comes naturally to most people.

So if you know someone who has autism, be extra patient when you're talking with him or her. Don't expect a person with autism to look at things the same way you do. You should also realize that some behaviours you think are rude (like interrupting you when you're talking) come from a different perception of the world: It's tough for people who can't read social cues and recognize the natural pauses in a conversation to know when to jump in with their own thoughts. The more understanding and supportive you are, the more enjoyable your time together will be.

Despite all the day-to-day hurdles, though, many people with autism lead fulfilling, happy lives on their own or with help from friends and family. Most teens with autism like school, and some can attend regular classes with everyone else. They have individual tastes and enjoy different activities, just like you do. Some people with autism go on to vocational school or college, get married, and have successful careers. Consider Temple Grandin, for example. Despite having autism, she was able to earn a PhD and become a college professor. She's even written a book about her experience called *Thinking in Pictures: And Other Reports from My Life with Autism*. Although she still struggles with the disorder almost daily, she leads a "normal" life, just like many other people with autism.

Useful websites and resources:

www.nas.org.uk

www.asperger.org.uk

www.autism.org

www.autismni.org

www.awares.org

www.kidshealth.org

www.bupa.co.uk

www.mayoclinic.com

Freaks, Geeks and Asperger Syndrome : A User Guide to Adolescence

by Luke Jackson.

Oakwood ASD Advisory Service,

Oakwood School & Assessment Centre,

Harberton Park,

Belfast BT9 6TX.

Guidelines for dealing with A.D.H.D./ A.D.D.

1. What is ADHD?

2. What are the symptoms?

3. How is it diagnosed?

4. What causes ADHD?

5. What are some of its related problems?

6. How is it treated?

7. ADHD in the classroom

8. For parents –how to help your child at secondary school.

9. Explanations for peers (teens)

What Is ADHD?

ADHD is a common behavioural disorder that affects an estimated 4% to 8% of school-age children. Boys are about three times more likely than girls to be diagnosed with it, though it's not yet understood why. Children with ADHD act without thinking, are hyperactive, and have trouble focusing. They may understand what's expected of them but have trouble following through because they can't sit still, pay attention, or attend to details.

Of course, all children (especially younger ones) act this way at times, particularly when they're anxious or excited. But the difference with ADHD is that symptoms are present over a longer period of time and occur in different settings. They impair a child's ability to function socially, academically, and at home.

The good news is, with proper treatment, children with ADHD can learn to successfully live with and manage their symptoms.

What Are the Symptoms?

ADHD used to be known as attention deficit disorder, or ADD. In 1994, it was renamed ADHD and broken down into three subtypes, each with its own pattern of behaviours:

1. an inattentive type, with signs that include:

- inability to pay attention to details or a tendency to make careless errors in schoolwork or other activities
- difficulty with sustained attention in tasks or play activities
- apparent listening problems
- difficulty following instructions and forgetfulness in daily activities
- problems with organization and easily distracted
- avoidance or dislike of tasks that require mental effort
- tendency to lose things like toys, notebooks, or homework

2. a hyperactive-impulsive type, with signs that include:

- fidgeting or squirming
- difficulty remaining seated
- excessive running or climbing
- 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

3. a combined type, which involves a combination of the other two types and is the most common

Although it can often be challenging to raise kids with ADHD, it is important to remember they aren't "bad," "acting out," or being difficult on purpose. And children who are diagnosed with ADHD have difficulty controlling their behaviour without medication or behavioural therapy.

How Is It Diagnosed?

Most cases of ADHD are treated by primary care doctors. Because there is no test that can determine the presence of ADHD, a diagnosis depends on a complete evaluation. When the diagnosis is in doubt, or if there are other concerns, such as Tourette syndrome, a learning disability, or depression, a child may be referred to a neurologist, psychologist, or psychiatrist. Ultimately, though, the primary care doctor gathers the information, makes the diagnosis, and starts treatment.

To be considered for a diagnosis of ADHD:

- a child must display behaviours from one of the three subtypes before age 7
- these behaviours must be more severe than in other children the same age
- the behaviours must last for at least 6 months
- the behaviours must occur in and negatively affect at least two areas of a child's life (such as school, home, day-care settings, or friendships)

The behaviours must also not be linked to stress at home. Children who have experienced a divorce, a move, an illness, a change in school, or other significant life event may suddenly begin to act out or become forgetful. To avoid a misdiagnosis, it's important to consider whether these factors played a role in the onset of symptoms

First, the family doctor will perform a physical examination of your child and ask about any concerns and symptoms, the child's past health, the family's health, any medications the child is taking, any allergies the child may have, and other issues. This medical history is important because research has shown that ADHD has a strong genetic link and often runs in families.

The family doctor may also perform a physical exam as well as tests to check hearing and vision so other medical conditions can be ruled out. Some emotional conditions, such as extreme stress, depression, and anxiety, can also look like ADHD.

Many questions will be asked about the child's development and his behaviours at home, at school, and among friends. Adults who see the child regularly like teachers, (who are often the first to notice ADHD symptoms) will probably be consulted, too. An educational evaluation, which usually includes a school psychologist, may also be done. It is important for everyone involved to be as honest and thorough as possible about the child's strengths and weaknesses.

What Causes ADHD?

ADHD is **not** caused by poor parenting, too much sugar, or vaccines!

ADHD has biological origins that are not yet clearly understood. No single cause of ADHD has been identified, but researchers have been exploring a number of possible genetic and environmental links. Studies have shown that many children with ADHD have a close relative who also has the disorder.

Although experts are unsure whether this is a cause of the disorder, they have found that certain areas of the brain are about 5% to 10% smaller in size and activity in children with ADHD. Chemical changes in the brain have been found as well.

Recent research also links smoking during pregnancy to later ADHD in a child. Other risk factors may include premature delivery, very low birth weight, and injuries to the brain at birth.

Some studies have even suggested a link between excessive early television watching and future attention problems. Parents should follow the American Academy of Pediatrics' (AAP) guidelines, which say that children under 2 years old should not have any "screen time" (TV, DVDs or videotapes, computers, or video games) and that children 2 years and older should be limited to 1 to 2 hours per day, or less, of quality television programming.

What Are Some Related Problems?

One of the difficulties in diagnosing ADHD is that it is often found in conjunction with other problems. These are called coexisting conditions, and about two thirds of all children with ADHD have one. The most common coexisting conditions are:

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

At least 35% of all children with ADHD also have oppositional defiant disorder, which is characterized by stubbornness, outbursts of temper, and acts of defiance and rule breaking. Conduct disorder is similar but features more severe hostility and aggression. Children who have conduct disorder are more likely get in trouble with authority figures and, later, possibly with the law. Oppositional defiant disorder and conduct disorder are seen most commonly with the hyperactive and combined subtypes of ADHD.

Mood Disorders (such as depression)

About 18% of children with ADHD, particularly the inattentive subtype, also experience depression. They may feel inadequate, isolated, frustrated by school failures and social problems, and have low self-esteem.

Anxiety Disorders

Anxiety disorders affect about 25% of children with ADHD. Symptoms include excessive worry, fear, or panic, which can also lead to physical symptoms such as a racing heart, sweating, stomach pains, and diarrhea. Other forms of anxiety that can accompany ADHD are obsessive-compulsive disorder and Tourette syndrome, as well as motor or vocal tics (movements or sounds that are repeated over and over). A child who has symptoms of these other conditions should be evaluated by a specialist.

Learning Disabilities

About half of all children with ADHD also have a specific learning disability. The most common learning problems are with reading (dyslexia) and handwriting. Although ADHD isn't categorized as a learning disability, its interference with concentration and attention can make it even more difficult for a child to perform well in school.

If a child has ADHD and a coexisting condition, doctors will carefully consider that when developing a treatment plan. Some treatments are better than others at addressing specific combinations of symptoms.

How Is It Treated?

ADHD can't be cured, but it can be successfully managed. The family doctor will develop an individualized, long-term plan. The goal is to help the child learn to control his own behaviour and to help families create an atmosphere in which this is most likely to happen.

In most cases, ADHD is best treated with a combination of medication and behaviour therapy. Any good treatment plan will require close follow-up and monitoring, and the child's doctor may make adjustments along the way. Because it is important for parents to actively participate in their child's treatment plan, parent education is also considered an important part of ADHD management.

Medications

Several different types of medications may be used to treat ADHD:

- Stimulants are the best-known treatments - they've been used for more than 50 years in the treatment of ADHD. Some require several doses per day, each lasting about 4 hours; some last up to 12 hours. Possible side effects include decreased appetite, stomachache, irritability, and insomnia. There's currently no evidence of any long-term side effects.
- Nonstimulants were approved for treating ADHD in 2003. These appear to have fewer side effects than stimulants and can last up to 24 hours.
- Antidepressants are sometimes a treatment option; however, in 2004 the FDA issued a warning that these drugs may lead to a rare increased risk of suicide in children and teens. If an antidepressant is recommended for your child, be sure to discuss these risks with your doctor.

Behavioural Therapy

Research has shown that medications used to help curb impulsive behaviour and attention difficulties are more effective when they're combined with behavioural therapy.

Behavioural therapy attempts to change behaviour patterns by:

reorganizing the child's home and school environment
giving clear directions and commands
setting up a system of consistent rewards for appropriate behaviours and negative consequences for inappropriate ones

Here are some examples of behavioural strategies for parents/guardians /teachers that may help a child with ADHD:

- Create a routine. Try to follow the same schedule every day, from wake-up time to bedtime. Post the schedule in a prominent place, so your child can see where he or she is expected to be throughout the day and when it's time for homework, play, and chores.
- Help your child organize. Put schoolbags, clothing, and toys in the same place every day so your child will be less likely to lose them.
- Avoid distractions. Turn off the TV, radio, and computer games, especially when your child is doing homework.
- Limit choices. Offer your child a choice between two things (this outfit, meal, toy, etc., or that one) so that he or she isn't overwhelmed and over stimulated.
- Change your interactions with your child. Instead of long-winded explanations and cajoling, use clear, brief directions to remind your child of his or her responsibilities.
- Use goals and rewards. Use a chart to list goals and track positive behaviours, then reward your child's efforts. Be sure the goals are realistic (think baby steps rather than overnight success).
- Discipline effectively. Use timeouts or removal of privileges as consequences for inappropriate behaviour. Younger children may simply need to be distracted or ignored until they display better behaviour.
- Help your child discover a talent. All children need to experience success to feel good about themselves. Finding out what your child does well - whether it is sports, art, or music - can boost social skills and self-esteem.

Alternative Treatments

Currently, the only ADHD therapies that have been proven effective in scientific studies are medications and behavioural therapy. But a child's doctor may recommend additional treatments and interventions depending on the child's symptoms and needs. Some kids with ADHD, for example, may also need special educational interventions such as tutoring, occupational therapy, etc. Every child's needs are different.

Parents should always be wary of any therapy that promises an ADHD "cure," and if they're interested in trying something new, they should be sure to speak with their child's doctor first.

ADHD in the Classroom

Children with ADHD are eligible for special services or accommodations at school under the Individuals with Disabilities in Education Act (IDEA) and an anti-discrimination law known as Section 504.

In addition to using routines and a clear system of rewards, here are some other tips for teachers for classroom success

- Reduce seating distractions. Lessening distractions might be as simple as seating the child near the teacher instead of near the window.
- Use a homework folder for parent-teacher communications. The teacher can include assignments and progress notes, and parents can check to make sure all work is completed on time.
- Break down assignments. Keep instructions clear and brief, breaking down larger tasks into smaller, more manageable pieces.
- Give positive reinforcement. Always be on the lookout for positive behaviours. Offer praise when the child stays seated, doesn't call out, or waits his turn, instead of criticizing when he doesn't.
- Teach good study skills. Underlining, note taking, and reading out loud can help a child stay focused and retain information.
- Parents - Supervise. Check that your child goes and comes from school with the correct books and materials. Ask that your child be paired with a buddy who can help him or her stay on task.
- Be sensitive to self-esteem issues. Provide feedback to the child in private, and avoid asking him to perform a task in public that might be too difficult.
- Involve our Support Teacher or SENCO. He or she can help design behavioural programs to address specific problems in the classroom.

These notes are aimed at parents but do contain some helpful information for teachers.

How to help your child at secondary school

Reviewed by Dr Chris Steer, consultant paediatrician and neurologist

The problems ADHD causes are similar to those at primary school. Your child finds it hard to listen, remember and think of the consequences of his actions. His behaviour and performance tends to be erratic - he may be able to do something one day but not the next.

But as your child gets older, the expectation is he takes more responsibility for his actions - especially with regard to punctuality, learning and behaviour. ADHD affects your child's ability to do this, which can also lead to your child being labelled immature.

Secondary school brings added difficulties for children with ADHD, i.e. multiple teachers, classrooms and subjects, and the pressure of GCSE coursework and exams.

Although your child is growing up, there are still things you can do as a parent to help.

What can you do as a parent?

First make sure the school is aware of any specific learning problems your child has.

Below are lots of things you can try to tackle the difficulties ADHD brings. Some of them will need the co-operation of teaching staff. Most you'll want to talk through with your child, because ideas that are imposed can seem like punishments.

Your child may not like these suggestions, and this can spiral so every issue turns into a confrontation. So 'pick your battles' - decide on what you think will help most and try to get your child's agreement.

If something doesn't work, or is causing lots of arguments, it may be worth dropping and revisiting later. If you're struggling or at your wits' end, go back to your GP, specialist, or SENCO and get their advice. They are there to support you and your child.

Getting the most out of your child

With ADHD, the watchwords are routine, regularity and repetition - all of which will help your child with essential components of a school day such as getting to school on time, or completing work.

Regular times for breakfast, homework, TV, breaks etc will provide a much needed framework for a child with ADHD.

Praise is also important, and crucial to building your child's self-esteem. A little praise given often is most effective, and keep it specific. 'You did your homework when I asked you to.' 'Your writing has got much neater over the last two months.'

Concentration problems

Distraction is a big problem for ADHD, so the best place for your child to sit is at the front of the class, where he can see the teacher's face.

If the school has set seating plans for each class, you can talk to the teacher and pre-arrange it before the start of term so it doesn't single your child out.

It's a different matter if your child chooses where to sit for each lesson. If your child won't sit at the front, try to encourage him to sit as near to the front as possible. In the first instance, see if you child will agree a trial period when he sits at or near the front.

If he gets better marks and is in trouble less - both with classmates and the teacher, he may come to the conclusion it's the best place to be. If it doesn't seem to make a difference to his performance, or it causes huge resentment, it may not be worth pushing.

Your child may also find it hard to focus at the beginning of lessons or after a break. Teach him a routine to help calm him down when he's in the classroom, such as counting backwards from 20.

Talking too much tends to be less of a problem in secondary school. Your child is more likely to tap and fidget. A squeezy stress ball that he can fiddle with quietly can help.

Interrupting the teacher

If your child is on medication, he's more likely to start interrupting or making smart comments when it wears off.

Ideally, the teacher should take this as a cue to check if your child has taken his medication. This should be done in a way that draws as little attention as possible to your child. How the staff will raise this issue is a good question to ask the school.

For your part, teach your child what to do if he's forgotten what he should be doing. Teach him the best way to get attention is to raise his hand and wait for the teacher to answer him, or to quietly ask another child. Role playing at home is a good way to do this.

Inattentiveness

Inattentiveness causes a number of problems. It can lead your child to miss parts of what the teacher is saying. This can mean he doesn't know what to do when work is set.

It can also make your child seem rude or as if he is not listening, leading to issues with teachers.

Things that will help your child are:

- short, specific instructions
- tasks split down into smaller chunks
- repetition and reviews of instructions
- written instructions on the board
- visual aids and checklists.

These will all be down to the discretion of the teacher, but you can raise these points with staff or the SENCO.

List-making can overcome some of the problems caused by inattention.

The first step is to teach your child to make lists of what he has to do when he's given tasks or instructions. You could try this with tasks at home or with homework.

The next step is to teach your child to prioritise tasks within the list. Ask your child what he thinks is most important on the list and go from there.

Get your child to use diaries, planners and any other tools your school provides to write down instructions, dates and deadlines.

Homework issues

This tends to be either your child forgets it completely, can't get started, or doesn't finish it.

How schools manage homework varies, but some schools have a homework diary that must be reviewed and signed off each week by parents.

If your child has large projects or coursework that needs doing over a period of time, you can help him plan the assignment and break it into small chunks. You may also want to draw up a timetable of deadlines and keep it visible - e.g. stuck on the fridge.

One option may be to quietly take a note of deadlines from the homework diary, without making a big issue. You could then ask your child how he's progressing at certain points before the deadline.

Have a homework routine: let your child have a break after school, then a set time for homework, then another break. Give your child a quiet place to do homework, with good light and no distractions such as music or TV.

Interest and encouragement in what your child's doing will also help, but it is easy for this to be seen as interference - you are the best judge of your child's reaction.

Learning difficulties

Your child may have specific learning difficulties - in which case the teacher or SENCO can give advice. Or your child may have more general problems with his work.
One of the most common problems is handwriting and written expression. If this is a problem, ask the school if your child can use other methods than writing, such as using a computer.
If your child has difficulty completing tasks, give him an overview before he starts working on the fine detail.

Rhymes, mnemonics and word association will help your child remember facts.

You may want to consider a private tutor to help with specific areas of difficulty.

Peer difficulties

Particularly if your child is impulsive, he may overreact to teasing or let himself be egged on to do something he shouldn't.

Problems caused by inattention, ie missing parts of conversation can also mean he has difficulty getting on with his classmates.

Ideas to help

- Teach your child to count to 10 before he reacts, or to walk away and talk to a teacher.
- Role-play situations with your child, particularly dealing with name calling and taunts.

  If other children complain about your child, or are at the brunt of bad behaviour, ask him how he'd feel in the other person's shoes.
- Try to teach him how to recognise other people's reactions - for example if he's being demanding.

Aggressive behaviour

Children with ADHD often feel different from other children. They can feel frustrated, misunderstood and 'picked on'. Self-esteem can be low. All this can lead to aggressive behaviour.

Unless there's a definite trigger for the aggression that can be tackled directly, there's no easy way to improve behaviour - any changes are likely to be slow rather than overnight.

- State what is not acceptable, but avoid lengthy debates, harsh criticism or backing your child into a corner.

  Give your child space to cool down. This gives your child a chance to find a solution without losing face.

- Agree rules with your child where possible. The more you agree on, the less likely rules will be broken.

Make your child responsible for his behaviour and the consequences. Some parents are very critical of their children. Others defend their children, regardless of behaviour. But criticism not tempered by praise will soon be ignored. Praise without criticism means your child will not learn boundaries.

- Apply punishments consistently – do not have one rule one day, and one rule the next for the same behaviour.

Parent Training

Parenting any child can be tough at times, but parenting a child with ADHD often brings special challenges. Children with ADHD may not respond well to typical parenting practices. Also, because ADHD tends to run in families, parents may also have some problems with organization and consistency themselves and need active coaching to help learn these skills.

Experts recommend parent education and support groups to help family members accept the diagnosis and to teach them how to help their child organize his or her environment, develop problem-solving skills, and cope with frustrations. Parent training can also teach parents to respond appropriately to their child's most trying behaviours and to use calm disciplining techniques. Individual or family counselling may also be helpful.

Being Your Child's Biggest Supporter

You're a stronger advocate for your child when you foster good partnerships with everyone involved in your child's treatment - that includes teachers, doctors, therapists, and even other family members. Take advantage of all the support and education that's available, and you'll be able to help your child with ADHD navigate his or her way to success.

ADHD and ADD - Info for peers/teens

ADHD stands for attention deficit hyperactivity disorder. ADHD used to be known as attention deficit disorder, or ADD. In 1994, it was renamed ADHD. The term ADD is still used, though, to describe a type of ADHD that doesn't involve hyperactivity.

ADHD is a medical condition that affects how well someone can sit still, focus, and pay attention. People with ADHD have differences in the parts of their brains that control attention and activity. This means that they may have trouble focusing on certain tasks and subjects, or they may seem "wired," act impulsively, and get into trouble.

Symptoms and Signs of ADHD

Although ADHD begins in childhood, sometimes it's not diagnosed until a person is a teen - and occasionally not even until someone reaches adulthood.

Because ADHD is a broad category covering different things - attention, activity, and impulsivity - it can show up in different ways in different people. Some of the signs of ADHD are when a person has:

- difficulty paying attention or staying focused on a task or activity
- problems finishing assignments at school or home and jumping from one activity to another
- trouble focusing on instructions and difficulty following through
- losing or forgetting things such as homework
- feeling easily distracted, even when doing something fun
- problems paying close attention to details or making careless mistakes
- trouble organizing tasks and activities
- difficulty waiting one's turn
- interrupting or intruding on other people
- blurting out answers before questions have been completed
- fidgeting with hands or feet or squirming about when seated
- feeling restless
- talking excessively and having trouble engaging in activities quietly

When the biggest problems have to do with attention, focus, and organization (in other words, when a person doesn't have signs of hyperactivity), doctors use the term ADD. When the problems including fidgeting, interrupting, and blurting out answers, this is ADHD.

Of course, it's normal for everyone to zone out in a boring class, jump into a conversation, or leave their homework on the kitchen table once in a while. But people with ADHD have so much trouble staying focused and controlling their behavior that it affects their emotions and how well they do in school or other areas of their lives. In fact, ADHD is often viewed as a learning disorder because it can interfere so much with a person's ability to study and learn.

Sometimes the symptoms of ADHD become less severe as a person grows older. For example, experts believe that the hyperactivity part of the disorder can diminish with age, although the problems with organization and attention often remain. Although some people may "grow out of" their symptoms, more than half of all kids who have ADHD will continue to show signs of the condition as young adults.

What Causes ADHD?

Doctors and researchers still aren't exactly sure why some people have ADHD. Research shows that ADHD is probably genetic and that it may be inherited in some cases. Scientists are also exploring other things that may be associated with ADHD: For example, ADHD may be more prevalent in kids who are born prematurely. It is also more common in guys than it is in girls.

Doctors do know that ADHD is caused by changes in brain chemicals called neurotransmitters (pronounced: nyur-oh-trans-mih-turs). These chemicals help send messages between nerve cells in the brain. The neurotransmitter dopamine (pronounced.. doe-puh-meen), for example, stimulates the brain's attention centres. So if a person has low amounts of this chemical, he or she may show symptoms of ADHD.

ADHD affects up to 8% of the population. So if you have 100 children in your grade at school, as many as eight may have ADHD.

How Is ADHD Treated?

Because there is no cure for ADHD, doctors treat people by helping them to manage the symptoms most effectively. Because some people have more trouble with the attention side of the disorder and others have more problems with the activity side, doctors tailor their treatment to the person's symptoms. This means that different people with ADHD may have different treatments.

Doctors usually follow what's called a multimodal (pronounced: mul-tee-moe-dul) approach to ADHD treatment. This means that they use several different treatment methods for one patient, such as medication, family and individual counselling, and changes at school to address particular learning styles.

Certain medicines can help people with ADHD by improving their focus and attention and reducing the impulsiveness and hyperactivity associated with ADHD. People with ADHD used to have to take medicine several times a day, but there are now several medicines that can be taken at home once a day in the morning. Scientists are constantly working to develop new medications to treat the condition. You can discuss treatment options with your doctor, but always follow the doctor's instructions about medication dosages. If you have been taking medicine for ADHD since you were a kid, your doctor will probably adjust your medication for changes in your symptoms as you get older.

Family counselling helps treat ADHD because it keeps parents informed and also shows them ways they can work with their kids to help. Family counselling also helps to improve communication within the family and to solve problems that come up between teens and their parents at home. Individual counselling helps teens with ADHD to better understand their behaviour and to learn coping skills. Sometimes group therapy - where lots of teens with ADHD work together in a group - helps people learn coping skills and how to get along better with others, if that's been a problem.

Schools are also involved in helping people with ADHD. Schools can make changes that will allow them to learn in the way that works best for them. The school will help develop a plan that's right for each teen.

People who have ADHD may also have other problems, such as depression, anxiety, or learning disabilities like dyslexia, that require treatment. They also may be at greater risk for smoking and using drugs, especially if the ADHD is not appropriately treated. That's why proper diagnosis and treatment are critical in improving the lives of people with ADHD.

If you or someone you know has ADHD

Most teens with ADHD are diagnosed as children, but some people aren't diagnosed until they are in their teens or even older. It's normal to feel overwhelmed, scared, or even angry if you've been diagnosed with ADHD. That's one thing counselling can help with. Talking about those feelings and dealing with them often makes the process much easier.

If you have ADHD, you may not be aware that you are behaving in a way that is different from others; you're just doing what comes naturally. This can sometimes cause problems with people who don't understand or know about your condition. For example, you might speak your mind to someone only to get the feeling that you've shocked or offended the person. You may not understand why people get mad at you.

Learning all you can about your condition can be a huge help. The more you understand, the more involved you can be in your own treatment. Here are some of the things you may be able to do to help with school and relationships:

- Sit in the front of class to limit distractions.
- Turn off email, instant messaging, and your phone when doing homework or other tasks that require focused attention. This will help protect you against being distracted.
- Talk openly with your teacher about your condition and work with him or her to be sure you're learning in a way that works for you. For example, some schools will allow people with ADHD more time for taking tests. Some teens may benefit from smaller class sizes and tutorial help.
- Use tools that help you stay organized. Keep a homework notebook to keep track of assignments, including a list of books and readings you'll need to bring home to do them.
- Write down classes, extracurricular activities, and other appointments in a daily planner so you don't forget.
- Keeping a daily agenda can also help you avoid making unplanned, impulsive decisions: If you're scheduled to start homework at 4:30, you'll know it's not a good idea to go with your girlfriend to watch her 4:00 soccer practice. The organization skills you develop now will serve you well in the future, too. Even people who don't have ADHD all find they need to develop these skills when they head off to the workplace - so you'll be ahead of the curve!
- Get plenty of exercise. Studies are starting to show that exercise can help people who have ADHD. If you feel hyper during school, talk to a teacher about taking activity breaks so you can stay focused and concentrate better when in class. Take frequent activity breaks while studying or doing homework.
- Practice relaxation techniques to relax and focus.
- Let friends know what is going on. Sometimes with our friends, we blurt things out and regret it later or we do silly impulsive things. If this happens to you, let your friends know that sometimes you just say things without thinking all the way through, apologize if you have hurt someone's feelings, and try to be extra careful in new situations.

If you have ADHD, it's natural to feel misunderstood and frustrated at times. It might seem like you're always losing your homework or having trouble following teachers' instructions, or you may have trouble making friends or getting along with your family members. It helps to learn as much as you can about yourself and ADHD and find the methods that will help you work to your full potential - both academically and socially. The good news is that doctors, counsellors, and teachers are learning more about ADHD all the time and have a greater understanding than ever of the challenges people living with it face.

Guidelines for dealing with Dyspraxia

What is dyspraxia?

Developmental dyspraxia is an impairment or immaturity of the organisation of movement. It is an immaturity in the way that the brain processes information, which results in messages not being properly or fully transmitted. The term dyspraxia comes from the word praxis, which means 'doing, acting'. Dyspraxia affects the planning of what to do and how to do it. It is associated with problems of perception, language and thought.
Dyspraxia is thought to affect up to ten per cent of the population and up to two per cent severely. Males are four times more likely to be affected than females. Dyspraxia sometimes runs in families. There may be an overlap with related conditions.
Other names for dyspraxia include Developmental Co-ordination Disorder (DCD), Perceptuo-Motor Dysfunction, and Motor Learning Difficulties. It used to be known as Minimal Brain Damage and Clumsy Child Syndrome.
Statistically, it is likely that there is one child in every class of 30 children. We need to make sure that everyone understands and knows how best to help this significant minority.

Reading and spelling

Children with dyspraxia may have difficulties with reading and spelling. Limited concentration and poor listening skills, and literal use of language may have an effect on reading and spelling ability. A child may read well, but not understand some of the concepts in the language. The child may also be reluctant to read aloud because of articulation difficulties or because they lack self-confidence.
Exercises may be beneficial for children with reading and spelling difficulties. Take Time by Mary Nash-Wortham and Jean Hunt provides a series of exercises for parents, teachers and therapists to do with children. Computers can also help with reading and spelling: Wordshark 2 is a widely used program, available from the Dyspraxia Foundation.

Research has shown that children with developmental verbal dyspraxia whose speech difficulties persist beyond the age of 5.6 years are at risk of having literacy difficulties. The risk is increased if there is a family history of speech, language or specific learning difficulties.

The child with developmental verbal dyspraxia has an impaired speech processing system, which affects their ability to make sound – letter links and to carry out phonological awareness tasks (e.g. segmenting, blending, rhyming etc) essential for literacy acquisition. Spelling is usually more affected than reading.

Handwriting

Poor handwriting is one of the most common symptoms of dyspraxia. Children who have poor handwriting don't need their parent or teacher to tell them about it. Every time they write, they can see that they are not as good as their friends.

Handwriting expert Dr Rosemary Sassoon believes that children with dyspraxia should be judged only against their own best efforts. They should be encouraged to progress in a relaxed way. Her leaflet A Quick Look at Handwriting Problems gives practical suggestions about working with children to develop handwriting skills.
As the child progresses through the educational system, the requirement for written work increases. Take Time by Mary Nash-Wortham and Jean Hunt provides exercises that can help with handwriting. Write from the Start by Ion Teodorescu and Lois Addy are two books which contain the Teodorescu Perceptuo-Motor Programme, for developing the fine motor and perceptual skills for effective handwriting.

Dyspraxia in children

Although dyspraxia may be diagnosed at any stage of life, increasing numbers of children are identified as having the condition.
Early recognition of dyspraxia will enable early intervention and practical steps to help your child to achieve their potential. Children whose dyspraxia is identified at an early stage are less likely to have problems with acceptance by their peers and with lowered self-esteem.
When children become teenagers their problems may change as social and organisational difficulties become more pressing.
The Dyspraxia Foundation can help and support you and your child through its services and publications.

Symptoms

By 3 years old

Symptoms are evident from an early age. Babies are usually irritable from birth and may exhibit significant feeding problems.
They are slow to achieve expected developmental milestones. For example, by the age of eight months they still may not sit independently.
Many children with dyspraxia fail to go through the crawling stages, preferring to 'bottom shuffle' and then walk. They usually avoid tasks which require good manual dexterity.

By 3 to 5 years old

Children with dyspraxia may demonstrate some of these types of behaviour:
· Very high levels of motor activity, including feet swinging and tapping when seated, hand-clapping or twisting. Unable to stay still
· High levels of excitability, with a loud/shrill voice
· May be easily distressed and prone to temper tantrums
· May constantly bump into objects and fall over
· Hands flap when running
· Difficulty with pedalling a tricycle or similar toy
· Lack of any sense of danger (jumping from heights etc)
· Continued messy eating. May prefer to eat with their fingers, frequently spill drinks
· Avoidance of constructional toys, such as jigsaws or building blocks
· Poor fine motor skills. Difficulty in holding a pencil or using scissors. Drawings may appear immature
· Lack of imaginative play
· Limited creative play
· Isolation within the peer group. Rejected by peers, children may prefer adult company
· Laterality (left- or right-handedness) still not established
· Persistent language difficulties
· Sensitive to sensory stimulation, including high levels of noise, tactile defensiveness, wearing new clothes
· Limited response to verbal instruction. May be slow to respond and have problems with comprehension
· Limited concentration. Tasks are often left unfinished.

Pre-school children

If dyspraxia is not identified, problems can persist and affect the child's life at school. Increasing frustration and lowering of self-esteem can result.

By 7 years old

Problems may include:
· Difficulties in adapting to a structured school routine
· Difficulties in Physical Education lessons
· Slow at dressing. Unable to tie shoe laces
· Barely legible handwriting
· Immature drawing and copying skills
· Limited concentration and poor listening skills
· Literal use of language
· Inability to remember more than two or three instructions at once
· Slow completion of class work
· Continued high levels of motor activity

· Hand flapping or clapping when excited
· Tendency to become easily distressed and emotional
· Problems with co-ordinating a knife and fork
· Inability to form relationships with other children
· Sleeping difficulties, including wakefulness at night and nightmares
· Reporting of physical symptoms, such as migraine, headaches, feeling sick

Primary education
By 8 to 9 years old

Children with dyspraxia may have become disaffected with the education system. Handwriting is often a particular difficulty. By the time they reach secondary education their attendance record is often poor.

School Age Children

When children with dyspraxia start school they begin to realise that they are different from their peers. To start to understand who they are and to say to teachers and other children 'I have dyspraxia' takes courage and self-confidence.
Coping with daily life can become increasingly difficult. In particular, getting to grips with social skills and with the rules of games can cause problems. At school, your child may experience bullying as well as problems with reading and spelling and handwriting.
The Dyspraxia Foundation may have a local group or contact which can offer support for you and your school-age child.
The Dyspraxia Foundation has published a booklet which explains dyspraxia in straightforward terms to the child. Discover Yourself , by health and social studies lecturer Gill Dixon gives the child's-eye view on how they can help themselves. As one 8 year-old said, 'This is the first book I've ever read that describes what it's like to be me!'

Dyspraxia in Teenagers

Life as a teenager can be particularly difficult if you have dyspraxia. All teenagers have to cope with bodily and emotional changes: those with dyspraxia may find that their co-ordination and ability to cope with daily life is affected by those changes.
School or college may become particularly challenging, academically and socially. Examinations can be the cause of stress and uncertainty.
Teenagers are particularly aware of appearing different and may be acutely self-conscious about their appearance. The Dyspraxia Foundation's newsletter for teenagers, Dyspraxia.nu is a forum for teenagers with dyspraxia to share their problems.
Coping with a teenager who has dyspraxia may require extra patience and understanding! Tips with Teens by Dr Lilian F C Beattie gives practical suggestions to help parents through the testing times.

Guidelines for dealing with Dyslexia

The strategies outlined here are intended to make the post-primary classroom conducive to learning for pupils with learning difficulties and in particular, pupils with Specific Learning Difficulties (Dyslexia).

These notes are not a *'How to teach dyslexics'* handbook. The ideas are not new but an 'aide memoire' for the busy teacher.

The transition from primary to post-primary education is a worrying time for many eleven year olds. They are often concerned as to how they will cope with the changes—a new, larger school, more teachers, more equipment, moving from class to class for lessons, homework etc. etc.

These fears are even greater for the dyslexic child who is worried by all these things because s/he knows it will take them longer than their peers to get used to a new routine.

They are also often concerned that their new teachers will think they are stupid because they might not be able to do a lot of the things expected of them quickly enough to please. They may be embarrassed by their limited literacy skills, poor memory and lack of organization and resort to task avoidance strategies to cover up.

By not making the assumptions outlined earlier and by adopting the strategies outlined in the following pages we can help to make the transition to secondary school much less threatening for the 20% of pupils who experience learning difficulties.

How* to *Make Your Classroom Dyslexia Friendly

Timetables
Managing a timetable can be a problem for some pupils. Many dyslexics have difficulty with organizational skills and may often forget to bring equipment. Displaying a large timetable A3 with illustrations showing the days they need to bring, for example, P.E. kit will help pupils to remember particularly if they have been involved in making the timetable. This can be a useful and effective activity during tutor time at the beginning of the school year. You could also give those pupils who have problems with remembering equipment a 'Memory Jogger Timetable' to take home and stick on the wall so that parents can help their son/daughter to remember when they need specific items for school.

Labels
Remembering where classroom equipment is stored can be difficult for many pupils. Help them by clearly labeling equipment and resources. Keeping things in the same place is a good idea because pupils will eventually become familiar with the layout of your classroom.

If you work in an area where practical equipment is used it is helpful to label it. This will ensure that pupils learn to recognise equipment and how to spell it when they refer to it in their written work. Where space is limited you might find it useful to put a list of equipment with a picture of each on the cupboard door.

Colour coding
This can be an effective memory jogger for pupils. By storing, for example, calculators in a cupboard with a yellow label and rulers in a cupboard with a red label you will be helping pupils to remember more easily where things are. You may also find that equipment is more effectively put away at the end of the lesson. Colour coding will be most effective if departments agree on a colour coding system and use it in all their teaching rooms.

Displays
Displays of basic information will be an invaluable aid for pupils who have difficulty remembering.

Display:
- the upper and lower case letters of the alphabet
- numbers 1—100
- days of the week
- months of the year
- sample mnemonics
- ***b/d*** fingers
- learn to spell the easy way
- times tables

Curriculum displays should include:
- key topic words that you expect the pupils to learn
- the aims of the topic
- the dates when completed work should be handed in

If it is not possible to display this information provide an information sheet at the beginning of each topic and refer to it during the teaching of that topic. Where teachers do not have their 'own' classroom, staff could take responsibility for providing displays in the room they most frequently teach in or register a group in. Continuity is important particularly for displays of basic information which pupils should have access to whatever curriculum area they are in.

Giving Instructions
When giving verbal instructions, try to limit them to no more than two. This will minimise the chance of the pupil getting confused. The dyslexic pupil, when too many instructions are given can have forgotten the first thing he was asked to do.

Ensure pupils know what is being asked of them by asking them to repeat or explain in their own words what they are being asked to do. Don't ask only the dyslexic pupil! It could be routine practice for all pupils to explain

to their neighbour what they have to do, while the teacher unobtrusively ‘listens in’ to those pupils most at risk of not understanding the task.

Homework
Where possible give homework at the beginning of a lesson or allow adequate time at the end of the lesson to record it accurately. It may be necessary to record homework for the dyslexic pupil to ensure that it is accurate and that parents can read it if they are to help their son. It will often take the dyslexic pupil much longer to complete homework than his/her peers so ***it*** is important to set realistic amounts to avoid ‘overloading’ the pupil.

Directions
When giving instructions of a directional nature ensure that the pupils know left from right. The instruction to draw a line down the left side of the paper should be illustrated where possible by showing an example. Don’t assume you will get a vertical line.

Boards
Copying from the board can be extremely difficult for dyslexic pupils and a source of great frustration. They will find it much easier to copy from a sheet of paper by their side. If they must copy from the board help them by numbering the lines so that they can follow the sequence of written work and will be able to find where they have got to if they are distracted as they move their eyes from the board to their own work.

They will need to keep their own written tally and mark off as they complete each line. For example 1 2 3 4 ***5 6 7***

Dates
Encourage pupils to write the day, month and year when they begin a piece of work.

Worksheets
- Check readability level—is it appropriate?
- Check typeface and size of print—is it clear/large enough?
- Check quality of copy—avoid blurred images
- Check spacing—avoid clutter
- Number the lines
- Group information and tasks—avoid lots of information followed by lots of questions
- Sequence the instructions/illustrations
- Present tasks in a separate box
- Remove non-essential language
- Provide examples of the type of response you require
- Provide audio tapes of the sheet where possible
- Provide copies on colours other than white

Mind Mapping

Show pupils how to plan their work using mind mapping techniques. These can be helpful to many pupils. Mind mapping allows pupils to draft their work in a variety of ways and encourages them to use their strengths when planning work. It is more flexible than flow charts because it can utilise words, symbols, colours etc. as well as written language.

Pupils who have very little written language can therefore plan their work using a series of pictures, colour coded shapes or key words to express their ideas. These could then be translated to a scribe or spoken into a tape recorder. ~ using this method pupils with written abilities lower than their peers can still participate in class work without losing self confidence.

The mind mapping technique is used among college lecturers and students and may be a valuable aid to the dyslexic child when faced with examination preparation.

* *The original idea for mind mapping and a detailed explanation of the idea can be found in books written by Tony Buzan.*

Mnemonics

Develop and encourage interest in the use of mnemonics as a valuable *aid* in helping to remember spellings, lists, facts for dyslexics and non-dyslexics alike. You are probably already using mnemonics in one form or another...

How do you remember the order of the colour of the rainbow or how to spell Wednesday or the letter sequence of 'ough' or the nine times tables? Pupils can **often** be inventive and creative when they are given the opportunity to think of their ways of remembering spellings, lists, facts etc.

Mnemonics can help you remember....

ough	**o**ld **u**ncles **g**et **h**eavy
ould	**o**ld **u**ncles **l**ike **d**riving
	o u lucky **d**uck
augh	**a**ll **u**nicorns **g**row **h**orns
ight	**I**' m **g**oing **h**ome **t**onight
people	**p**eople **e**at **o**ranges **p**eople **l**ike **e**ggs
said	**S**ally **A**nne **i**s **d**ancing
together	**to—get—-her**
because	**b**ig **e**lephants **c**an't **a**lways **u**se **s**mall **e**ntrances
Wednesday	**Wed—nes—day**

Remember,~

When two vowels go out walking
the first **one usually does the talking (i.e. says** its **name e.g. meat, pain etc.)**

Class Mouse Trap

Teaching Tips

Provide:

- ***C*oncise verbal instructions**
- ***L*ots of reading material**
- ***A*lternatives to written work**
- ***S*mall *S*teps**

- ***M*ultisensory approach**
- ***O*bjectives that** are **clear**
- ***U*nderstanding**
- ***S*uitable text/tasks**
- ***E*xamples of what you expect**

- ***T*ime to think**, **organise, complete**
- ***R*einforcement**
- ***A*ccess to the curriculum**
- ***P*raise for effort**

Guidelines for internet research

Dyslexia is a specific learning difficulty which is neurobiological in origin and persists across the lifespan.

It is characterised by difficulties with phonological processing, rapid naming, working memory, processing speed and the automatic development of skills that are unexpected in relation to an individual's other cognitive abilities.

These processing difficulties can undermine the acquisition of literacy and numeracy skills, as well as musical notation, and have an effect on verbal communication, organisation and adaptation to change.

http://www.bdadyslexia.org.uk/

Dyspraxia

Dyspraxia can affect any or all areas of development – intellectual, emotional, physical, language, social and sensory - and may impair a person's normal process of learning. Usually, it's said to be an impairment or immaturity of the organisation of movement. However, associated with this may be problems of language, perception and thought.

Problems arise in the process of forming ideas, motor planning and execution, since people with dyspraxia have poor understanding of the messages their senses convey and difficulty relating those messages to actions.

This means physical activities are hard to learn, difficult to retain, and hesitant and awkward in performance.

http://www.bbc.co.uk/health/conditions/dyspraxia2.shtml

ADHD

Attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD) refer to a range of problem behaviours associated with poor attention span.

These may include impulsiveness, restlessness and hyperactivity, as well as inattentiveness, and often prevent children from learning and socialising well. ADHD is sometimes referred to as hyperkinetic disorder.

http://www.netdoctor.co.uk/diseases/facts/adhd.htm

Asperger syndrome

These conditions are known as autistic spectrum disorders. Those with Asperger syndrome are usually more mildly affected than those with autism, in fact many with milder symptoms are never diagnosed at all.

What are the symptoms?

There are three main aspects to Asperger syndrome:

Difficulty in social relationships - People with Asperger syndrome often enjoy or want to develop social contacts but find mixing with others very hard. They particularly have problems with :

- Understanding non-verbal signals such as body language, gestures, facial expressions and tone of voice
- Obsessions with particular objects or routines

Difficulty with communication - Although they may be able to speak fluently, sometimes there are difficulties judging or understanding the reactions of those they are talking to. Common problems include :

- Failing to notice the body language of others
- Appearing insensitive to the feelings or views of the listener
- Continually talking, unaware of the listener's interest
- Appearing over-precise in what they say
- Taking comments very literally (for example misunderstanding jokes, metaphors or colloquialisms)

Lack of imagination and creative play - Children with Asperger syndrome are often of average or above intelligence, and may be particularly good at learning facts and figures. However they may also lack imagination and find creative play, or thinking in the abstract very difficult. This means that :

- They may be particularly good at topics such as maths or history, but struggle with subjects such as philosophy, religious education or creative arts

http://www.bbc.co.uk/health/conditions/autism2.shtml

St Mary's Grammar School Belfast **Individual Education Plan**

Education Plan

Pupil:	Class:	D.O.B.
SEN Key:	C.o.P. Stage	E.P. No:
Date:	Other Agencies involved:	

Pupil Strengths:	Areas of Difficulty:

Targets (Sept- Dec)	Targets (Jan- May)
Review 1	Review 2

Current Support:
Monitoring Arrangements:
Pastoral/Medical:

Teacher: _____ Department:_____

Appendix 2a SEN Information Recording Sheet: KS3

Pupil Name: **Class:** **Learning Difficulty:**

Subject	Teacher Signature	Date Information Given
English		
Mathematics		
Science		
Religion		
ICT		
Music		
Art		
PE		
Technology		
History		
Geography		
Irish		
French		
Spanish		
Citizenship		
Learning for Life and Work		
Drama		

Appendix 2b

SEN Information Recording Sheet: GCSE & 'A'Level

Pupil Name: **Class:** **Learning Difficulty:**

Subject	Teacher Signature	Date Information Given
English		
Mathematics		
Biology		
Chemistry		
Physics		
Religion		
ICT		
Business Studies		
Sports Studies		
Music		
Art		
Technology		
Language		
Geography		
History		
Learning for Life and Work		
Financial Services		
Politics		
Psychology		
Theatre Studies		

Approvals ▪ Signatures: Principal Chair of Governors ▪ Date of approval by Governors: ▪ Date of next annual review:	 _____ _____ ____ / ____ / _____ ____ / ____ / _____