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Disability and Diversity

General Information and Guidance to support those with Learning Difficulties and Disabilities

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Amendment Sheet

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07/04/2016	Standardisation on all ACPs to include Amendment Sheet	J Stones	1.06
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The aim of this guidance

The aim of this guidance is to provide basic information about some of the key Learning Difficulties and Disabilities, along with some strategies that may be helpful in supporting cadets.

The RAFAC policy relating to cadets with learning difficulties and disabilities and/or chronic conditions is contained in ACP 20.

Definitions

Specific Learning Difficulties

Specific Learning Difficulties is an overarching term for a number of associated learning difficulties which may manifest across all ability ranges and with variable severity or significance. Specific learning difficulties include dyslexia, dyscalculia and dyspraxia.

A cadet with Specific Learning Difficulties is of at least general intelligence but still has trouble with learning. They may have difficulties in one or more areas but have average or above average results in others.

Cadets with specific learning difficulties may experience particular difficulties in learning to read, write, spell or manipulate numbers to the extent that their performance in these areas is below their performance in other areas.

They may also experience problems with the speed of processing information, with working memory, organisational skills, phonological awareness and co-ordination. Those affected by specific learning difficulties often underachieve within the training environments unless they receive appropriate support enabling them to minimise their weaknesses and utilise their strengths.

Both the severity of the impairment and the effectiveness of strategies to compensate for the difficulty vary widely and it is important that the adults working with these young people understand them, how they learn and support appropriately.

Global Learning Difficulties

A cadet with global learning difficulties or non-specific learning difficulties will find all areas of learning difficult regardless of how they are taught. These cadets tend to be categorised as slow learners. This does not mean they *cannot* learn, but that expectations around their learning should be less than that of their peers, and training should be modified to suit their needs and pace of learning.

When cadets have learning difficulties that are more generalised and do not relate to a specific neural problem or immaturity, they can be described as having moderate, severe or profound and multiple learning difficulties, depending on their degree of difficulty.

Many cadets with global or non-specific learning difficulties have other associated special needs.

Moderate Learning Difficulties

The majority of cadets with moderate learning difficulties are educated in mainstream schools, with provision made for additional help and support appropriate to their needs. Often, by secondary school age, the gaps between those with moderate learning difficulties and other learners have widened considerably. Cadets with moderate learning difficulties may appear immature and find it difficult to mix with other cadets; many are vulnerable and may experience bullying as a result. Often

they are needy with an over-reliance on adult help and support.

Cadets described as having moderate learning difficulties, or global learning difficulties, experience great difficulty following a training programme, despite receiving suitable help and intervention. They have general developmental delay resulting in attainment which is significantly below expected levels in most areas of the training. There may be other, associated special needs such as dyspraxia.

Generally cadets with moderate learning difficulties will demonstrate some or all of the following characteristics:

- Difficulty understanding basic concepts.
- Problems acquiring basic skills in reading, writing and numeracy resulting in a lack of confidence to use and develop the skills they do have.
- A lack of logic.
- Poor problem-solving skills.
- An inability to generalise learning and apply it to new situations.
- Limited communication skills coupled with immature social and emotional understanding.
- Poor fine and gross motor skills.
- Difficulty with personal organisation.
- Poor auditory or visual memory.
- Poor long and short term memory; difficulty remembering what has been taught.
- Speech and language delay.
- Emotional and behavioural difficulties.
- Sensory impairment.
- A lack of social skills.

Strategies that can help those with moderate learning difficulties:

- Routine and structure.
- High expectations.
- Giving responsibilities.
- Encouragement, praise and reward - not only for work and achievements but also for positive behaviour.
- Building on knowledge and understanding.
- Ensuring learning objectives are realistic and that success is achievable.
- Giving clear instructions and including careful questioning to ensure they know what is expected of them and of the task.
- Checking understanding at every stage.
- Careful planning and differentiated work, broken down into small manageable tasks.
- Regular reinforcement of tasks to be mastered and the opportunity to practise and apply skills.
- Showing how things are done rather than just explaining.
- Revisiting tasks and breaking them down into short, frequent bursts.
- Writing frames to help structure work.

- Use of IT, including where applicable, modified hardware.
- Monitoring, recording and reporting of progress.
- Ensuring that support is a tool, not a crutch.
- Facilitating friendship groups.
- Having positive role models.
- Providing opportunities to participate and be fully included.

Severe Learning Difficulties

Cadets with severe learning difficulties are likely to find it difficult to understand, learn and remember new skills. As a result they will have problems with both the acquisition of skills and their application to new situations. Additional problems with a number of social tasks, such as communication, self-care and awareness of health and safety, may mean they require supported living.

Those with severe learning difficulties have acute global development delay, such that intellectual or cognitive impairment, coupled with possible sensory, physical, emotional and social difficulties, will make it difficult for them to follow the curriculum without substantial help and support.

Difficulties may be further compounded by poor co-ordination, and communication and additional special needs. The use of symbols, Picture Exchange Communication System (PECS), or signing such as Makaton, may aid communication.

Those with severe learning difficulties will require substantial help in gaining independence or self-help and social skills. It is likely that most areas of achievement will be affected, not just basic skills.

Attention Deficit Disorder - Attention Deficit and Hyperactivity Disorder

Attention Deficit Disorder (ADD) is an extremely distressing condition affecting up to 8% of school-age children. It is a neurological condition where the sufferer has a limited ability to sustain attention and has reduced control over words or actions as a result of impulsiveness and lack of appropriate forethought. When there is also hyperactivity (ADHD), sufferers find it hard to control the amount of physical activity appropriate to a situation and their behaviour may be highly disruptive.

There is little precise data on the cause of ADD and ADHD, but recent research suggests that it is due to an inherited imbalance of neurotransmitters. There are many examples of adults who were never diagnosed (or who were misdiagnosed) as children, who are later diagnosed. Often the evidence was always there, but little or no appropriate action taken.

The most recent explanation for those more obvious hyperactive or impulsive types is 'response inhibition', which suggests that individuals live essentially in a constant state of being on high alert and are unable to shut out any sensory, visual or auditory stimuli coming their way and therefore unable to concentrate enough to make use of incoming information.

Typical signs of Attention Deficit Disorder

Often clingy, quiet and shy, they are easily led yet find instructions difficult to understand. ADD sufferers are inattentive, may have problems in concentrating and focusing, and may have difficulties with verbal and emotional impulsiveness. The work they complete is often erratic and unpredictable. They tend to be daydreamers. Both ADD and ADHD sufferers are prone to become victims of bullying.

Managing Attention Deficit Disorder and Attention Deficit and Hyperactivity Disorder

One-to-one interaction generally results in improvements in concentration and behaviour (for a short duration).

All young people with ADD or ADHD are different and display individual behaviour patterns. Medication, in the form of Ritalin, can have an important role to play in ADD or ADHD management and an awareness of a medication regime is essential.

Many young people with ADD or ADHD display some, if not all, of the following:

- Inattention.
- Impulsiveness.
- Over-activity.
- Social clumsiness.
- Poor co-ordination.
- Poor organisation.
- Over-sensitive to criticism.
- Low self-esteem.

- Lacks interest in work.

Strategies that may be effective in the classroom

The most effective teaching of a child with ADD or ADHD arises from taking an open-minded view to using another option or an adaptive approach to the teaching and management.

The following strategies may effective in supporting a young person with ADD or ADHD:

- Run an absolutely predictable and organised classroom.
- Control the classroom without being controlling.
- Have positive expectations.
- Break down tasks by giving short, achievable targets and give immediate rewards on completion.
- Use checklists for tasks which the young person can tick on completion.
- Seat the cadet close to the instructor and good role models, but away from windows and doors.
- Make a lot of eye contact during verbal instruction.
- Speak clearly in brief, understandable sentences.
- Repeat instructions and present them in more than one way.
- Encourage the cadet to verbalise and then repeat what is to be done first.
- Provide tasks that require as much activity on the cadet's part as possible.
- Be prepared to act as an auxiliary organiser to get the cadet organised and on task.
- Monitor progress regularly throughout a lesson and give constant feedback.
- Display rules which are unambiguous and positive.
- Be consistent, firm, fair and patient.
- Ignore minor disruptions; know how to choose your battles.
- Know when to back off when the cadet's level of frustration begins to peak.
- Rewarding appropriate conduct is a more effective way to alter behaviour.
- Give the cadet minor responsibilities.
- Liaise closely with parents or carers.

For further Information, contact ADD Information Services www.addiss.co.uk.

Autistic Spectrum Disorder - Autism and Asperger's Syndrome

Autism is characterised by impairment in three areas: social interaction, communication, and imagination. This 'triad of impairments' is found in varying degrees and forms and therefore the concept of the autistic spectrum disorder (ASD) covers a wide range of abilities and disabilities. This includes childhood autism at the less able end of the spectrum, to Asperger's Syndrome at the more able end. Autistic spectrum disorders are not rare; it is estimated that about 1 in 110 people have an ASD.

Autism is a lifelong developmental disability affecting the way a person communicates and relates to people around them. Some people have accompanying learning disabilities; others have average or above-average intelligence. However, all have some degree of social and communication difficulties.

In contrast, those who have Asperger's syndrome develop language at the same time as other children, but their language use is often unusual. They may use rather formal words and phrases, which make them seem old-fashioned and different from their peers, or they may speak in a stilted or monotonous way.

Difficulties in social interaction also pose particular problems.

Those with an ASD find it difficult to read social cues and non-verbal signals about what other people are feeling. For instance, a person with an ASD may not be able to spot when a companion is upset, angry or bored.

Characteristics of young people with autism:

- They appear lacking in empathy for other people's feelings, which could be interpreted by someone not aware of their disability as wilful self-centredness.
- They may demonstrate poor social timing, lack of social understanding, rejection of normal body contact or make inappropriate eye contact.
- They may show no interest in what other people are doing.
- They avoid joining in activities with their peers.
- They are often described as being engrossed or in a world of their own.
- They may have difficulty with verbal and non-verbal communication - speech, intonation, gestures, facial expression and body language.
- They may lack imagination and demonstrate a rigidity and inflexibility of thought.
- They may be hyper-sensitive to sounds, light, touch, smells and tastes.

Asperger's Syndrome is used to describe people with an ASD who are usually above average ability and with good verbal skills. They have a genuine desire to make social contact. However, they have anxieties related to low self-esteem, fear of failure, fear of being misunderstood, of not understanding others, of being different and not fitting in. They can be very egotistical and chauvinistic and create impossibly high standards for themselves.

Young people with Asperger's Syndrome often show a desire to be sociable, but their attempts to make friends may be thwarted by their lack of understanding of the social nuances of negotiating friendships.

Routines and repetition

People with an ASD dislike things that upset their routines; they resist change, are obsessive and ritualistic, because routine gives them a sense of security. Cadets with autism often repetitively perform the same actions and show no signs of developing their imagination. Others may become fascinated by a particular topic, for example aircraft recognition, and become extremely knowledgeable about it, but may not be interested in branching out to other related subjects.

Strategies to support young people with ASD

- Prepare carefully for new situations, so that they know exactly where they are and what is expected of them.
- Make use of pattern and routine so that they feel secure.
- Reduce noise where possible.
- Allow them to go to a quiet, supervised place when stressed.
- Ensure you have their attention before speaking.
- Speak clearly and calmly.
- Give one step of an instruction at a time.
- Use visual clues to help explain things.
- Tell them what should be done, not what should not be done.
- Do not use sarcasm or idiom as they will not understand it.
- Give them longer to complete a task before you repeat the instruction.
- Give them the opportunity to explain things from their point of view.
- Acknowledge the need for personal space.

Further information is available from The National Autistic Society www.nas.org.

Diabetes

Around 1.4 million people in the UK are known to have diabetes. It can occur at any age and becomes more common as people get older. There are also estimated to be around another million people who have diabetes but don't know it.

Diabetes develops because the glucose in a person's body is not being turned into energy, either because the pancreas is not producing enough natural insulin or because the insulin produced is not working properly. Glucose is developed from the digestion of sugar and starchy foods. The first symptoms of diabetes are often tiredness, weight loss and constant thirst.

There are two types of diabetes

Type 1 Diabetes usually affects younger people and both sexes are affected equally. People affected by Type 1 Diabetes need regular injections of insulin.

Type 2 Diabetes usually appears in middle-aged or older people, although occasionally it does affect younger people. Overweight people are more likely to develop Type 2 Diabetes and it often runs in families. Type 2 Diabetes can be managed by a controlled diet.

How to help cadets who have diabetes

- Recognise that concentration may be erratic depending on glucose levels.
- Young people with diabetes may need to eat or drink during training.
- Make a private space available for insulin injections and self-administered blood tests.
- Know what to do if the cadet should fall into a diabetic coma (diabetics should carry glucose tablets with them). If in doubt call 999.
- Know who your nearest first aider is.

The majority of people receiving treatment for diabetes live normal working and personal lives, taking part in any activities they wish. Untreated diabetes, however, or lack of attention to prescribed medication and dietary advice can be very serious, leading to a person going into a diabetic coma. In the longer term, a lack of satisfactory regular treatment can cause serious health problems, including blindness, heart disease and kidney failure.

Diabetes UK provides useful information and advice, and has regional offices and voluntary groups working throughout the UK. Further information can be obtained from www.diabetes.org.uk.

Dyscalculia – Difficulty with Maths

Very little is known about the prevalence of dyscalculia, its causes or treatment. 3% to 6% of cadets may be dyscalculic.

The DfES booklet (2001) on supporting pupils with dyslexia and dyscalculia in the National Numeracy Strategy defines dyscalculia as:

'A condition that affects the ability to acquire mathematical skills. Dyscalculic learners may have difficulty understanding simple number concepts, lack an intuitive grasp of numbers, and have problems learning number facts and procedures. Even if they produce a correct answer or use a correct method, they may do so mechanically and without confidence.'

Many young people experience difficulty because they rely on memory – trying to learn rules and answers by rote rather than investigating and understanding how the numbers are working in relation to each other. Even more fundamentally, maths is a 'building' subject, and new information will never make sense unless all the foundation blocks are firmly fixed.

Sometimes these foundation blocks get missed. Gaps in knowledge affect ability in maths in a basic way quite different from other subjects and if cadets who are slow processors do not grasp every principle before moving on, the whole subject very quickly becomes confusing.

Indicators of dyscalculia include some or all of:

- A difficulty in recognising 'how many' when looking at a small group of objects.
- An over-reliance on counting to arrive at number facts and answers.
- A persistent difficulty in recalling basic facts, especially multiplication facts.
- A problem recognising the symbols of maths (in giving them the right name and in knowing what they mean).
- Difficulties with the vocabulary and the language of maths.
- Working at a slow speed.
- A distinctly lower level of achievement than in other subjects and in comparison with their peers.
- An avoidance of maths and lack of confidence with maths tasks.
- Anxieties around anything mathematical.
- Poor awareness of money values.
- Poor mental arithmetic skills and/or poor written arithmetic skills.
- Persistence of the difficulties despite lots of help.

Strategies that may help

- Never make the problem an 'issue'.
- Don't say 'Never mind, I could never do maths, either.'
- Practise in low-stress ways to cope and do a little at a time.
- Make your expectations realistic.
- Have lots of small targets rather than a few big targets.

- Look for improvement, not perfection.
- Do not stick with only one target, move around a little, but keep revisiting previous work.
- Make learning multi-sensory. Use equipment, apparatus, visual aids etc.
- Make maths practical and where possible related to everyday experiences/the world.
- Get the cadet to explain how they have come to an answer, whether right or wrong.
- Explain concepts carefully.
- Emphasise key words, syntax and basic mathematical rules.
- Allow the use of a calculator if relevant.
- Use mnemonics to aid memory.
- Encourage workings which show thought processes rather than just answers.
- Make use of IT.
- Help with and encourage good personal organisation.

Dysgraphia – Difficulty with writing

Does a cadet have spider writing with letters of all shapes and sizes, appearing above and below the line, some joined-up, and some printed with a random mixture of capital and lower case letters?

Do they avoid writing or tire easily when writing? Are they unwilling or unable to copy from the board? Do they exhibit an awkward or tense pencil grip? Is their work littered with spelling mistakes?

If you recognise some, or all, of these symptoms in an otherwise fairly bright, articulate cadet, they may well suffer from dysgraphia.

Dysgraphia describes a difficulty with the physical aspect of handwriting, resulting in poor, variable or illegible copy. Neat work will only be produced very slowly and even then, the writing will quickly deteriorate. Young people with dysgraphia invariably have to write very slowly if they are to produce legible copy. They will find writing extremely tiring and frequently experience hand cramps. They will have trouble with writing or copying, especially from the board, and may have an unusual or awkward pencil grip. They are frequently articulate and lively contributors to discussion but will avoid putting pen to paper.

How to spot a person with dysgraphia

- Clumsy and uncoordinated.
- Poor at ball or team sports.
- Has difficulty with fine and/or gross motor skills.
- Prone to motion-sickness.
- Ambidextrous.
- Directionally challenged, may confuse left/right, over/under etc.

There may be a substantial over-lap with dyspraxia and associated difficulties with directions, spatial awareness and sequencing are common-place.

Practical help for cadets with dysgraphia

- Extra time to complete written tasks.
- Use of a computer.
- Use of a scribe.
- Use of someone to transcribe.

Other strategies include

- Voice recognition software.
- Practise letter formation.
- Keep a pencil sharpener to hand**,** always ensure pencils are sharp.
- Encourage the use of different pencil grips.
- Use a heavyweight pen or ErgoSof pen.
- Do not over-do it**,** give the young person rest breaks.

- Build in rewards.
- Do not avoid hand-writing, but make tasks simpler and inject fun.
- Cursive (joined-up writing) is often easier for the dysgraphic young person.
- Use paper with guide-lines.
- A sloping desk is often recommended and is especially helpful for cadets with poor muscle tone.

Dyslexia

Dyslexia is a common difficulty, but that does not make it less of a problem. Despite its being so well recognised, there are still those who deny its existence or, more subtly, underestimate or ignore the significance of the problem for a particular individual.

It is estimated that around 4% of the population of the UK are severely dyslexic and a further 6% have mild to moderate dyslexia.

The word dyslexia originates from a Greek word meaning 'difficulty with words'. It is a difference in the area of the brain that deals with language, affecting the underlying skills needed to read, write and spell. Brain imaging techniques show that dyslexic people process information differently.

From a very early age, there are different indications that a person may be dyslexic, for example, enjoying being read to but showing no interest in letters or words; later than expected speech development; difficulty remembering words associated with familiar objects like a table or chair.

A dyslexic person will often display the following characteristics

- Fails at school despite adequate intelligence.
- Writes 41 for 14, reads 'on' for 'no', writes b for d and can't remember the sequence of letters that make up a word.
- Hears a clock ticking, the sound of pencils scratching on paper, but does not hear instructions.
- Forgets the names of people, places, own phone number, date of birth, but remembers the ads on television.
- Loses work, misplaces a book, and does not know what day it is.
- Has a messy room and looks untidy – shirt tail hanging out, shoelaces undone and a generally unkempt appearance.
- Does not look where he or she is going, bumps into doors and does not look at the person who is talking to him or her.
- Has trouble lining up, doesn't stop talking, fidgets and fiddles with things.
- Calls breakfast 'lunch**'**, says 'Good morning' in the afternoon and has little sense of time.
- Has a limited concentration span**,** especially with anything that is written.
- Is reluctant to try new things, to accept even minor changes in routine.
- Says 'I don't care' or 'I won't' when he or she means 'I can't', and would rather be labelled bad than stupid.
- The quiet one who has withdrawn from involvement in any classroom-based activity.

Indicators of dyslexia

- Dyslexia amongst other members of the family.
- Problems with speech and language, including mispronouncing or jumbling words, poor use of syntax, difficulties with rhymes, inaccurate and inconsistent use of words, word-naming problems.

- Problems with sequencing, and poor organisational skills including difficulty dressing.
- Visual difficulties. Standard eye tests may reveal perfect vision, but there may be underlying problems with tracking, ordering or sorting.
- There may be auditory difficulties. A cadet may hear, but not be able to distinguish sounds. Hearing test results may be normal, but the person may have problems remembering a string of instructions, days of the week or months of the year, or have poor rhythm.
- Counting**,** especially counting backwards may be problematic.
- Fine motor skill problems may be apparent – perhaps holding a pencil awkwardly, having difficulty with scissors or cutlery, problems tying shoe laces.
- Gross motor skill difficulties may be apparent - the person may have difficulty in hopping or jumping, appear clumsy and bump into things or have difficulty distinguishing right from left.

In isolation these indicators of dyslexia would not normally give cause for concern. However, It is when several indicators are present that dyslexia (or another specific learning difficulty) may be present.

People with dyslexia sometimes lack self-confidence and worry about their ability to earn a good living. However they can work in many different professions. They may have excellent creative skills, be good at dealing with people and problems or work in sports and activities for example.

Activities such as listening to a lecture, taking notes, or organising the writing of answers or notes, may be very challenging to the dyslexic cadet and can cause immense stress.

Many people with dyslexia are successful, too, in professions needing skills with words - such as journalists, authors, editors, scriptwriters, politicians, actors and actresses, presenters and singers. Some well-known dyslexics are Albert Einstein, Richard Branson, Keira Knightly, Orlando Bloom and Tom Cruise.

Some strategies that may be helpful in working with dyslexia

- Be aware of your language; vary your speed of delivery.
- Create a multi-sensory learning environment; videos, pictures, diagrams, practical and experiential activities.
- Introduce new ideas and concepts explicitly.
- Provide an overview of your topic to provide an overall picture of what to expect.
- Allow time for questions and give concrete examples.
- Give explicit instructions.
- Teach specific strategies for organising work.
- Be sympathetic.
- Give constructive feedback on errors or mistakes.
- Avoid putting a young person in a position of public failure (i.e. by asking them to read aloud).
- Provide handouts and summaries before lectures for pre-reading.

- Do not expect a dyslexic person to answer questions in the whole group or talk in large groups.
- Use clear overhead projections, slides or PowerPoint presentations (i.e. do not put too much information on a single slide).
- Encourage the use of IT.
- Give the spelling of new or difficult vocabulary.
- Encourage a young person to find 'buddies' who will share notes.
- Present material in short chunks.
- Allow time for absorption of information, reinforcement and frequent revision.

Eyes and Dyslexia

Around 35%-40% of people with dyslexic difficulties experience visual disturbance or discomfort when reading print. They may experience one or several of the following:

- Blurred letters or words which go out of focus.
- Letters which move or present with back to front appearance or shimmering or shaking.
- Headaches from reading.
- Words or letters which break into two and appear as double.
- Find it easier to read large, widely spaced print, than small and crowded.
- Difficulty with tracking across the page.
- Upset by glare on the page or oversensitive to bright lights.

Any of these symptoms can significantly affect reading ability. It can also make reading very tiring.

Many dyslexic people are sensitive to the glare of white backgrounds on a page, white board or computer screen. This can make the reading of text much more difficult.

- The use of cream or pastel coloured backgrounds can help as can coloured filters used either as an overlay or as tinted reading glasses.
- Research shows that people who need coloured filters, who are said to have visual stress, need to have exactly the right colour. Parents will need to be asked for advice about appropriate filters.
- The choice of colour of text on white backgrounds can also affect clarity. For example, using red on a whiteboard can render the text almost invisible for some dyslexic students.

Dyslexia Friendly Text - advice from the British Dyslexia Association

The aim is to ensure that written material takes into account the visual stress experienced by some dyslexic people, and to facilitate ease of reading. Adopting best practice for dyslexic readers has the advantage of making documents easier on the eye for everyone.

Media

- Paper should be thick enough to prevent the other side showing through.

- Use matt paper rather than glossy. Avoid digital print processing which tends to leave paper shiny.
- Avoid white backgrounds for paper, computer and visual aids. White can appear too dazzling. Use cream or a soft pastel colour. Some dyslexic people will have their own colour preference.

Font

- Use a plain, evenly spaced sans serif font such as Arial and Comic Sans. Alternatives include Verdana, Tahoma, Century Gothic, Trebuchet.
- Font size should be 12-14 point. Some dyslexic readers may request a larger font.
- Use dark coloured text on a light (not white) background.
- Avoid green and red/pink as these are difficult for colour-blind individuals.

Headings and Emphasis

- Avoid underlining and italics: these tend to make the text appear to run Together. Use bold instead.
- AVOID TEXT IN BLOCK CAPITALS: this is much harder to read.
- For headings, use larger font size in bold, lower case.
- Boxes and borders can be used for effective emphasis.

Layout

- Use left-justified with ragged right edge.
- Avoid narrow columns (as used in newspapers).
- Lines should not be too long: 60 to70 characters.
- Avoid cramping material and using long, dense paragraphs: space it out.
- Line spacing of 1.5 is preferable.
- Avoid starting a sentence at the end of a line.
- Use bullet points and numbering rather than continuous prose.

Writing Style

- Use short, simple sentences in a direct style.
- Give instructions clearly. Avoid long sentences of explanation.
- Use active rather than passive voice.
- Avoid double negatives.
- Be concise.

Further information: The British Dyslexia Association, 98 London Road, Reading, RG1 5AU. 0118 966 2677. Helpline: 0118 966 8271. Website: www.bda-dyslexia.org.uk Local Adult Education Centre and Jobcentre Disability Employment Advisor.

Local dyslexia associations and adult education centres can provide advice and information on available tuition for adults to improve their skills.

The British Dyslexia Association website has useful background information on dyslexia and full details of local associations and other relevant contacts. It also provides specific information for organisations and dyslexia awareness training.

Instructor checklist for dyslexia

If you suspect that a cadet may have dyslexia, complete the checklist on the following page, answering 'yes' or 'no' in the right hand columns. If your cadet has more 'yes' than 'no' answers, consider speaking to his or her parents and the possibility of providing dyslexia support.

Questions	Yes	No
Does the cadet have a Statement of Educational Needs or have they received extra support at school?		
Do you find there are discrepancies between the quality of the cadet's ideas, understanding and ability when speaking and the quality of their written work?		
When writing, does the cadet use simple, unsophisticated language avoiding the use of long words?		
Does the cadet write less than you would expect?		
Does the cadet make persistent errors with spelling even in common words, especially homophones: there, their, no, know?		
Does the cadet display confusions with b and d; p and q; 6 and 9?		
Does the cadet have poor handwriting, ie. inconsistent in formation; difficult to read; variable in style; messy?		
Does your cadet have difficulty taking notes and listening at the same time?		
Is your cadet a 'quick forgetter'?		
Does your cadet have difficulty maintaining concentration in class?		
Is your cadet easily distracted?		
Is your cadet often late for classes or forgets which room they should be in?		
Is your cadet disorganised, eg. folders in a mess?		
Does your cadet have difficulty with the pronunciation of multi syllabic words?		
Have you noticed your cadet using avoidance strategies when reading is required, e.g. being absent, never volunteering for roles that involve reading?		

Dyspraxia or Developmental Co-ordination Difficulty (DCD)

Dyspraxia is often referred to as 'clumsy child syndrome'. It is a developmental difficulty that can overlap with other conditions such as dyslexia and attention deficit and hyperactivity disorder (ADHD) and social and communication difficulties including Asperger's syndrome.

Many people actually have a combination of co-ordination difficulties and other learning difficulties as well. However, each person is unique and there is no 'classic' person with dyspraxia.

Dyspraxic people may be more likely to fall or trip up, or bump into things. They may be messy eaters, find it hard to use a knife and fork together or spill drinks. They may be disorganised and leave possessions and clothes all over the place.

The umbrella term Developmental Co-ordination Difficulty (DCD) is used by medical experts and is in common usage in some other countries and dyspraxia specifically means a motor-planning difficulty. Motor planning is thinking about how to do something and then plan how you will do it. Only a few children have this difficulty.

The term Dyspraxia is more generally used in the UK to describe the broader range of co-ordination difficulties.

Dyspraxia is a delay or disorder of the planning and/or execution of complex movements. It may be developmental, part of a young person's make-up or can be acquired at any stage in life as the result of brain illness or injury. Males are four times more likely to be affected than females. Dyspraxia sometimes runs in families.

Characteristics of people with Dyspraxia

- May be a bit floppy (low-toned).
- Find it hard to stay sitting up straight at the table or desk.
- Slouch when sitting at a table.
- May be bendy or very flexible and so not so good at controlling the range of movement some of their joints can make (joint hyper-mobility syndrome).
- Find completing more than one task at a time difficult to do, especially at speed.
- Have greater difficulty in learning skills such as throwing and catching a ball, hopping and jumping, or riding a bike.
- May have a delay in language development or have 'sloppy' sounding speech.
- At school, writing becomes one of the major difficulties and is the one that tends to stay with the child more than other difficulties.
- May find concentrating and staying on task difficult to do and may be fidgety, wanting to move around and fiddle with things around them.

People with dyspraxia are often of average or above-average intelligence and the inability to do what they can clearly see how to do can be very frustrating for them. Often they are articulate and can voice their ideas, but have difficulty transferring them to paper.

Signs to look out for

- Behavioural problems.
- Clumsiness.
- Low self-esteem.
- Verbal dyspraxia.
- Handwriting problems.

Strategies to use in the classroom

- Sit away from doors/windows to reduce distractions.
- Sit close enough to hear and see instructions.
- Give clear and unambiguous instructions.
- Repeat verbal instructions several times and keep them simple.
- Break down activities into smaller steps.
- Provide a sloping surface to write on.
- Use sheets with spaces for answers to reduce the amount of writing.
- Allow extra time for completing work.
- Teach strategies for remembering things.

Further information: The Dyspraxia Foundation Tel: 01462 454986
www.dyspraxiafoundation.org.uk.

Developmental Verbal Dyspraxia (DVD)

Developmental Verbal Dyspraxia (DVD) is a type of dyspraxia affecting speech and results from an immaturity of the speech-production area of the brain. It is characterised by difficulty in making and co-ordinating the precise movements of the speech apparatus necessary for clear speech. The causes of DVD are unknown but DVD occurs when the speech area of the brain does not send out consistent messages to the tongue, lips and larynx.

Signs to look out for

- Difficulty in making speech sounds.
- Difficulty in sequencing sounds to make words.
- Difficulty in keeping speech clear in sentences.
- Difficulty in controlling the speed, rhythm and loudness of speech.
- History of speech/ language delay.

Strategies to use in the classroom

- Discuss with parents the signs, sounds and words used for basic requests.
- Explain to other cadets that a young person with DVD finds it difficult to say words.
- Avoid correction or comment for imperfect speech, instead encourage effort (a person with DVD cannot achieve better speech without speech therapy).

Epilepsy

Epilepsy is the tendency to have recurrent seizures originating in the brain as a result of excessive or disordered discharge of brain cells. Also known as a seizure disorder, it is a neurological condition, which affects the nervous system. It is usually diagnosed after a person has had at least two seizures that were not caused by some known medical condition.

There are three main causes of epilepsy:

Idiopathic Epilepsy often starts in childhood or adolescence and is largely due to genetic causes. People with idiopathic epilepsy may inherit a low seizure threshold. This would mean that given certain conditions (individual to each person) they might have a greater susceptibility to having a seizure.

Symptomatic Epilepsy may be due to brain damage or anomaly from any cause, for example infection, tumours, brain damage or specific syndromes.

Cryptogenic Epilepsy has no known cause and can begin at any time in an individual's life.

What is a seizure?

- A seizure is a sudden surge of electrical activity in the brain that usually affects how a person feels or acts for a short time.
- Seizures are not a disease in themselves. Instead, they are a symptom of many different disorders that can affect the brain.
- Some seizures can hardly be noticed, while others are totally disabling.

There are two categories of seizures:

Generalised seizure: both hemispheres of the brain are involved and the sufferer loses consciousness. The seizures include major convulsions with jerking of all limbs and unconsciousness; seizures when the body goes stiff or floppy; jerks of the limbs; and momentary lapses of consciousness (or absences).

Partial (or focal) seizure: the disturbance of brain activity starts in, or involves, a specific part of the brain. The nature of such seizures depends upon the area of the brain involved. Partial seizures may be simple or complex. Consciousness is not lost in a simple partial seizure, but is impaired in a complex partial seizure.

Symptoms of a seizure

A seizure is usually defined as a sudden alteration of behaviour due to a temporary change in the electrical functioning of the brain, in particular the outside rim of the brain called the cortex.

Seizures can take on many different forms and seizures affect different people in different ways.

Seizures have a beginning, middle and an end

When an individual is aware of the beginning of a seizure, it may be thought of as a warning or aura. On the other hand, an individual may not be aware of this and therefore have no warning.

The middle of the seizure may take several forms. For people who have warnings, the aura may simply continue or it may turn into a complex partial seizure or a convulsion. For those who do not have a warning, the seizure may continue as a complex partial seizure or it may evolve into a convulsion.

The end to a seizure represents a transition from the seizure back to the individual's normal state. It may last from seconds to minutes or even to hours, depending on several factors including which part(s) of the brain were affected by the seizure and whether the individual was on anti-seizure medication. If a person has a complex partial seizure or a convulsion, their level of awareness gradually improves during the post-seizure period, much like a person waking up from anaesthesia after an operation.

Epilepsy is perfectly compatible with a normal, happy and full life. The person's quality of life, however, may be affected by the:

- Frequency and severity of the seizures.
- The effects of medication.
- The reaction of onlookers to seizures.
- Other disorders that are often associated with or caused by epilepsy.

Acquiring a positive outlook may be easier said than done, especially for those who have grown up with insecurity and fear. Instilling a strong sense of self-esteem is important. Many children with long-term, ongoing illnesses (not only epilepsy but also disorders such as asthma or diabetes) have low self-esteem. This may be caused in part by the reactions of others and in part by parental concern that fosters dependence and insecurity. Children develop strong self-esteem and independence through praise for their accomplishments and emphasis on their potential abilities.

What to do in the event of a seizure

- Make sure the cadet is safe and will not harm him or herself or anyone else.
- Call the parents or carers.
- **DO NOT ATTEMPT TO MOVE THEM.**
- Time the seizure if it continues for more than **2 minutes** call an ambulance. The paramedics will need to know how long it has been going on for and if medication was given and at what time.
- When the seizure has finished place the cadet in the recovery position.

Further information: British Epilepsy Association: www.epilepsy.org.uk.

Hearing Impairment

Some people describe hearing impairment as a hidden special educational need, because it is not always obvious, but its effects can lead to misunderstanding and confusion.

People with a hearing impairment range from those with a mild hearing loss to those who are profoundly deaf. It is not be easy to spot the difference between a disaffected, dreamy young person and one with a hearing loss.

For educational purposes, young people are regarded as having a hearing impairment if they require hearing aids, adaptations to their environment and/or particular teaching strategies in order to follow the curriculum.

Deafness alone is not defined as a special educational need, although, as with any Learning Difficulty or Disability, there may be an associated disability or learning difficulty.

Warning signs of a hearing impairment include:

- Limited attention span.
- Daydreaming.
- Slowness of responses.
- Breathing through the mouth.
- Irritability.

Four categories of hearing impairment are generally used: mild, moderate, severe and profound.

Some young people with a significant loss communicate through sign language such as British Sign Language (BSL) instead of, or as well as, speech. Those with mild or intermittent losses will not receive specialist educational support and neither will their families and schools.

There are two types of hearing loss:

Conductive deafness

This occurs when there is some abnormality in the outer or middle ear. Transmission and amplification of sound vibrations are affected as they are conveyed to the inner ear. Generally, conductive deafness involves mild hearing loss, and is temporary. Any blockage of the outer ear – glue, wax or a cyst – will cause a degree of deafness. The most common cause is Otitis Media, or glue ear, associated with an infection of the upper respiratory tract that leads to inflammation of the middle-ear cavity. If this becomes chronic a thick fluid develops in the middle ear. Glue ear is treated with antibiotics, and/or surgery to ventilate the middle ear by inserting a grommet in the drum.

The consequences on development of undetected hearing impairment may be long lasting.

Sensori-neural deafness

Sometimes called nerve deafness, this type of hearing impairment is usually more serious than conductive deafness and medicine or surgery can do little or nothing to remedy it. The causes of sensori-neural deafness can be hereditary, or associated with diseases such as meningitis or rubella, or induced by trauma. It is relatively rare (4 per 10,000), but is permanent, and may worsen over time.

Sensori-neural deafness occurs in the inner ear or neural pathways and usually means that the cochlea is not processing the sound effectively. Sounds will appear quieter and may also be distorted. There may be variations in perception of sounds at different times, and difference in sensitivity to sound at different frequencies. It can be extremely difficult for people with moderate sensori-neural hearing loss to acquire normal speech and language.

Signs to look out for

- Is slow to react.
- Is the last to follow instructions
- Is always coming to check what they should be doing
- Seems to be daydreaming
- Turns their head to one side when listening
- Watches others reactions and then follows

Strategies to use during training

- Quiet areas for teaching.
- Seat near to the instructor.
- Gain the young person's attention before speaking.
- Ensuring the instructor's face is always clearly visible. Look directly at the cadet, do not cover lips and maintain eye contact.
- Stand still and maintain a 1 to 2 metre distance to allow for lip reading.
- Speak slowly, clearly and naturally.
- Write key words on the board and provide notes for reference.
- Maximising communication via visual aids.
- Allow time to study visual aids or instructions before talking.
- Limiting the time spent having to listen to the teacher.
- Use of small group teaching or individual tuition.
- Encourage other cadets to speak one at a time and to put their hand up before speaking.
- Keeping background noise to a minimum.
- Letting other cadets repeat instructions.
- Repeat what other cadets say.
- Break up long sentences.
- Avoid note taking – provide written notes.
- Obtain feedback to check the young person's level of understanding.

Further information: RNID www.rnid.org.uk.

Language and Users of English as an Additional Language

Some cadets do not have English as their first language. You may notice difficulties such as:

- Problems with word order.
- Repetition of words and ideas.
- Sentences are very simple, or longer and inaccurate.
- Phonetic spelling.
- When you read the cadet's work, it does not read smoothly because the sentences are not linked.
- Some tend to write more in sentences than paragraphs and paragraphs do not always follow a central theme.
- The over-use or limited use of a full stop.
- Regularly miss out or misusing 'the'.

As an instructor you can help by

- Using a variety of teaching strategies.
- Giving clear and explicit instructions.
- Avoiding using idioms and slang as these can cause confusion.
- Using visual and kinaesthetic strategies such as those used with dyslexic cadets are often very helpful.

Users of English as an Additional Language

There are overlapping, but not identical issues here and a further group of issues which relate specifically to refugees. There is a backdrop of attitudinal, political and cultural questions which is worth noting when considering delivery to these groups.

Users of English as an additional language

- A great diversity of language is represented with many being multi-lingual.
- Facility in the use of English does not correlate with ethic origin or with the level of previous skill attainment and least of all with intelligence.
- Learn from your cadets what they already know as well as what it is they wish to achieve.

Refugees

Many refugees are dealing with significant barriers to learning:

- They may have been through terrifying and traumatising experiences.
- They may have lost close relatives or have relatives who are missing.
- They may have had bad experiences with officials.
- It may be hard for them to concentrate on other issues.
- They are significantly poorer since arriving in Britain.
- They face an uncertain future.

However, most refugees have characteristics which make them effective and committed learners:

- Many are highly motivated and determined to learn fast.
- A high percentage of refugees are well educated although not necessarily in English.
- Many have already acquired formal English.
- Many are looking forward to a new start.

Myalgic Encephalomyelitis (ME)

Myalgic Encephalomyelitis is a serious neurological condition affecting the brain and central nervous system. It is also known as *Post Viral Fatigue Syndrome (PVFS)* and was formerly known as *Atypical Polio. Chronic Fatigue Syndrome* is an alternative name (originally invented for research purposes) but this term also includes other fatigue states.

- Numbers of children in the UK with ME are estimated at 25,000 out of 300,000 sufferers of all ages.
- The incidence of ME is growing.
- Clusters occur in families, schools and communities.

Symptoms

ME can cause severe pain, weakness, exhaustion, chemical intolerance, inability to concentrate, think or speak correctly, temperature and blood pressure abnormalities, racing pulse and palpitations, abnormalities of sensation, mood swings, digestive disturbance, sensitivity to sound and light. Abnormal brain cortisol levels mean that the normal stresses of life can provoke relapse, as can physical or intellectual demands upon the body.

Unique to ME is delayed exhaustion after physical or intellectual effort – up to 72 hours' delay.

Strategies to use during training

- Energy management and pacing of life appears to be the key to supporting the body while it heals.
- Instruction must be extensively modified to take account of the cadet's special educational needs, to avoid relapse and promote recovery.

Speech and Language Difficulties

There are many kinds of speech and language difficulty but all of them affect communication. Development may be delayed or disordered. Young people may have difficulty with:

- The structure of language (phonological, grammatical or semantic).
- Receptive language (processing the language they hear).
- Expressive language (verbalising their thoughts and feelings).

Signs to look out for

- Difficulty articulating sounds, syllables and words.
- Faulty word, phrase or sentence structure.
- Echoing what has been said.
- A tendency to avoid speaking or give one word answers.
- Very restricted vocabulary.

Strategies to use in the classroom

- Sit at the front.
- Tell the cadet to look and listen.
- Say the cadet's name before asking a question.
- Outline to work to be covered.
- Speak in clear, short, simple sentences.
- Simplify instructions.
- Support speech with visual prompts, signs or gestures.
- Explain vocabulary clearly avoiding excessive jargon/ technical language.
- Use pictures/symbols to aid understanding.
- Group related key words.
- Make new words or concepts as concrete as possible.
- Use any new vocabulary lots of times.
- Ask the cadet to tell you in their own words what they have been asked to do.
- Allow extra time for the cadet to formulate oral answers.
- Plan the careful use of computers and IT to facilitate learning.

Visual Impairment

Visual impairment is a low incidence condition affecting approximately two cadets per thousand. There are many causes of blindness and partial sight and the effect of particular conditions is unique to the individual. The broadest definition is that vision can be considered to be impaired if, even with the use of contact lenses or glasses, a person's sight cannot be fully corrected.

Signs to look out for

- Works slowly.
- Watery, itchy or inflamed eyes.
- Frowns, squints or peers at work.
- Appears clumsy.
- Difficulty in copying from the whiteboard or from a book.
- Misses out words and lines when reading.
- Dislikes strong light or glare.

Strategies to use in the classroom

- If the cadet wears glasses, encourage them to wear them.
- Seat close to the board or screen.
- Always give clear instructions and descriptions. A cadet may misread gestures and facial expressions.
- Provide enlarged text where necessary.
- When reading a lengthy text, allow for rest breaks.
- Allow extra time for finishing tasks.
- Consider seating and grouping. This may apply particularly when using additional technology.
- Using all cadets' names and giving more verbal feedback to compensate for difficulty in seeing body language.
- Backing up visual information with verbal instructions or descriptions (e.g. reading out loud what is being written on the board).
- Providing copies of information.
- Ensuring worksheets are clearly presented, uncluttered and produced in clear, large (standard case) typeface.
- Using matt paper; shiny may cause glare.
- Ensuring that resources are well organised so that the cadet will have independent access.
- Making sure that there is good lighting in work areas, with no glare. However, where a cadet is photophobic (sensitive to light), they may be more comfortable in a shaded area of the room.
- Giving short tasks rather than long ones as visual impairment people tire more easily.
- Giving extra time to complete work.

Further information: www.RNIB.org.uk