



# Trends in SEN identification: contexts, causes and consequences

September 2020

## Trends in SEN identification: contexts, causes and consequences

### SUMMARY

This policy seminar addressed these current issues and questions: i. Are there shifts from an interactive to within-child model of identification? And if so, what are the factors that are contributing to this, ii. What are the changing relationships between parents, schools and LAs and their influence on identification practice? And iii. What kind of identification and assessment framework do we need for the future?

The first speaker Jo Hutchinson, from the Education Policy Institute, presented on “How fairly and effectively special educational needs and disabilities (SEND) are identified?” in which she summarised her interim findings about school attainment and inclusion questions. One of her key findings was that about four in ten children have some interaction with the SEND system over the course of their schooling. This is a lot more than the commonly held assumptions about SEN incidence (one in five or six). Further analysis indicated that factors that best predicted the identification of SEN Support in primary schools were measures of deprivation and prior attainment. There were moderate effects for absences, ethnicity, looked after child status and child in need status. Lesser but still significant factors were sex, months of birth, EAL status and school mobility. The communication language and literacy scale of the Early Years Foundation Stage Profile was the best predictor of being identified with SEND at the SEN Support level. Also, analysis showed that most of variation in SEN Support identification was predicted by school variations, indicating that individual effects were halved once school factors were taken into account. Analyses for secondary and SEN at the EHC Plan level were still to be completed.

Dr Sami Timimi, Consultant Child and Adolescent Psychiatrist, presented on ‘the social construction of autism’. In his presentation he deconstructs the ‘common sense’ understanding of autism to argue that it is a construct that lacks a coherent basis in science and can result in therapeutically unhelpful dynamics. In presenting a historical background to psychiatric diagnosis he argues that there is no such thing as a psychiatric diagnosis of autism. Part of this argument is that concepts like ASD do not even work well as a descriptive classification as they operate as ‘thin descriptions’, overlooking what matters about individual people. He concluded his presentation by pointing out that an ASD diagnosis can be a ticket to services but also a reason to exclude from services and that it can disempower parents and teachers by accident.

The third presenter Neil McKay, a consultant and trainer, presented on ‘dyslexia – definitions and identification’. Though he started by acknowledging the problems with the IQ discrepancy diagnosis of dyslexia, he took a particular perspective on the ‘dyslexia debate’ based on his teaching and advisory practice. He questioned whether a dyslexia diagnosis unlocks provision at the expense of others, arguing that all children with a reading difficulty regardless of IQ, should be encouraged to seek intervention. His central point was that Elliott and Grigorenko (who question dyslexia) rely on a narrow view of reading by concentrating on accuracy. This is the basis for the argument that, because dyslexic and non-dyslexic poor readers show almost identical patterns of difficulty, that dyslexia does not exist. McKay’s position is to focus on “unexpected difficulties” by interpreting unexpected difficulties as being about comprehension; a position which derives from practitioners’ experience of children with “unexpectedly good” comprehension despite poor reading accuracy. He advocates the Scottish HMIE concept of dyslexia as ‘marked differences in certain areas, especially with regard to oral versus text-based skills’. From this stance, he concludes that high quality teaching based on validated synthetic phonic approaches empowers most learners, regardless of label, to learn to read. But, it is the unexpected gap between reading accuracy and higher order comprehension and thinking skills that often typifies the dyslexic learner.

In the group discussions there were common themes about an increase in prevalence of several conditions, with some questions about whether this was due to getting better at diagnosing particular types of need and / or that only by a focus on a within-child model of identification would parents be taken seriously. Several groups believed that the role of parental expectations was central to this increased prevalence and the growing tensions between parents, schools and authorities. The kind of identification and assessment framework that was supported in several groups involved these features: multidisciplinary, collaborative, independent from budget holders, transparent, one aiming to build parental trust in the system and one that is values driven. There was some concern about whether there was proper scrutiny of environmental factors, and if not, whether this can lead to adopting a reduced within-child model and a sense of learned helplessness in schools. A graduated response was endorsed by some as an appropriate model for an identification framework.

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## **Section 1: Introduction**

This policy seminar on Trends in SEN identification: contexts, causes and consequences took place on 3 Feb, 1.30 for 2-5pm St Albans Centre, Leigh Place, It addressed the following issues and questions:

- Are there shifts from an interactive to within-child model of identification? And if so, what are the factors that are contributing to this
- What are the changing relationships between parents, schools and LAs and their influence on identification practice?
- What kind of identification and assessment framework do we need for the future?

The programme consisted of three presentations followed by discussions in small group. Jo Hutchinson, Education Policy Institute (EPI) presented on: How fairly and effectively special educational needs and disabilities (SEND) including those with social, emotional and mental health needs) are identified. This was followed by Dr Sami Timimi, Consultant Child and Adolescent Psychiatrist on ASD: The social construction of Autism. Finally, Neil McKay, Consultant and trainer presented on Dyslexia: its changing patterns of definition and identification. The conclusions of the small group discussions are summarised at the end of this policy paper.

### **SEN Policy Research Forum**

The SEN Policy Research Forum, which organised this seminar, incorporates the aims and work of the previous SEN Policy Options group in a new format and with some expanded aims. The Forum's website is at:

<http://blogs.exeter.ac.uk/sen-policyforum/>

The aim of the Forum is to contribute intelligent analysis, knowledge and experience to promote the development of policy and practice for children and young people with special educational needs and disabilities. The Forum will be concerned with children and young people with special educational needs and disabilities from preschool to post 16. It will cover the whole of the UK and aim to:

1. provide timely policy review and critique,
2. promote intelligent policy debate,
3. help set longer term agendas – acting like a think-tank,
4. deliberate over and examine policy options in the field.
5. inform research and development work in the field.
6. contribute to development of more informed media coverage of SEND policy issues.

The uncertainties over what counts as 'special educational needs' and 'disabilities' in relation to a wider concept of 'additional needs' are recognised. These will be among the many issues examined through the Forum.

The Forum, which continues the work of the SEN Policy Options group has been continuing this work for over 20 years. It started as an ESRC seminar series with some initial funding from the Cadbury Trust. The Forum appreciates the generous funding from NASEN and the Pears Foundation to enable it to function, though it

operates independently of these organisations.

**Lead group and coordination of the Forum:**

Dr Peter Gray - Policy Consultant (co-coordinator)  
Professor Brahm Norwich - University of Exeter (co-ordinator)  
Yoland Burgess, Young People's Education and Skills, London Councils  
Professor Julie Dockrell – UCL Institute of Education  
Beate Hellawell, Lewisham local authority  
Dr Brian Lamb - Policy consultant  
Professor Geoff Lindsay - University of Warwick  
Nick Peacey, First Director , SENJIT. Institute of Education  
Penny Richardson - Policy Consultant  
Chris Robertson, University of Birmingham  
Dr Rob Webster, UCL Institute of Education  
Professor Klaus Wedell UCL, Institute of Education  
Julie Wharton, Winchester University

**Membership:**

If you would like to join the Forum, go to the website and follow link to register as a member. You will be invited to future seminars and be able to participate in discussion through the Jiscmail system. SEE SENPRF website for joining instructions.

For further information please contact the co-coordinators of the Forum, Brahm Norwich, Graduate School of Education, University of Exeter, Heavitree Road, Exeter EX1 2LU (b.norwich@exeter.ac.uk) or Peter Gray (pgray@sscyp) .

**Past Policy Options Papers (see website for downloadable copies)**

1. Bucking the market: Peter Housden, Chief Education Officer, Nottinghamshire LEA
2. Towards effective schools for all: Mel Ainscow, Cambridge University Institute of Education
3. Teacher education for special educational needs: Professor Peter Mittler, Manchester University
4. Resourcing for SEN: Jennifer Evans and Ingrid Lunt, Institute of Education, London University
5. Special schools and their alternatives: Max Hunt, Director of Education, Stockport LEA
6. Meeting SEN: options for partnership between health, education and social services: Tony Dessent, Senior Assistant Director, Nottinghamshire LEA
7. SEN in the 1990s: users' perspectives: Micheline Mason, Robina Mallet, Colin Low and Philippa Russell
8. Independence and dependence? Responsibilities for SEN in the Unitary and County Authorities: Roy Atkinson, Michael Peters, Derek Jones, Simon Gardner and Philippa Russell
9. Inclusion or exclusion: Educational Policy and Practice for Children and Young People with Emotional and Behavioural Difficulties: John Bangs, Peter Gray and Greg Richardson
10. Baseline Assessment and SEN: Geoff Lindsay, Max Hunt, Sheila Wolfendale, Peter Tymms

11. Future policy for SEN: Response to the Green Paper: Brahm Norwich, Ann Lewis, John Moore, Harry Daniels
12. Rethinking support for more inclusive education: Peter Gray, Clive Danks, Rik Boxer, Barbara Burke, Geoff Frank, Ruth Newbury and Joan Baxter
13. Developments in additional resource allocation to promote greater inclusion: John Moore, Cor Meijer, Klaus Wedell, Paul Croll and Diane Moses.
14. Early years and SEN: Professor Sheila Wolfendale and Philippa Russell
15. Specialist Teaching for SEN and inclusion: Annie Grant, Ann Lewis and Brahm Norwich
16. The equity dilemma: allocating resources for special educational needs: Richard Humphries, Sonia Sharpe, David Ruebain, Philippa Russell and Mike Ellis
17. Standards and effectiveness in special educational needs: questioning conceptual orthodoxy: Richard Byers, Seamus Hegarty and Carol Fitz Gibbon
18. Disability, disadvantage, inclusion and social inclusion: Professor Alan Dyson and Sandra Morrison
19. Rethinking the 14-19 curriculum: SEN perspectives and implications: Dr Lesley Dee, Christopher Robertson, Professor Geoff Lindsay, Ann Gross, and Keith Bovair
20. Examining key issues underlying the Audit Commission Reports on SEN: Chris Beek, Penny Richardson and Peter Gray
21. Future schooling that includes children with SEN / disability: Klaus Wedell, Ingrid Lunt and Brahm Norwich
22. Taking Stock: integrated Children's Services, Improvement and Inclusion: Margaret Doran, Tony Dessent and Professor Chris Husbands
23. Special schools in the new era: how do we go beyond generalities? Chris Wells, Philippa Russell, Peter Gray and Brahm Norwich
24. Individual budgets and direct payments: issues, challenges and future implications for the strategic management of SEN  
Christine Lenehan, Glenys Jones Elaine Hack and Sheila Riddell
25. Personalisation and SEN  
Judy Sebba, Armando DiFinizio, Alison Peacock and Martin Johnson.
26. Choice-equity dilemma in special educational provision  
John Clarke, Ann Lewis, Peter Gray
27. SEN Green Paper 2011: progress and prospects  
Brian Lamb, Kate Frood and Debbie Orton
28. A school for the future - 2025: Practical Futures Thinking  
Alison Black
29. The Coalition Government's policy on SEND: aspirations and challenges? P. Gray, B. Norwich, P Stobbs and S Hodgson.
30. How will accountability work in the new SEND legislative system?  
Parents from Camden local authority, Penny Richardson, Jean Gross and Brian Lamb
31. Research in special needs and inclusive education: the interface with policy and practice, Brahm Norwich, Peter Blatchford, Rob Webster, Simon Ellis, Janet Tod, Geoff Lindsay and Julie Dockrell.
32. Professional training in the changing context of special educational needs disability policy and practice. Neil Smith, Dr Hazel Lawson, Dr Glenys Jones.
33. Governance in a changing education system: ensuring equity and entitlement for disabled children and young people and those with special educational needs. Peter Gray, Niki Elliot and Brahm Norwich.

34. School commissioning for send: new models, limits and possibilities, Tom Jefford, Debbie Orton and Kate Fallon.
35. An early review of the new SEN / disability policy and legislation: where are we now? Brian Lamb, Kate Browning, Andre Imich and Chris Harrison.
36. Preparing for adulthood - developing provision for children and young people with SEND. Yolande Burgess Justin Cooke. Ellen Atkinson and Gill Waceba.
37. A worthwhile investment? Assessing and valuing educational outcomes for children and young people with SEND. Graham Douglas, Graham Easterlow, Jean Ware & Anne Heavey
38. Changes in SEN / disability provision, pressures on ordinary schools and parental choice: a review of inclusive education and its prospects. Alison Black, Lizzie Harris, Jayne Fitzgerald, Claire-Marie Whiting and Jenny Andrews.
39. Policy for SEND and Inclusion: examining UK national and some European differences. Chris Robertson, Alfons Timmerhuis Niels Egelund and Camilla Brørup Dyssegaard, Cecilia Simón and Gerardo Echeita and Richard Rieser. 2018
40. Exclusions, barriers to admission and quality of mainstream provision for children and young people with SEND: what can be done? Jules Daulby, Louise Gazeley, Nicola Furey and James Roach. 2019
41. Accountability, performance management and inspection: how to enable positive responses to diversity? Jonathan Roberts, Nick Whittaker, Jane Starbuck and Robin Banerjee.
42. A review of policy in the field of special needs and inclusive education since the 1990s Lorna Selfe, Robin C. Richmond with Peter Gray and Brahm Norwich

**Copies of most of these papers can now be downloaded from the website of the SEN Policy Research Forum <https://senpolicyresearchforum.co.uk/past-policy-papers/>**

## **Section 2;**

### **How fairly and effectively special educational needs and disabilities (SEND) are identified?**

Jo Hutchinson

#### **Policy background**

Since joining the Education Policy Institute since mid-2016 I wanted to look into vulnerability as there was not that much quantitative data analysis type research around special educational needs and disabilities. So I have been looking at school attainment and school inclusion questions. I am presenting 'interim findings', so this is not a final version of what the findings of the research.

Here is some background and a window into my thoughts when I decided to undertake this research. Back in 2010 Ofsted had undertaken reviews of special educational needs and disabilities in 'A Statements is not enough' which some key findings. It is uncontroversial to say that SEND support is a postcode lottery but being a quantitative researcher what I really wanted to do was to put numbers on that postcode lottery and that is in a nutshell version what I am trying to do in this research.

Obviously, since 2010 the Government have implemented the Children and Families Act and new SEND Code of Practice reforms from 2014. So, it is actually a moving picture and not a static one, with a key element focusing partly on joint planning across education health and care. Another focus was that relationship with parents and also the extension of entitlements to age 25 which has obviously expanded the group that local authorities are trying to make provision for with that higher age range.

Fast forwarding to today this research started in 2017 and things inevitably have moved on since then. There is currently a new SEND review and high needs funding review underway, It is difficult to tell whether they are really underway or whether they have been waiting for the new Government to get in place. So, we can acknowledge that all is not well and actually there are some issues in the SEND system that still need to be addressed after sort of six years after roll-out of the Children and Families Act.

We know that up to 2011 schools had a school accountability mechanism which meant that if a child was identified with SEND they would effectively be given a lower expectation of how much progress they would make in their current Key Stage. But, that is no longer the case since 2011 when we now have an accountability system where there is effectively no control or a contextualisation of pupils who have SEND within the results that schools are delivering and being measured against.

On the financial side schools have to find the first £6,000 of funding for support per pupil. We also know the sort of general context of school funding is that it is been very squeezed over recent years. There are staffing cost pressures that are still increasing so, although the Government is now starting to talk about more money for schools, a lot of it is already earmarked to pay for increases in staffing costs before

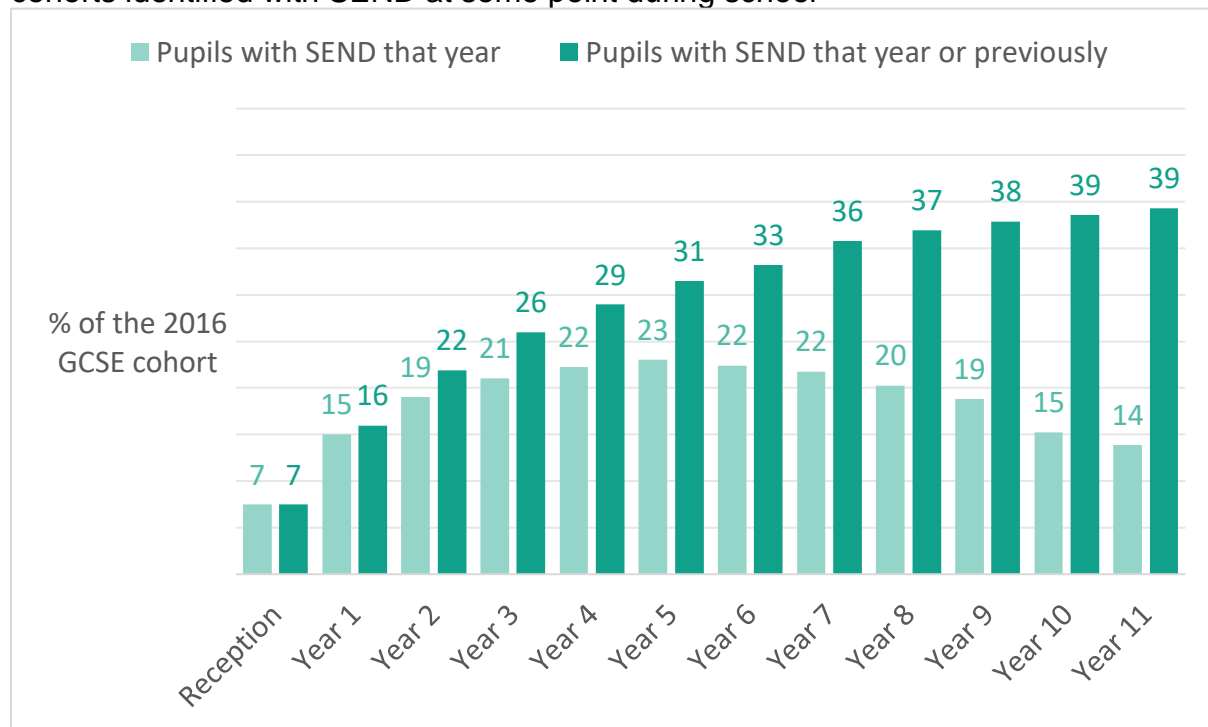


they start doing more things for the pupils. We also know that local authority budgets have reduced substantially and local authorities have been more focused on things like acute social care, in fact the only things that really increased over recent years has been acute social care and thirty hour free childcare offer in terms of increased spending by local authorities on children, sort of on average nationally. Looking forward there are now policy noises about expansion of alternative provision which could potentially affect the high needs budgets of local authorities.

### SEN identification

I started off thinking from what we do know about SEND before we delve into the sort of big questions of the research. We thought we knew was that you were looking at in the region of maybe 20%/21% of children identified with SEND. But, actually there is so much churn within the SEND system that this is only telling us about half of the number of children who are at one time or another are identified as having a special educational need or disability.

Figure 1: Prevalence for ages 5-16 reveals almost 4 in 10 children in recent GCSE cohorts identified with SEND at some point during school



In Figure 1, the paler green bars on the chart show the proportion of children identified with SEND at a particular point in time from Reception Year through to Year 11 there; the dark green bars are adding up all the children who have ever been identified up to that point in time. It looks like more like four in ten children have some interaction with the SEND system over the course of Reception through to Year 11. This is a lot more than people expected and when we think about the sort of policy around special educational needs and disabilities, it is framed as a minority concern but actually there are very large numbers of children that come into contact with the system. This was the first thing that I found out.

In terms of policy implications this means that really we are looking at most of the bottom half of the attainment distribution that come into contact with the SEND system. This can be seen to conflict with some of the ways that education policy tends to generalise its expectations about children and what they are going to achieve. So, if we look at the Government's target to have 90% of children entered into the EBacc at GCSE by 2025 and ask how well that fits with having 40% of children, at one time or another, identified with special educational needs and disabilities. One of the problems with the system is that those two sort of levels have not knitted well in national policy, leading to ask about what are the goals of the system, what can we expect in outcomes from schools? When thinking about what are the inputs and who are the children that we are dealing with, what are the challenges they face?

So, my project aimed to research how fairly and effectively SEND is identified and try and map patterns of access to support in school. A second strand to the research will look at children's access to child and adolescent mental health services and look at the overlap between school SEND services and child and adolescent mental health services. It has been a really long road to get this far with the research.

So, the strand 1 research questions were:

1. What are the factors that best predict a child being identified with SEND?
2. How do these factors differ between different need types, and levels of SEND?
3. Do these factors differ by socio-economic background?
4. Can we identify areas of England, types of provision, or other clusters of children identified at a significantly higher or lower level than predicted?
5. Is 'under-identification' or 'over-identification' of SEN relative to predicted levels associated with socio-economic disadvantage, generally or for specific types of need?
6. Have levels and patterns of under/over-identification changed over the last seven years, and are any potential effects of the pathfinders or national reforms suggested?

We wanted to examine which types of SEND children were most likely to be identified if they had different background characteristics. But, we found that the picture was so fragmented in terms of the use of the categorisations within the system that it was unlikely to be able to make sense of that, certainly below the Statement ? EHCP level of SEND. Finally, we wanted to think about whether socio-economically disadvantaged children have fair access to SEND support compared with other children, for example, and there are the patterns by children's ethnicity and the types of schools they attend.

We went about this research by using a lot of information about children, their characteristics and their experiences in school. I will talk about primary school and used that information to try to predict which children are going to be identified with SEND and which are not and then compare that with which children are actually identified with SEND and which are not. So, the basic idea behind the research is that nationally there will be patterns with certain groups of children more likely than others to be identified with SEND and we will then see how that varies at a more local level whether that is local authority level in different kinds of schools between different schools within an area, for example.

This involves using logistic regression analysis to extract the the odds of being identified with special educational needs and disabilities and what are the events or characteristics of children that might be associated with this as the first step.

So, what are the kinds of things that we're looking at that might predict which children are more or less likely to be identified with SEND? Figure 2 shows the list we ended up with after much testing of many different data items that we have been able to piece together from the administrative data and the national pupil database. So, you can see the things that have turned out to have a statistically significant association with being identified with SEND are absences from school.

**Figure 2: Modal predictors: Factors with significant effects on identification:**

- Absences from school (authorised, unauthorised, sickness)
- EYFSP age 5 assessments
- Ethnicity
- Deprivation
  - FSM duration
  - IDACI mean, max, standard deviation during primary
- Gender
- Month of birth
- School mobility (number of moves)
- English as an additional language
- Time in care
- Number of Child Protection Plans
- School attended (between schools variation)

We look at identifications between Year 1 and Year 6 in order that we have some prior information on children, what are their characteristics etc. and that means we can look at the Early Years Foundation Stage Profile Scale results for the children at age five. Those are also associated with the probability of being identified with SEND unsurprisingly. We look at children's ethnicity and at deprivation both in terms of the individual child and their history of free school meals eligibility, but also in terms of area deprivation (how deprived is the area they live in). In cases where they have lived in more than one area over the course of primary school, how much has that changed and what is the most deprived area that they've lived in over that period of time. We looked at some basic characteristics like gender, month of birth, as well as school mobility, the number of school moves that have taken place for an individual child. We also looked at English as an additional language whether the child has ever been recorded as having EAL. We then look at any time spent in local authority care and how long that period has been, if you add together all periods in which the child was in care and we look at how many child protection plans, if any, the child has recorded in their Children in Need data and we look at which school they attend which turns out to be very important indeed.

### Figure 3: Predictive margins (predicted probability of identification)

- Overall margin = 18.5%
- Deprivation, prior attainment (EYFSP) = largest effects
- Absences, ethnicity, LAC and CIN experience = moderate effects
- Sex, birth month, EAL, school mobility = significant but small effects

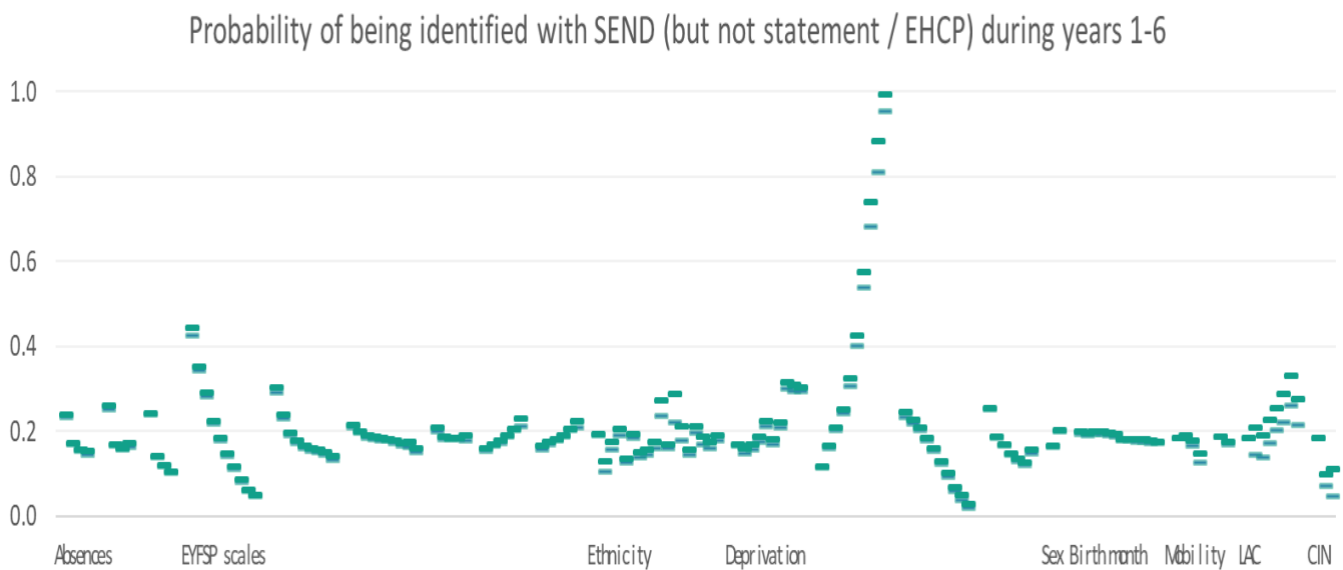
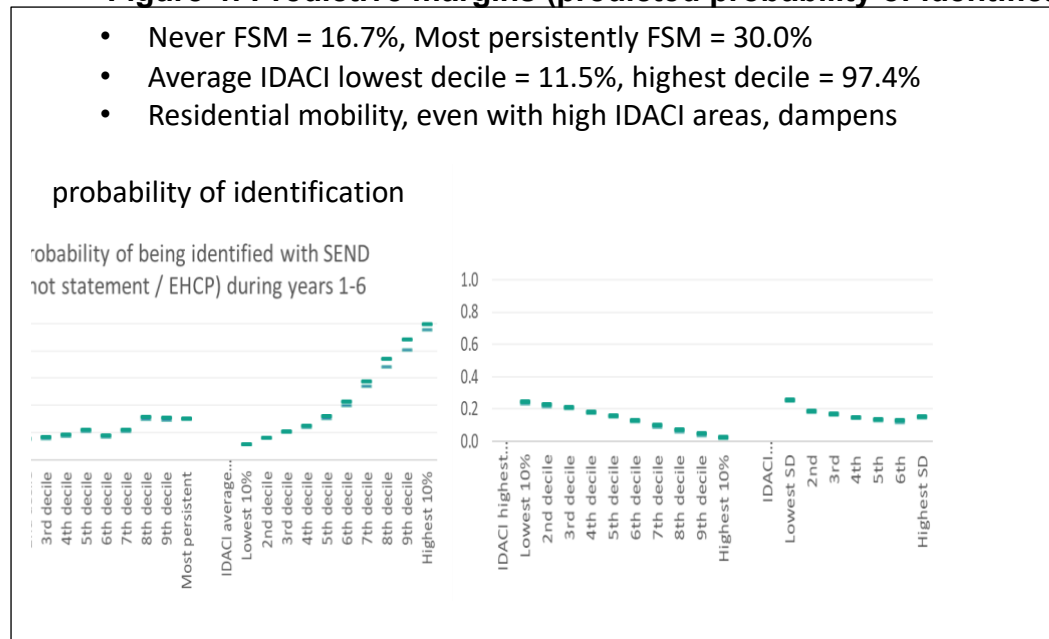


Figure 3 gives an idea of the range of the effect sizes for these factors on the probability of being identified with SEND. We are looking at the below statement / EHCP level of SEN here. So, the first time a child is identified at School Support level or the previous access of School Support level is identified on the vertical axis (the top is a hundred percent chance of being identified with SEND between those time periods and zero is no chance at all). There is a range of different factors there just to give you an idea of how some of them are a lot more important than others. For example, for the early foundation stage profile attainment that is making much more difference than say the absences from the school which are the first group. The large ladder towards the right goes all the way up to almost a hundred percent ;that is deprivation.

I now focus in a couple the more important factors in terms of how big is the effect on the likelihood of being identified with SEND. The overall probability for all children is 18.5% (see Figure 3) over the course of primary school and you see the largest effects are for deprivation and prior attainment then some sort of moderate effects for absences, ethnicity, looked after child status and child in need status. Then some statistically significant but very small differences by sex, months of birth, EAL status and school mobility. So, they help us to correctly classify children into the SEND or

not SEND group, but they do not individually have a large effect on the likelihood of them being identified with SEND.

**Figure 4: Predictive margins (predicted probability of identification)**



So, here are the deprivation effects in Figure 4. I am not going through all of this in detail, but just the really big ones to see how the breakdown for different types of deprivation. So, the first batch is the blob on the left is looking at the child individual free school meals history and it looks at what proportion of their time in school they have been eligible for free school meals. So, it shows, for example, that a child who is never eligible for FSM has 17% chance of being identified with SEND over that period and the children who are most eligible for the FSM, which is 80% to 100% of their time in school, have a 30% chance of being identified with SEND. So, that makes quite a big difference to the chances, but nothing like as much difference as the area deprivation (the second cart on the left) in Figure 4). The lowest decile, the lowest 10%, of areas by childhood deprivation have a 11.5% chance of being identified with SEND. But, then if you look at the highest defile of area deprivation a 97.4% chance that a child is actually going to be assessed as needing SEND support by their school during primary school; an enormous effect.

The smaller charts on the right of Figure 4 point in the other direction; they are about residential mobility which show that moving to areas that are more or less deprived over time dampens down the probability of being identified with SEND there. So, there are some other effects going on for children who move around and are not in the same neighbourhood throughout primary school.

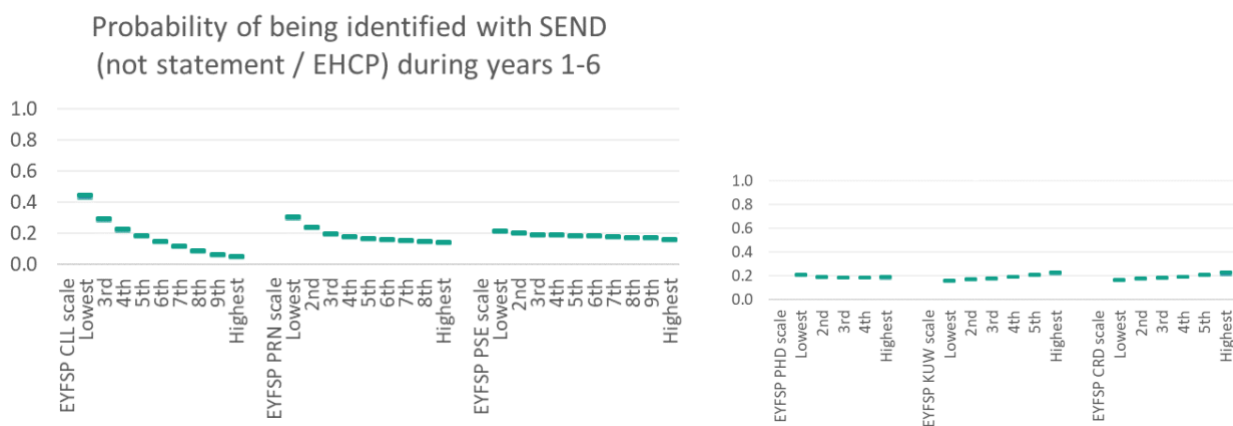
Looking at the earliest foundation stage profile (see Figure 5), the first thing to note is the old framework here because the timing of the cohort means they are not using the current framework. The chart on the left which has the biggest effect is the communication language and literacy scale. Unsurprisingly children in the lowest decile on that scale have a 44% chance of being identified with SEND compared with 4.8% for those with the highest scores on that scale. That is the most predictive

one of the scales, but there are also lesser effects for the problem-solving reasoning in the numeracy scale which is the second chart from the left.

**Figure 5: EYFSP prior attainment effects**

Predictive margins (predicted probability of identification)

- Lowest Communication, Language & Literacy = 44.0%, highest = 4.8%
- Lowest Problem-solving, reasoning & numeracy = 30.0%, highest = 13.8%
- Small *positive* effects of *higher* Knowledge & Understanding of the World, Creative Development attainment on identification



The effect on the personal social and emotional scale is smaller again; the third one along from the left. There is then only a very small effect for physical development and some small reverse effects looking at knowledge and understanding of the world and the creative development scale. I cannot explain why that is, but children with higher scores on those scales are slightly more likely to be identified with SEND. You do see the same pattern when you look at the relationship between those scales and later attainment at Key Stage 1 and 2 in primary school.

Finally, we can examine school effects and tell a lot and correctly classify quite a large proportion of children using all that individual information about the child and the neighbourhood they live in. But, once we start entering the school that the child attends into the model we find that most of the child and neighbourhood factors are proxying for which school the child is attending. This is because primary school is quite heavily segregated compared with secondary school; it tends to be a smaller neighbourhood catchment for primary school and so children tend to be more clustered by all of those characteristics we have looked at.

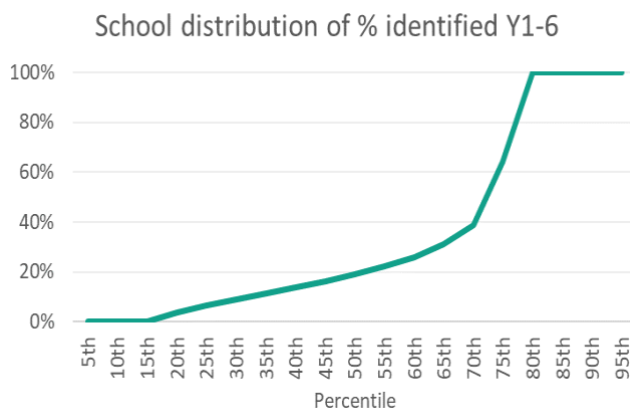
So, Figure 6 shows the distribution of primary schools by the proportion of children in the school who are identified with SEND during that year one to six period; it is not a normal distribution at all. The flat bit from either end is showing that about 17% of primary schools where no children at all are newly identified with SEND during years 1 to 6. That does not mean they do not have any children with SEND, but any that they have, have already been identified by the end of Reception Year, so there is

nothing new learned about which children have SEND after that in those primary school. At the other end of the scale, we have also got a massive chunk of schools for which about 20% of primary schools for which all children within the cohort. the cohort that got to Year 6 in 2017, were identified for the first time with SEND between Year 1 and Year 6.

### Figure 6: School effects

The distribution of Y1-6 identifications is not normally distributed

- When we include the school attended, 71% of variation is explained by which school was attended (1% by the LA below statement/EHCP level)
- Models only considering individual pupil characteristics are good classifiers, but it turns out that the strong predictors such as deprivation and prior attainment are mostly proxying for which school the child attends



Those schools on the right (with all the children being identified) are disproportionately very small schools with tiny cohorts. I think having such large numbers in there is inexplicable even accounting for their small size. However, the ones that have no children with SEND are really not more likely to be small schools with potentially unusual intake. So, I had hoped to be able to show what difference it makes to those individual characteristics once you take the school into account; to see that some of those effects are actually about the school and not about the child's characteristics. But the analysis is not finished.

So, we find that 71% of the variation in the chance of a child being identified with SEND with SEN Support in that period is by which school they attended. The school as the dominant factor in predicting which children are going to get SEND support (below statement, EHCP level) and only about 1% explained at the LA level. I anticipate that this will be different for children with statements and EHCPs, but that analysis is to be done as is the analysis for higher levels /more severe SEND.

So, if you just want to know where are the children who are most likely to be identified with SEND (SEN Support level) and therefore potentially where you might distribute greater resources, you can tell a lot about that from the individual child risk characteristics. However, school makes a strong difference, but the results also indicate that the schools with no children identified over there on the left of the Figure

6 graph are much more likely to be academy schools than local authority maintained schools. However, this findings needs further examination.

**Concluding comments:**

The next things I am to analyse are how much smaller all those individual characteristic effects are once the school is taken into account. Early analysis indicates these individual effects are roughly halved once you factor in which school the child attended. And I then want to look at what are the school level factors that account for this large variation between schools in children's likelihood of being identified with SEND. One of them is going to be academy status, but also, whether the schools are segregated by their intakes. This latter factor may actually be a driving factor: if you attend a school where lots of children have SEND, is this school more likely to be good at spotting SEND, for example, and therefore you are more likely to be identified with SEND. I will then move on to statements / EHCP identifications. In the final stage I will look at how these patterns have shifted over time.



### **Section 3: The social construction of Autism**

Sami Timimi

In this paper I will deconstruct our 'common sense' understanding of autism and demonstrate that it is a construct that lacks a coherent basis in science and that can result in therapeutically unhelpful dynamics.

#### **A brief history**

The word 'autism' was first used in psychiatry in 1911 by the psychiatrist Eugene Bleuler who used the term 'autistic' to denote the state of mind of psychotic individuals who showed extreme withdrawal from the fabric of social life. It is probably the most accurate use of the term as Bleuler used the word to describe a state of mind rather than as a diagnosis. Then, in a paper published in 1943, the child psychiatrist Leo Kanner (1943) first proposed 'autism' as a diagnosis and used the term to label a group of 11 children of middle class parents who were emotionally and intellectually impaired and showing an 'extreme aloneness' plus other features (such as stereotypies and echolalia) from early life. It has been suggested that

Kanner coined this new diagnosis in order to have a different word to use after pressure from some parents who did not wish their child to be labelled with the more stigmatising label of 'Mental Retardation'. Autism then remained as a rare diagnosis given to young people who had considerable impairments in day to day functioning and moderate to severe learning difficulties with, according to the early epidemiological studies, an estimated prevalence rate of 4 in 10,000 (Lotter et al, 1966). The concept and descriptions that Kanner came up with was the basis for diagnosing autism right up until the early 1990s.

The year after Kanner first proposed 'autism' as a diagnosis, Viennese psychiatrist Hans Asperger published a paper in 1944, largely ignored at the time, in which he described four children with no easily recognisable intellectual impairment, but with social communication problems (Asperger, 1944). This work took place in the context of Nazi ideology that was preoccupied with the task of classifying human types. American historian Edith Sheffer, drawing on records discovered by Austrian researcher Herwig Czech, documents that Asperger wrote wholly damning descriptions of at least 42 of his patients, transferring them to the notorious Am Spiegelgrund clinic where almost 800 children were deliberately allowed die from neglect or lethal overdoses (Sheffer, 2018). Asperger actively endorsed the forced sterilisation laws believing that some people were "a burden on the community" and in his actions it is implicit that he supported the euthanasia of those considered to have 'a life not worth living'. One of Asperger's tasks as a paediatrician in Nazi Vienna was to sift out potentially educable children to prevent them from becoming victims of the covert euthanasia 'T4 programme' (which would lead to the murder of over 300,000 disabled and/or institutionalised people). The significance at the time of his writing his paper on these four young people whom he described as having 'autistic psychopathology' was that he believed these young troubled patients were potentially educable and therefore could be spared from being sent to the death hospital.

In the late 1970s, psychiatrist Lorna Wing saw a similarity in some people she was seeing and those described by Asperger. Dr Wing's ideas intersected with another psychiatrist, Michael Rutter, and formed the basis for the expansion of the concept of autism into Autistic Spectrum Disorders (ASD). Revisiting the seminal papers by Wing and Rutter reveals the extent to which this expansion of the concept of autism was not the result of any new scientific discoveries, but rather new ideologies. For example, in her 1981 paper proposing the 'Asperger Syndrome' diagnosis, Wing (1981) describes six case histories that appear to have little in common with the four cases Asperger described, beyond sharing a lack of social reciprocity. Four of Wing's cases were adults, whereas all of Asperger's were children; two had some degree of learning disability, whereas none of Asperger's did; most of Wing's cases spoke late whereas most of Asperger's spoke early; most of Wing's cases were described as having little capacity for analytical thought whereas Asperger's cases were described as highly analytical; and none of Wing's cases were described as manipulative, mendacious, cheeky, confrontational or vindictive (terms Asperger used about his cases) and so on.

In his seminal paper on the subject, well-known British psychiatrist Michael Rutter (Rutter, 1978), suggested that autism likely exists on the spectrum with a strong genetic contribution to its expression. He formulated the familiar triad of symptoms; impaired communication, impaired social skills, and a restricted imagination that, together with Wing's Asperger Syndrome, formed the basis for a new 'imagining' of an expanded autism spectrum. None of these developments were accompanied by any new scientific discoveries about the bodies and brains of those now being thought to *have autism* even though it is now spoken about as a genetically predetermined, lifelong, neurodevelopmental disorder.

Over the next couple of decades the concept of autism started to attract more professional and public interest boosted by popular media coverage such as through the film 'Rain Man' and the vaccine controversies. More people were talking about this 'thing' called autism. Soon there were courses, assessments tools, research, services, documentaries, experts, and institutions all dedicated to furthering our knowledge and understanding of autism and how to treat or prevent it. Autism was now a fact of culture. Diagnosis rates expanded, leading to more services, research, talking about it (and so on). Now a group of adults who identified with idea of autism but rejected the notion that this was a disorder emerged. These activists started talking about autism as a difference – a different, but equally valid way of viewing and interacting with the world as a result of a different neurological 'wiring'. Tensions have sometimes emerged between this latter group who spoke of themselves as part of the spectrum of 'neurodiversity' and those (often parents) who were struggling to cope with the behaviours of diagnosed children, who were often desperate to find 'treatments' and felt the 'disorder' side of things. Autism had become a visible and lively discourse, by now simply assumed to represent a real tangible identifiable 'thing' that could be differentiated from other potential problems (if you identified with 'disorder' side) or that produced something fundamentally different to 'neurotypical' subjects (if you identified with the difference perspective). No one, it seemed to me, was asking the obvious question: On what evidential basis can you conclude that autism represents a natural category that can be differentiated from other natural categories, whether disorder or difference?

## **The nature of scientific evidence**

Science is generally regarded as the intellectual and practical activity encompassing the systematic study of the physical and natural world through observation and experiment. Science uses a methodological approach involving hypothesis generation and then testing the hypothesis through empirical methods. The best scientists can live with and accept uncertainty as a prerequisite to being objective in the pursuit of knowledge. Knowledge develops and builds through generating a hypothesis (often using results from previous research) and then carrying out an investigation aimed at proving something called a 'null hypothesis' can't be true. The null hypothesis is a general statement or default position that there is no relationship between certain measured phenomena. Rejecting or disproving the null hypothesis—and thus concluding that there are grounds for believing that there is a relationship and the actual hypothesis may be true, is a central task in the practice of science.

In terms of autism then, the correct scientific stance is to assume that what we are characterising as autism or ASD does not exist as a natural category until we can demonstrate that this null hypothesis cannot be true. If we want to classify this as a genetically predetermined neuro-developmental disorder we have to demonstrate that the null hypothesis – that there are no specific genes or neurological abnormalities/differences – can't be true.

## **What is the scientific evidence?**

Decades of biological research looking at genetics, brain imaging, and different developmental features, has come to an impasse leading to what is referred to as the 'replicability crises' in autism research. Theories come and go with none sticking because different research teams cannot replicate what others apparently find. We thus have a picture of consistently inconsistent findings. This problem is endemic leading to some leaders in the autism research field such as Professor Gillberg concluding that "ASD should be disbanded in research because it lacks validity" (Warehouse et al, 2016).

Neuroimaging reviews typically conclude that "Replication rates in ASD neuroimaging research have been unacceptably low ... the field has been outstandingly productive in generating thousands and thousands of findings reaching statistical significance in one or the other cohort, but disappointingly incapable of creating a coherent picture of neurobiological features underlying ASD" (Muller and Amaral, 2017). Similarly, genetic research is leading to blind alleys, "With the advent of next generation of sequencing techniques, the number of genes found that are associated with ASD is increasing to over 800 genes; consequently, it is becoming even more challenging to find unified explanations and functional associations between the genes involved (Al-jawahiri and Milne, 2017). The most likely reason for researchers not finding anything specific or characteristic, despite the enormous amount of time and money going into such biological research, is that there is not anything specific or characteristic to find – that, biologically speaking, there is no such thing as a natural kind for what we call autism. Scientifically we must assume that the null hypothesis (that there is no characteristic neurodevelopmental or genetic abnormality or difference associated with those who get an ASD diagnosis) remains intact (for further analysis of the biological research findings see Timimi and McCabe, 2016).

### **There is no such thing as a psychiatric diagnosis**

Apart from the dementias (which are still often dealt with by psychiatry) there is no such thing, in a technical sense, as a psychiatric diagnosis. Understanding why requires understanding how we classify phenomena. We classify all sorts of things in the world to help us negotiate our way around the environment and the world around us. Different classification systems use different principles for classifying. A diagnostic system of classification is classification based on *cause*. That is why when we go to the doctor we want to establish the diagnosis because we want to understand, at least proximally, the reason for what we are experiencing. If I go to the doctor with a persistent cough, I do not expect the doctor to say “you’ve got persistent cough disorder”. We would expect them to try and elicit the possible proximal reason for developing that cough. The doctor might listen to my chest, order an x-ray, take a sputum sample, or a blood test; i.e. access empirical data independent of their subjective opinion, because there can be different underlying reasons for why I have developed a cough. A diagnosis then tells us the reason/cause of that cough, which is vital to choosing the correct treatment. If you have a pneumonia being treated with a generalised approach, like a steroid inhaler, it will not do anything to the chest infection and may make it worse in the long run as steroids lower our immune response.

Thus in medicine, diagnosis is the process of determining which disease or condition explains a person’s symptoms and signs. Diagnosis therefore points to causal processes. Making an accurate diagnosis is a technical skill that enables effective matching of treatment to address a specific pathological process. Pseudo-diagnoses, like for example ‘depression’, cannot explain behaviours or experiences as there are only ‘symptoms’ that are descriptions (not explanations) and there is no access to data that is independent of subjective interpretation. Even using the word ‘symptom’ may be problematic, as in medicine ‘symptoms’ usually refers to patients’ suffering/experience as a result of an underlying disease process and is therefore associated in our minds with a medical procedure leading to an explanation for the ‘symptom’. Because we use the concept of diagnosis, our patients and their supporters imagine that a diagnosis points to an underlying and specific medical disease.

When we imagine that a psychiatric diagnosis explains our experiences we end in a philosophical tautology. For example, saying that hyperactivity is caused by a ‘hyperactivity disorder’ is no different to saying that the pain in my head is caused by a headache. A description cannot explain itself. If a parent says to me “why does my son have such difficulty in interacting with other peers?” and I were to say, “It’s because they have autism”, a reasonable question for that parent to ask me is “how do you know that it’s autism that’s causing that?” My only answer would be that, “I know it’s autism because he’s having trouble interacting with his peers.” This is the craziness that results if we confuse a descriptive classification with a diagnostic (explanatory) one.

However, concepts like ASD do not even work well as a descriptive classification as it is what narrative therapists would call a ‘thin description’ because it leaves out all sorts of other things that might be important to understand in that person’s life (family, social environment, school, trauma’s etc.) as well as their skills, abilities, and

things they do well in. These other features recede into becoming of lesser importance than the more prominent 'diagnosis', through which other descriptors and events may now be read and seen as secondary.

There is another issue worth mentioning that arises when we talk about something being on a 'spectrum'. A spectrum means we are all to some degree on this spectrum. However, people who get classified with an 'autistic spectrum disorder' are put into a different category to the rest of us. A diagnosis is a binary classification. You either 'have it' or you don't. Calling something a 'disorder' turns a spectrum into, at some point, no longer on a spectrum, but something that exists as a separate category. You do not see this in the rest of medicine. You do not find people saying you have an 'asthma disorder' or 'diabetes disorder' or 'heart failure disorder'. By sticking the word 'disorder' on the end we make it into a condition so when we classify somebody with ASD we're not saying "You're on the ninetieth percentile of the spectrum", you just have a disorder or you do not.

### **Reflections from practice**

When I was training as a child psychiatrist in the early to mid 1990s I came across two children diagnosed with autism in the whole of my four years of training placements. Both had marked functional impairments and had to attend specialist schools. According to some recent local data I have seen, 1.6% of school age children in my county have a diagnosis of autism. This means that in the space of two or three decades prevalence has gone from 0.04% (using the narrow definitions of Kanner discussed earlier) to 1.6%, a phenomenal increase of 4000%.

Here is a little clinical anecdote that illustrates how our social construction of autism has radically changed. Recently a colleague I was supervising presented a case of a young patient who had been abandoned by their mother, who had drug use problems, and was now living with their grandmother. The grandmother was struggling and there were considerable behavioural problems as well as financial and other social issues for the family to deal with. I warned my supervisee to be careful as, despite the history of attachment trauma and social hardship, given the behaviours the young patient was displaying, sooner or later someone is going to suggest they get an autism assessment. The supervisee then explained that they have already been given a diagnosis of autism!

Autism has become the new catch all for young patients who do not follow what we consider are the increasingly narrow boundaries of expected behaviours and to such an extent that we overlook histories that would obviously have an impact on their presentations. Autism now keeps coming up as a "maybe they have autism" in meetings and clinical reviews, as if that's going to provide an explanation for behaviours that concern, frustrate or infuriate us.

One of the things we do not really talk to parents about is whether a diagnosis of autism is going to be stigmatising. According some national figures I have seen, only 15% of adults with an ASD diagnosis are in employment. We should be careful about how a diagnosis could influence beliefs about a person's limitations and what they are capable of. There are also certain professions, such as the services and police, who may automatically refuse to employ anybody with an ASD diagnosis. One of the books I was involved in writing titled '*The Myth of Autism*' (Timimi et al,

2010), I co-wrote with two adults who were diagnosed with an autistic spectrum disorder but had come to wonder about it. One of the co-authors (Neil Gardner) wrote about how, for many years, he was putting on his occupational health statement in job applications that he had autism and he just did not get shortlisted or if he was he would not get the job. So, as an experiment he decided to stop putting this on his applications and soon after got a job and has been in employment ever since. Whatever the reasons for this, it is worth considering how a diagnosis can have many unforeseen negative consequences.

### **Implications for practice**

*An ASD diagnosis tells you very little about the person who gets this label.*

Because the presenting 'symptoms' are so wide and so varied, and because it leaves out so much other important information about that person's life, you cannot even assume that you have much of a description of what they are presenting with. You certainly will not understand anything about possible causes of their behaviours. An ASD diagnosis is pretty useless if you want to understand the person's history, context, what they would like to change, and what might be helpful for them.

*An ASD diagnosis can be a ticket to services and a reason to exclude from services.* For example, there are often educational services that cannot be accessed without a diagnosis. However, it can also lead to an exclusion from services. For example, I have often seen in practice that if somebody presents with anxiety and they have an ASD diagnosis they may be told, "that's part of your autism and there's nothing we can do about it" and so are not offered a service.

*Each person will develop personal meanings as well as the more broadly socially constructed ones.*

For example, I have seen adolescents who were feeling suicidal because they thought that they had this condition, that it is lifelong, and there is nothing they can do about it. Helping them understand that many do not go on to have 'symptoms' into adulthood, that there's no real evidence that there's anything wrong with their brain, and that there is every chance that they will find a positive (for them) way forward in life can be helpful, as well as looking at the specifics that the person wants to change and collaborating with them on that.

*An ASD diagnosis can disempower parents and teachers by accident.*

This is because there is an assumption that they do not have the expertise to know how to intervene and to know what the 'right' way to support their child is. Ordinary things can fly out the window and so I have seen families where the power dynamics have switched because of parents' concern that if they intervene in any way in their young person's life they might make things worse. So, they end up walking on eggshells around the young person at the same time as panicking about their future, making for a very tense household. This assumption can paralyse parents and others, leaving them feeling deskilled and waiting for more 'qualified' professionals to advise them or even better, provide the 'right' 'expert' therapy to get through to their child.

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## **Section 4:**

### **Dyslexia – definitions and identification**

**Neil McKay**

#### **Introduction**

The work of Elliott and Grigorenko (2014a) and their subsequent book, *The Dyslexia Debate*, examined how we use the term "dyslexia" and questions its efficacy as a diagnosis. The authors' premise was that a diagnosis of dyslexia added little value and, in what has since been recognized as something of a flight of fancy, they attempted to argue that a diagnosis of dyslexia in some way led to scarce resources being directed away from others with equally pressing learning issues, resulting in "more favourable intervention at the expense of other learners". We in the dyslexia community can only wish that a diagnosis of dyslexia had such authority in the school system.

Elliott and Grigorenko built the case around their view that a diagnosis of dyslexia is not meaningful in terms of differentiation, treatment or prognosis. They argued that there is an erroneous belief that a diagnosis of dyslexia can inform appropriately tailored forms of intervention which somehow go beyond existing approaches with poor decoders. Further they seek to build their case around the view that all learners with reading disabilities share a similar profile of weakness around phonological processing, rapid naming, working memory etc. – in other words, according to Elliott and Grigorenko, there is little discernible difference in reading and spelling problems experienced by dyslexic and non-dyslexic learners.

The writers also questioned whether dyslexic children respond differently to intervention to those with more generalized learning problems and, in rejecting this, they highlighted an absence of clear evidence that there is a particular teaching approach more suitable for a dyslexic sub group than for other poor readers (Elliott and Grigorenko, 2014b). As will be shown later, practitioners acknowledge that this argument needs to be flipped – the teaching approach developed for dyslexic learners – more structured, more phonic, more step by step and more chunked – is eminently suitable for most poor readers. It is also worth flagging at this point that, when Elliott and Grigorenko talk about reading, they only seem to be referring to reading accuracy.

They argued that splitting poor readers into two groups – "dyslexic sheep and poor-reading goats" has little practical value for dealing with literacy problems. And they saw their main point being that, rather than pour resources into dyslexic assessments we would be wiser to target all poor readers at an early age. As would be expected, "The Dyslexia Debate" is not without criticism. Rasmus (2014) regretted that "the book prefers to emphasize inconsistencies and disagreements rather than .....focusing on converging lines of evidence and points of broad agreement". From my perspective, as an international trainer and consultant in the field of dyslexia and other additional learning needs, I know of no school in any of the countries I have worked in the UK, Europe, Asia and Australasia, that seeks to split readers into groups by "label" and does not seek to target all poor readers at an early age. Rose (2009) observed that Elliott and Grigorenko's core argument, that a diagnosis of dyslexia somehow leads to more effective support for some children



with reading difficulties at the expense of others, is misplaced, while John Rack (2014) asks for the evidence that children with dyslexia actually get an “unfair” share of available resources. He, like Rose, urges that the debate moves on from whether dyslexia is a useful concept to shine a spotlight on ways to support all of those struggling with a range of difficulties. Indeed, the opportunity to reaffirm the importance of high quality, high impact reading interventions for all could be seen as one positive element to come from Elliott and Grigorenko’s otherwise rather sensational attempt to demolish the concept of dyslexia.

One of the conventional wisdoms used to identify dyslexic learners is the notion of “unexpected difficulties”, especially in relation to IQ. In other words, if learners with a high IQ can reason, form concepts and communicate ideas at an ability appropriate level, why can they not read and spell at a similar level?

However, there is growing evidence from a number of researchers, including Turner and Greany (2010) that the relationship between IQ and the phonological deficit underlying dyslexia may actually be quite weak. Findings suggest that the brain-based weakness in phonological awareness that is thought (by some) to be the leading cause of dyslexia is similar in poor readers irrespective of their IQ scores. Tanaka et al (2011) challenge this long standing and widely applied diagnosis of dyslexia by IQ discrepancy and what is intriguing is that writers and researchers from both sides of the “Dyslexia Divide” agree that all children with a reading difficulty regardless of IQ, should be encouraged to seek intervention. But, as Rack commented earlier, where is the evidence that this is not already happening? Where, indeed, is the evidence that a diagnosis of dyslexia unlocks provision at the expense of others?

Against this, two of the giants of dyslexia diagnosis and provision, Shaywitz and Shaywitz (2003), have used imaging studies to reveal marked differences in brain activity patterns of dyslexic readers compared to those in good readers, specifically a fault in the system which leads to under activation of neural pathways in the back of the brain. They see this as the source of initial problems with word analysis and sound symbol correspondence. But – and it is a huge “but” – Shaywitz and Shaywitz do not appear to offer any evidence that these “faults” are not also present in the brains of non-dyslexic poor readers. If there is no difference, this would seem to call into question the “unexpected difficulty” paradigm. However, once we move away from a narrow view of unexpected difficulties built around comparisons between ability and reading accuracy, criticism of Elliott and Grigorenko’s position become more valid and focused.

Elliott and Grigorenko and other researchers seem to be relying on a very narrow view of the reading process and are concentrating on accuracy – presumably because this is easy to measure. And this has led some to argue that, because dyslexic and non-dyslexic poor readers show almost identical patterns of difficulty, dyslexia does not exist. This is where the notion of “unexpected difficulties” needs to come to the fore. Most experienced practitioners will be able to cite many examples of “unexpectedly good” comprehension despite poor reading accuracy. Therefore, it is appropriate to ask if the notion of unexpected difficulty is better examined from the perspective of comprehension and higher order thinking rather than reading accuracy? Many schools use a cognitive profile as part of the assessment procedure

and I showed a graphic of a Lucid COPs Profile in which a pupil scored below the 20<sup>th</sup> centile on memory, reading non-words, segmenting, single word reading, sentence reading and spelling, suggesting significant issues with phonological processing. Yet the student scored at the 92<sup>nd</sup> percentile for reasoning. This is the epitome of “unexpected difficulties” - assuming the pupil had been taught using high impact synthetic phonic approaches, how is it such an able student is failing to acquire reading and spelling skills at an ability appropriate level?

The likely reason is that the pupil is on the “dyslexia spectrum,” effectively described by Shaywitz as “a weakness on phonology surrounded by a sea of strengths in higher order thinking,” the “sea of strengths” being the key phrase to highlight the paradox of appropriate skill levels in a range of areas set against highly specific issue around literacy acquisition – hence the notion of dyslexia as a “specific learning difficulty. While it would be inappropriate to make a diagnosis of dyslexia based on the COPs profile alone, it should result in changes in the way a pupil is taught, triggering a range of inclusive accommodations in the classroom and then, if/when these fail to have “enough impact,” it needs to be topped up with intervention in the form of small group work to address aspects of specific difficulty. While the notion of the unexpected is really important in this discussion it is also important to point out that, contrary to the views of Elliott and Grigorenko, provision for a child with global delay will be similarly triggered by any assessment that shows a failure to progress from starting points – having a dyslexic profile does not unlock extra resources.

There are many definitions of dyslexia and, sadly, many are so convoluted in their desire to encompass everything, they are meaningless to many teachers, parents and especially those on the dyslexia spectrum. The description I find the most useful is from HMIE Scotland (HMIE, 2008) which refers to “marked differences in certain areas, especially with regard to oral versus text-based skills” (page 1) So, in my professional development courses, I always pose the question, “Who do you teach who sounds like this?” and the figures are usually around 20% in every class – that is, 20% of pupils who comprehend at an ability appropriate level after watching a video or listening, but who struggle to do so in traditional comprehension tasks, who use subject jargon words correctly in speech but who struggle to spell them and who express concepts accurately and with appropriate insight during discussions but who struggle to get ideas down on paper. The British Dyslexia Association quote a figure of 10% but experience suggests 20% to be a more realistic figure.

So, in pursuit of the unexpected, I could only recommend one book, it would be “The Dyslexia Advantage” by Eide and Eide (2011). They focus on evidence validated insights into the strengths and weaknesses that accrue as the result of dyslexia and show that, while verbal and visual reasoning tend to be ability appropriate along with listening comprehension and oral expression, there are significant “unexpected difficulties” in working memory, processing speed, oral reading accuracy and spelling.

It is important to understand that the unexpected difficulties will occur at all levels of ability because dyslexia occurs at all levels of cognitive ability. Regardless of cognitive ability, dyslexic students tend to reason and understand as well as their “statistical neighbours” of similar ability but will usually perform significantly less well

in tasks requiring quick processing, rote learning and traditional comprehension and writing tasks.

Eide and Eide identify listening comprehension, oral and, perhaps surprisingly, reading comprehension as being roughly age/ability appropriate but, when compared to a statistical neighbour, accuracy, spelling and composition can be much less well-developed. So, this is another unexpected element which needs to be placed alongside issues with speed of processing – the ability to come up with the great answer to a question long after it was asked, but rarely when it was actually posed in class. Most teachers will know the infuriating children who put their hand up to answer a question and then think it through, whereas dyslexic children need time to think and to process. What is interesting is that when they are given more time the answer is often just as good as any other.

Eide and Eide provide a useful summary of the pattern of typical strengths and weaknesses – understanding of the global big picture, comprehension, word association, context and gist tend to be ability appropriate while performance in tasks calling for fine detail, word accuracy, precision and exactitude can be years behind. Once again, this is unexpected.

What is clear again from the writing of most researchers in the field, is the importance of early intervention from an adult with specific training using an evidence validated synthetic phonics programme. It is generally acknowledged that around two thirds of children will learn to read and spell regardless of the approach used – often despite the approach used, especially if whole language/three cuing/searchlight type approaches are used. But one third can only move forward if they are taught to develop sound-symbol correspondence via synthetic phonic approaches and it looks very much as though a failure to identify potential struggling readers before age 9 means that these youngsters will fall incrementally behind year on year.

To give credit where it is due, the position taken by Elliott and Grigorenko has led to the opportunity for some of us to re-think the unexpected difficulties paradigm. I am very happy to accept that, if reading accuracy is the only measure used, it is very difficult to differentiate between dyslexic and non-dyslexic poor readers. However, when comparisons of comprehension and higher order thinking are made between these two groups, there is often a very distinct difference – despite reading no more accurately than their non-dyslexic peers of similar age and ability, dyslexic learners often demonstrate much more effective comprehension and reasoning. And, this difference will result in differences in the way some children are taught as teachers recognise abilities in these areas and push hard for cognitive ability appropriate progress through differentiation, especially by outcome, where individuals receive the same teaching but are offered multiple ways of demonstrating understanding. So, this returns to the original premise that, according to Elliott and Grigorenko; that the label of dyslexia somehow confers more opportunities, resources and a different way of teaching reading at the expense of non-dyslexic poor readers with similar profiles of reading accuracy.

I hope I have shown that in terms of teaching the core skills of literacy there will be no difference in the approaches used. However, it is when we move towards higher

levels of comprehension – prediction, inference etc. – that the difference between dyslexic and non-dyslexic poor readers often becomes apparent. What is certainly true, based on decades of classroom teaching experience, is that high quality teaching based initially on evidence validated synthetic phonic approaches empowers most learners, regardless of label or ability, to achieve their potential. But it is the unexpected gap between reading accuracy and higher order comprehension and thinking skills that often typifies the dyslexic learner.

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## **Section 5:**

### **Discussion group summaries:**

Groups considered the following seminar questions:

1. Are there shifts from an interactive to within-child causal model of identification? And if so, what are the factors that are contributing to this
2. What are the changing relationships between parents, schools and LAs and their influence on identification practice?
3. What kind of identification and assessment framework do we need for the future?

#### **Group 1:**

This group talked first about the increase in diagnoses and whether that means that there is an increase in prevalence or are we getting better at diagnosing particular types of need. They talked about parental expectations with an example of one area in one large local authority which had a sharp increase in the proportion of referrals coming from parents. As for the pressures around schools the one thing they seemed to have in common was resourcing; a chasing of resources to try and facilitate inclusion. This links to the 'yes but' approach for inclusion. We would be inclusive in our school, but you know it is going to cost you.

The group also talked about the use of labels, whether the thirteen categories of need that we have are particularly useful. They are very useful for data analysts but they are not really there to serve their purposes. As one person said we do not pine for the days when we differentiate between ineducable and educable pupils.

They concluded by talking about the possibility of strength-based frameworks and whether there is anything in the Early Years Framework around levels of security that might point the way forward.

#### **Group 2:**

This group thought that it was very important to define the education identification system in terms of values; these are the values that drive the identification system. We answered the questions that there has been a shift in the model of identification. All sorts of reasons could be given; that it is somehow a shortcut to focus on the child as it is easy for schools and teachers in terms of responsibility. Perhaps, there is a wider influence of a child centredness ethos; it might have the risk that any issues would be attributed mainly to the child. A related factor was thought to be a resources rationing process and also a depletion of levels of local authority and school expertise.

There was consensus about a growing tension between parents, schools and authorities to do with a lack of clarity about roles and responsibilities of schools and local authorities. The Code of Practice was in a sense not sufficient in that respect and this generated confrontation. This is seen in the context of schools being less flexible, with the rise in special school numbers which goes back to 2007, so that is quite a long-established rise in special school numbers reflecting a performance culture of schools. There has been less focus on progress more on attainment.

Somebody also pointed to the growth of elective home schooling with some cases of parents being advised to educate at home to avoid exclusion.

There were also some general points about the importance of the question, what sort of system do we need? It was felt that this was a system that focuses more on the identification of support strategies than reasons for child failure. This is about finding out what schools actually do for children who are struggling in terms of how they use the basic funding. Also, various people wanted to emphasise that any system needs to be couched within a strong values ethical statement of that also recognises that the allocation of resources is scarce and there can be competition for resources.

### **Group 3:**

This group covered some of the above points from previous groups. But, in addition this group also talked about why parents are pushing for a diagnosis. This group also thought that there is more of a focus on a within child model of identification. They thought parents are pushing for diagnosis because they feel that if they do not actually have a diagnosis, they are not necessarily taken seriously. If you go to a school and say my child is struggling with X, Y and Z, then it is easier for that to be dismissed than if you actually go with a diagnosis and a label. So, it gives parents some assurances.

This group also talked about the Code of Practice and how potentially the focus on the parents' voice and the child's voice has made it more of an individual model. The approach is not just on what the child is doing now, but on how future planning and outcomes are now linked as well to the child's individual needs.

This group also considered that there was more confrontation, a more adversarial relationship with local authorities refusing to assess. There are financial pressures on schools who need to get certain results. They thought that the communication between local authorities and the schools is sometimes problematic. In addition, there was talk about how parents seem to be more informed and knowledgeable. And, although there is an emphasis on individual focus in the Code of Practice, parents are working more collectively and supporting each other and helping other. There is more collective action through campaign groups and social media.

About an identification and assessment framework, this group thought it needed to be multidisciplinary, collaborative, independent from budget holders, transparent, aim to build parental trust in the system and so have greater accountability. They also considered looking at the schools as well as the children as part of that assessment.

### **Group 4:**

This group also thought that the current model is still a diagnostic focused model. This group also saw parents' voice as still restricted and that the system is designed more to keep the young person out of the system than involved in it. This is despite the Education and Healthcare Plan principles with a lot less access for the young person. Some of the schools are trying their best, but then they have restrictions of funding.

This group talked about the role of good quality teaching, that probably used to be seen more in the past, teaching that enhances the offer more for young people. This was seen to require less specialist trained staff in schools which schools cannot afford. This related to what someone had said about teaching a dyslexic child or teaching an autistic child, that this is actually good teaching practice teaching. There should be more of that. The investment of time by professionals to focus on the child should be increased too. Systematic diagnostics takes much time with paper work, though it is something to be done to an extent. But, actually the interaction with the child is being lost. The interaction is often with the parents, so the interaction between the teacher and the child is being lost in the middle of that, especially with secondary age children who have a stronger voice or more knowledge about themselves.

This group also talked about how some schools are still pushing back against parents and the local authorities because of funding gaps. There were parents who feel quite unwelcome when they go to an open day or an open evening to explain that their child has successfully got this label. They might find that the school is less likely to welcome them.

#### **Group 5:**

This group took it that 'within-child' was proxy for the medical model. It was suggested that a factor that might move in that direction is the range 'from birth to 25 model', which itself seems to start with the medical model, when talking about small children. With regard to Educational, Health and Care plans, care does tend to be more aligned with health, which also aligns to a medical model than look externally.

This group considered the pressures on schools, especially to produce learner outcomes of a particular type. If some pupils turn out to be different from this, then there is a view that this is not 'our fault' because all school environments are the same. This raises questions about whether we are looking properly at the environmental factors, and if not this can reduce ourselves to a within-child model.

On question two this group discussed issues about local authorities no longer having a strategic overview that they used to have several years ago. This has some serious implications in terms of local authorities' relationships with schools, as well as local authorities' relationships with parents. Some parents are almost being driven to use an EHC plan as almost their only lever to have some form of interaction and communication with a school about their child's transition.

On the third question it was suggested that some things are simply fairly predictable. For example, it is generally predictable that you will have children on the autistic spectrum disorder as part of your normal school population. So, if that is predictable you should be doing something about it and it is no longer exceptional.

#### **Group 6:**

This added a few additional comments to what had already been reported. In response the first question about a move towards within-child models, one driver considered was that tribunals, pressure groups, but also teachers felt that they needed labels to know what they were supposed to be doing. This was considered to

be understandable, though something should be done about it. Also, the data returns actually require putting labels on individuals, and maybe we should abolish that. On the second question they talked about transitions, an area that is perhaps beginning to be recognised. There is a lot that can be done in terms of good transitions between the different school phases than at the moment. This is where the children often fall through the cracks and if more could be done, then labels would perhaps be less needed.

This group's final point was that the graduated response was quite a good model in terms of an identification framework. But, it was thought that was still very poorly understood by teachers and maybe even SENCOs in terms of how it would help to address the needs of a cohort rather than for just individual children.

#### **Group 7:**

Some of what has been reported was covered in this group. But, this group focussed on the factors contributing to the move towards a within-child model. They explored the concept of learned helplessness within schools. Schools have come to believe that they cannot manage certain things and that the only way that these things can be managed is through additional resources brought in usually through an EHCP. So, it was suggested that this is leading to a more within-child approach. They also thought about the difference made by multi-academy trusts and their CEOs on how schools respond. It was considered that there is a willingness to work in a way that the group members might want, but there are directives from above not to do that. So, it is really hard for schools to do so, even if they would like to be different. Sometimes they are not able to be different. Individual SENCOs or teachers might make a difference but the systemic approach has probably changed now.

Another related point was that in some areas schools are setting themselves out to be the school that you go to if you want to go to X secondary school or Y university. So, it is not that schools do not want to meet needs, it is just that they do not see those children as part of their natural cohort and therefore those children do need to go somewhere else.

#### **Group 8:**

Again much already reported was covered in this group. This group too thought that there was a shift to more within-child factors. This was partly because it is a quick fix; it is easily measurable with there being measures of lots of elements of children. It is much harder to measure some of the nuances around environmental factors, particularly around children's mental health needs. We are still really grappling with how we encapsulate our children's experiences, children who are looked after, who have experienced trauma. How do we encapsulate that in a way that makes sense to others within the system?

The group reflected on the changing relationship between parents, schools and local authorities. They thought that there was good collaborative practice within some local authorities, who were genuinely coming together and thinking about the child's views. In other local authorities, this was less so. Often it is only the school-based professionals who are thinking about how to best meet that child's needs.



Finally, they had some reflections around what works. They were mourning the loss of the inclusion agenda within schools and actually how the drivers for achievement and attainment seem to have eroded much of that good practice within our school provisions. This was about moving away from a deficit based model of identifying young people, when they were failing, and thinking about that as a route to allocate resources, trying to turn that on its head and allocate resources according to what was working within schools. So, this is about allocating funding for interventions that are being successful. and so giving schools more skills and developing their professional practice and rewarding that so that they are able to support the pupils that they have already identified.

### **Group 9:**

Something that had not been covered by other groups was about incentives for identification at three levels. One, if you are a parent a diagnosis helps with disability living allowance for your child. Two, if you are a school having a diagnosis and we had a real example in Lincolnshire where if you have a diagnosis you get free access to the specialist autism service, Three, at a DfE level contextual value added data has gone and of course that is an interactive measure.

Questions two and three were dealt with together. The focus was on mental health; about normalising the fact that children get emotionally upset and they have not all got a mental health disorder. It was suggested that there was an emerging dependency on CAMHS for everything that was experienced as different. The group also talked about the predictability of a school population and that schools have accessibility duties and their accessibility plan is a predictive duty for curriculum services and so on. It was suggested that this gets forgotten and does not get a mention in the reforms.

In terms of a future identification framework that is relevant to education, they wanted to move away from diagnosis-driven teaching. Others referred to the incentives or the perverse incentives that arise for schools to take part in fair access panel where children just get moved around schools and end up being excluded anyway. The group also talked about how to measure school level responses to inclusion. What is it about a school's behaviour that can be monitored with child level responses.

A final reflection in this group was given by one of the presenters, Sami Timimi. He argued that one way of thinking about our task in services for mental health is that there are three elements towards constructing intervention. He considered that this might apply to other areas in the field too. One is contextual, to do with an understanding of the context of the person. The second is technical to do with the models that we use and the third is relational to do with the relationship between the people working and in this case the doctor therapist and the people they are working with. The evidence very clearly points towards outcomes being influenced mainly by contextual and relational matters. In mental health, the technical is the model that you use, which has virtually no impact on outcomes. This means that in terms of practice, the development of practice based on process and assessment for the type of classification and matching that to a type of practice does not lead to any improvement in outcomes.

So, this requires understanding that we have developed services in the past that have built on that knowledge and it did work. So, basically now when he see families and young people, one of the things that he avoids is sending them for any assessments. People who go for more assessments just end up collecting more different labels and things just get more complicated and more treatments; they seem to get nowhere. He focuses on the relational and contextual aspects, so there are three questions that he asks when not following the standardised protocols that are supposed to be followed: first, what brought you to our service?; second, what sort of change do you hope to achieve?; and thirdly, how do you imagine our service might be able to help in achieving that change? These are the three things that guide his practice.