LIVERPOOL
JOHN MOORES
UNIVERSITY

Early Work
By Student
Researchers

SPARK

ISSN 2050-4187

Issue 5
November
2014

Spark

Issue 5, November 2014

ISSN 2050-4187

Editorial team

Publication date: 26/12/14
Published by: **Liverpool John Moores University**, Faculty of Education, Health and Community, IM Marsh Campus, Barkhill Road, Aigburth, Liverpool, L17 6BD.

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Editorial

Welcome to Issue 5 of ***Spark****.*

Welcome to this Special Educational Needs edition of Spark. We will be showcasing examples of students' excellent work in Education Studies and Special and Inclusive Needs. We have included a wide range of topics, that we hope you will find interesting. We have kept all work in the original format, allowing for individual differences, to show that not everything has to be the same to be excellent. We hope you find this edition interesting and we are looking forward to hearing any comments you have about this issue of Spark. If you have any queries feel free to contact us at V.L.Moss@2012.ljmu.ac.uk or S.Scott1@2012.ljmu.ac.uk

Victoria Moss and Samantha Scott *(Student editors)*
Level 6 Education Studies and Special & Inclusive Needs

We are very excited to present this special edition of SPARK focussing on submissions from Level 5 Education Studies and Special and Inclusive Needs students. We would like to thank Victoria Moss and Samantha Scott for their contributions as student editors and encouragement to other students to consider publication in SPARK. If you would like to get involved as a student editor please contact any member of the editorial team or me at a.s.garden@ljmu.ac.uk

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Reflection

This assignment is a reflective piece about a four week project carried out by myself and two others, as part of our university module, Developing Employment Skills. Throughout the four weeks, we visited three different primary schools and a nursery in three diverse areas. For the purpose of the project the sessions were carried out across a variety of age ranges from nursery up to Year Two. Two sessions were completed in each of the classes over a two week period. Throughout the project we found it vitally important to reflect back at the core goals we were set and the personal learning goals that, as a group, we set together to ensure that we got the most from carrying out our project and we got all the information we needed to develop our knowledge for our future careers.

Before starting our project, I decided to get some training on a recognised type of sign language. After discussions with the schools and my group a decision was made to choose *Sign Along*, as this was the type of sign language most commonly used to support children with learning disabilities (Sign Along, 2007). When we spoke to the schools about our project, School ‘A’ suggested that we went on a 3 week course with them (School ‘A’ identified, 2013) to gain an introductory qualification in Sign Along. This would enable us to support the children in the schools who may be non-verbal or have learning disabilities to raise their self-esteem (Levitt, 2004). It also helped us achieve our aim to promote inclusion (Crim and Thompson, 2013). Attending the three week course in Sign Along, helped me to develop my knowledge and skills to support children with learning disabilities and promote inclusion at an early age (McWilliam and Casey, 2008).

Learning Sign Along will help to develop my employment skills further as it shows I have a recognised qualification in signing and have had experience teaching it to the children. Sign Along is often used to support children who have learning difficulties (Sign Along, 2007). When working in a special needs school it is likely that I will come across a child who is hearing impaired or has a learning difficulty. Learning Sign Along will help me to teach these children to communicate as it is mainly based on British Sign Language (BSL) and therefore suitable for all abilities (Kennard, 2014). However, according to Sign Along (2007) unlike BSL, Sign Along focuses mainly on the communication between others rather than just teaching a block of signs to its trainers. As this is what I would like to be able to do Sign Along seemed much more suited to me. By gaining an introductory qualification it allows me to be able to start to communicate with those who use Sign Along in my future career goal (The Sign Along Group, 2007). My next step is to progress onto gaining my foundation qualification in Sign Along and broaden my knowledge of signs and how to use them (Sign Along, 2007).

In conclusion overall I feel that I have met my target in gaining a sign language qualification in Sign Along and throughout my project gained experience in teaching and using sign language to communicate.

Prior to us starting our project we had to research the attention span of children in the age range (Essex County Council, 2005) we would be teaching in order to include this in plans to keep the pupils engaged at all times allowing them to get the best use from the sessions (Linsin, 2011). We originally planned for the sessions to last between 45 and 60 minutes. There being three parts to the session; the starter, the main and the plenary.

When researching we found that each part of the session on average should only last a maximum of 15 minutes per activity to keep the children engaged (University of Southampton, 2005). When we began our project we found that the activities we had planned where too long for some of the classes and the pupils became disengaged and disruptive for the rest of the session (Linsin, 2011). During the sessions when the children had lost interest and become distracted we had to improvise and come up with something between us to re-engage their interest. (Zusho et al., 2003). In one case we made up a game called guess the sign. This resulted in all the children having the opportunity to show off what they had learnt to the rest of the class and ask for help when needed (Chan et al., 2003). The conclusion we drew from this was that some of the children had only become disengaged because they were struggling with what they had learnt and did not quite understand some of the signs they were shown (Stratuss, 2013).

Therefore as a result we adapted the second session to shorten the time scales with more one to one tuition offered in order to support the children who we found where beginning to struggle (Gov, 2013). We motivated those we found to have become distracted by asking them which signs they would like to learn (Campbell and Beverly, 2012). This proved successful resulting in re-engagement of pupils as they wanted to know the answers and to participate in the session (Vansteenkiste et al., 2004).

Overall in conclusion, I learnt that sometimes you need to use your initiative to bring the children who are becoming dis-engaged to re-engage with the session by changing the activity or offering extra help and to spot the signs before it becomes disruptive for the rest of the class (Stratuss, 2013).

Whilst we were doing our project at School ‘A’, after our first session, we discovered that one of the pupils had English as an additional language (EAL). She therefore did not understand any of the session we had given due to her being new at the school and unable to speak any English.

When asking for the feedback from the session, the main teacher of the Reception class asked for our advice on how Sign Along would help to support the child with EAL (Mistry and Barnes, 2013). She enquired if we had any other ideas of how they could support her in her transition to learning to speak English (Burke, 2009). Due to previously doing voluntary work in this school and already assisting a child with EAL, I suggested using the sign language resource pack we were leaving behind, and labelling everything in the classroom written in her main language and underneath in English (Gershon, 2011).

After coming away from the session we did further research as to how to teach a child with EAL. We discovered that this could be done through the use of flashcards, one to one tuition and Sign Along, and gradually she would begin to learn the language (Teachers First, 2010). We adapted our session plans to suit her needs by adding pictures of the objects and names of the signs we were teaching that day and during the nursery rhyme session. I sat with her and supported her one on one when singing the song at a slow pace whilst showing her the signs to go with it until she was successfully able to sign most of the song without prompting (BBC, 2011). We also left a resource pack with the teacher at the end of the session with a few different signs of objects around the classroom for the teacher to put up and label to help the pupil and also left a few journal articles with some tips of how to teach a child with EAL.

During our sessions at School ‘B’, when we were carrying out the main part of our session I let my group act out the nursery rhyme ‘5 little ducks’ as this is what they requested. This resulted in them becoming distracted from the initial task which was to sign the nursery rhyme. When at the end of the session we asked the pupils questions about the signs they had learnt they were unable to answer due to them being distracted (Young Minds, 2014). The class had spent time watching the group acting out the rhyme rather than paying attention and trying to learn the signs (Linsin, 2012) This had a negative impact on all pupils by putting them at a disadvantage, as a result of them becoming distracted they missed out on the learning opportunity of learning the signs (Linsin, 2012).

This lead on to further problems as during the next session when we changed the groups around, the group who had previously done the ‘5 little ducks’ rhyme were doing ‘5 little monkeys’ rhyme and wanted to act out the nursery rhyme as they had previously done. Again all the other groups attention was diverted away to see what the group was doing and whether they were acting their rhyme out (Linsin, 2012). This caused further problems as we were not prepared for this and it was hard trying to improvise to motivate the children and re-engage them with the session that we were teaching (Stipek, 1993). In order to try to re-engage the pupils I let them use whiteboards to draw the signs they were going to use as a memory aid (Lewin et al., 2008). I set a task for them involving performing all the signs without singing using repetition to help them remember what they were doing (Hutchinson, 2000).

In conclusion, this went well and gave me the learning opportunity of how to keep the students engaged and focused on what they are meant to be doing rather than letting them do something else which could be a potential distraction.

Whilst we were carrying out our project, we analysed the different learning techniques throughout the classroom and the way in which the pupils engaged best. At the end of the final session we ensured that we asked, on the feedback form, if the teacher found our sessions appropriate for the different learning techniques within the room. We received positive feedback from all the schools and the nursery.

As a group we decided that this was an extremely important goal to achieve as we wanted every child in the room to learn something from our sessions and find them engaging. When researching about learning techniques we found that there are three main styles of learning. Auditory, Visual and Kinaesthetic (Learning RX, 2014) and the best way to incorporate these learning styles is through talking to the students, using visual aids and hands on tasks (Learning Styles, 2014). When we were planning our sessions we took this into consideration and got as many resources together as we could. This included pictures of the signs we were teaching (Faber, 2013).

During our first session in the nursery we found that a lot of the children on the carpet part of the session began to become dis-engaged when it involved just talking. However, by working one on one with this small group of pupils and giving them extra support by showing them images of the signs we were showing them helped to grab their attention and re-engage them within the session (Faber, 2013). This also allowed them to learn some new signs by remembering the image they saw to go with it, as gathered on feedback by talking to the pupils they said on the whole that they felt they had learnt something new from the session and commented on the images, this concludes that this approach was successful.

By carrying out these activities it also allowed us to support the non-verbal pupils and the children with EAL and find what learning style best suited them. We adapted our second sessions further as we were then aware of the styles within the individual classes. This allowed the second sessions to run a lot more smoothly. However in School ‘B’ there was one boy who asked us when were they just going to sit down and do work on sign language as he was finding himself becoming bored just watching the signing and doing the activity in group work using visual aids. Therefore if we were to do this project again I think I would research more about the kinaesthetic learning style and try to plan activities better to suit this (Learning FX, 2014).

When planning for our project, we decided to research and look at how we could include parts of the National Curriculum for the specific age ranges within the school, with the signs that we were teaching to assist the children in what they were already learning.

We decided to teach the alphabet from reception to Year 2 and counting up to 10 to the pre-school pupils as these are the basics of what each year group should know or should be beginning to learn (Gov, 2013). All the children interacted with this and were able to tell us the initial letter of their name in sign language and the large majority of them were able to count to 10 using their hands.

During the second session, the schools were beginning to learn about Chinese New Year and the different animals for the different years, this year being the horse (Chinese New Year’s, 2014). Therefore we planned to teach the children some different animal signs for the basic animals that they would know. This fitted well within the lessons they had previously been learning about for the New Year and they were able to sign and talk about the animals they had been learning about and ask about any others that they were unsure about.

The teacher and the class had really good feedback about this session as the teacher said that they would be able to continue to use these signs within her lessons about the upcoming event and this could be used as an aid for her to incorporate the children with EAL and the non-verbal children so that they could be included within the session (Teachers First, 2010).

We planned to achieve our third placement goal whilst planning the project by asking the schools what time frames we would be in and what is before and after the sessions, therefore we would be able to plan our sessions around them.

For instance, if our session was planned for after dinner time then it was highly likely that the children would come in rather excited from their break (Karnasiewicz, 2013). Therefore to engage the children back into a learning environment it was important that we allowed them time to have a drink and start the session with something exciting and new to encourage them to engage in listening (Weigle, 2010).

This worked well as a number of our sessions where originally planned for after dinner time and all the children were excited to be learning some sign language so they tended to settle down quickly.

When we were at School ‘B’ our sessions were planned for after lunch but on the second session all the children were really enjoying the session so asked us if we could stay through their break and teach them some more signs until it was time for them to go home. The teacher gave her permission for us to do this so this allowed us extra time to teach and for us to plan more things amongst ourselves to fill out the remaining time. We did this by using extra tasks to support us from what we had already planned to teach.

Overall we were able to carry out our sessions effectively and keep all the children engaged for the majority of the set time without them becoming bored or disinterested and the time slots were enough for the students to absorb the material that we had given.

Throughout our project one of our main aims was to create an inclusive environment for children of all abilities and ages through creating inclusive resources. We wanted all children to learn something from our sessions and feel that they were included and able to communicate through sign language with at least a few signs that we had taught.

Prior to starting our project we asked the nursery and each of the schools whether there were any special and/or inclusive needs that we needed to be made aware of to support or assist us when doing the planning for the project. Each of the schools and nursery all said no. However when we got there we discovered a number of students who had EAL and/or were non-verbal. Therefore we had to adapt our sessions whilst we were there to the best of our ability to include these individuals (Mistry and Barnes, 2013).

For the second session at School ‘A’ we had a child with EAL and a non-verbal child so we decided to create a separate resource pack to meet their needs by printing pictures of what the signs were that we were teaching. We also sat with the child going through these allowing them to copy the signs and be aware of what they were learning. By offering one to one tutorials (Mistry and Barnes, 2013) with the child allowed her to communicate with us through sign as she was successfully able to sign a minimum of 5 signs back to us. When we held up the pictures of the signs she was able to guess it and show us what we were asking for (Teachers First, 2013).

Overall, the resource packs that we made to support the sessions worked really well to assist the children who were non-verbal and had EAL as they used the signs appropriately to communicate with us and participate in the nursery rhyme time and story at the end to the best of their ability.

In conclusion, overall I felt that we had met and successfully reviewed the goals that we set at the beginning of the project with only a few things to adapt further if we were to perform this project again. On the whole I have developed my strengths and weaknesses through the duration of this project and felt that I have learnt a lot of background knowledge to teaching and about sign language to enable me to work on and analyse to improve further in order to achieve my chosen career.

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Bereavement

Bereavement is the ‘objective situation one faces after having lost an important person via death’. The services available and help provided can alter across cultures and through religions due to differing methods of dealing with death and opposing attitudes. Some cultures believe that ‘mourning is a waste of time and energy’ and that when a person dies the main focus should be to remove the body as quickly as possible, and carry on with life as if the event had never occurred (Parkes et al 2003, pg. 5). Different religions also have varied methods of coping with bereavement and ways in which they will react but, the main focus of support appears to be through communicating with others. ‘The mere presence of another person who cares is important’ and it is this idea of support and sharing that is emphasised within our culture (Parkes et al., 2003, pg. 8). The likes of the Alder Centre and Winston’s Wish provide very different services for different people but the methods used are extremely similar.

The key notion within each service is to provide continuous support through a variety of methods in order to allow each individual to grieve and mourn in a way that they feel most comfortable. The Alder Centre focuses primarily on the loss of a child for a parent and the experiences that they may go through whilst trying to cope with this loss, whereas Winston’s Wish has a much wider network and provides services for children who have been bereaved. ‘About 20% of bereaved children are likely to show higher than expected levels of psychiatric difficulties’ and this is often due to a lack of continued and consistent support and issues within agencies working together in order to gain the best level of assistance for the individual.

The Alder Centre immediately outline that this is an individual experience and everybody will have a completely unique encounter. Within their booklet ‘When a Child Dies’ it is stated that ‘everyone acts and feels differently’ and that there is ‘no right or wrong way to grieve’ (The Operational Bereavement Group, pg. 3). The centre aims to provide ‘care and education for anyone affected by the death of a child’ and supply an immediate response following the death of a child, with members of staff available at all times. The bereavement support team are a relatively small group of five employees with each working on a part time basis, due to how emotionally draining the role is. This team are often the first contact that the family will have following the death of their child and so a lot of information is required and confusion and distress is to be expected, especially if the death was sudden. They will arrive within an hour of the child dying and will liaise with other members of nursing staff to gain all the required information about the child.

It has been suggested that there can be issues with this method of bereavement support as the team have ‘no time to prepare’ and ‘do not know the family well’ meaning that there is no previous bond to build upon and trust can be extremely hard to gain from the family (Cook et al., 2013). As well as these issues the support worker is required to provide all information needed including the next steps, funeral proceedings, what will happen to the body and the role of the coroner, if this is required. ‘Continuity of care’ is vital in order to fully support the family or the individual and this can be done through counselling, support groups, volunteer befriending, the Child Death helpline and therapeutic breaks. Winston’s Wish are often discussed in conjunction with this service in order to offer help to siblings and other young people dealing with loss, which is a major problem in the

UK with one in twenty five children experiencing the bereavement of a parent or a sibling (Winston’s Wish, 2014).

It has also been suggested that there are distinctive gender differences which start from adolescence that need to be accounted for. Masculine feelings are found to be limited or toned down with thinking preceding and often dominating feelings and intense feelings are mainly expressed privately (Doka et al., 1998). Conflicting this are the feminine feelings which tend to involve seeking support, expressing aguish through tears and not being afraid to discuss grief (Doka et al., 1998). As well as cultural and religious variations the support worker must also understand that there may be differences between age and gender to also consider when offering support and approach each individual in a flexible way.

The involvement of the Spiritual Care team can be vital at this time in order to provide required information for different religions, however it has been stated that ‘if human beings go to heaven or hell when they die they cannot also be reincarnated’ (Parkes et al., 2003). This is a clear indication of losing faith at a difficult time and the Spiritual Care team can be utilised in order to restore faith or advice about non-religious ceremonies.

It is imperative for the practitioners of the Alder Centre to have a very strong persona within this role and the ability to separate their work life from their personal life. As well as counselling individuals who have experienced bereavement it is also important for them to receive separate counselling for themselves to offload some of the issues that they may be having. Training is extremely important in order to work effectively within this role, whether this is as a befriending volunteer or as a support worker. Although specific degrees or qualification are not required, as many establishments will provide training from within, there are various skills which are vital such as being patient, caring and compassionate around this sensitive subject. It has been suggested that ‘potentially untrained people may do more harm than good’ which is a clear indication of the importance of a thorough training system being in place with plenty of support for the staff members if it is required, either from the hospital itself or from other individuals (Baugher et al., 2012).

The staff at Winston’s Wish have all endured previous experience in either the education or the health sector, meaning that previous work with either illness or children was already gained before beginning with the charity, which would ensure that the staff force were already comfortable and confident within this role. It is vital to ensure that this skill set is present even after death as many people still get ‘waves of grief’ and it has been stated that a day does not go by without a memory being stirred (Moore, 2013).

The family or the individual that are dealing with the bereavement must be provided with all possible information to help them to cope with everyday life. Worden (1992) suggests that there are four tasks of mourning including to ‘accept the reality of loss’, to ‘work through pain or grief’, to ‘readjust to the environment in which the deceased is missing’ and to ‘emotionally relocate the deceased and move on with life’. This is a very linear model and does not take into account that every experience is unique, something that is imperative for a bereavement practitioner to work by and allow to be at the forefront of their work.

The Bereavement Support service become involved immediately when a child dies within the hospital. There is always a member of staff available at any time of the day and they will go straight to the family, who are usually with the deceased child. However in a case were the death has been ‘anticipated’ it is possible for the service to become involved at an earlier point, meaning that a relationship can be formed (Rolls et al.,2007). When this is not possible the bereavement support worker will gather all of the information required about the family from the nursing staff that have worked with them in order to ensure an effective change-over of professionals. It is also possible for the team at the Alder Centre to visit the home if necessary which will often be the case if the family have chosen to take the child home before death or after the death certificate has been received. It is also possible for the child to be transferred to a Bereavement Suite, which is a non-clinical setting allowing families to spend time with their child, were photographs can be taken and the child can be washed and dressed. This is also a time when all documentation can be prepared including the Patient Death Order Set and the certification of the death on Meditech by the support worker.

The main method of funding for the centre is through charitable donations which provide for various areas within the hospital including the play and garden areas, the teenage treehouse and the provision of personalised bedrooms for extremely ill children. This also allows for extra funds for the bereavement support service which is now considered as a fundamental part of the hospital and an integral part of future planning (for funerals and provisions post death). Money raised by the charities goes on ‘enhancing the NHS service, not subsidising it’ although many people’s response to providing to a hospital charity is that they pay taxes and therefore do not need to (Mathieson, 2013).

The hospital charity in particular has managed to gain support from local businesses and from the Aintree race event which is country renowned, resulting in ‘a great awareness raiser’ that may not have been originally the case (Mathieson, 2013). The hospital itself is publicly funded directly from taxation and supports the idea that ‘good healthcare should be available to all, regardless of wealth’, however it has been suggested that much more could be done in terms of bereavement support (NHS Choices, 2014). It has been stated that many relatives are unable to visit the deceased in hospital due to a lack of space and that going to collect property and certificates from wards affects the dignity and privacy of the rest of the family (Waller, 2011). This is something that the Alder Centre is much more flexible towards, allowing relatives to have pictures with the deceased child if desired and for meetings to take place away from the place of death if necessary. ‘Some funeral directors are beginning to consider bereavement support as part of their service’ as it has been found how much of an impact this can make to the families overall development without their loved one (Faull et al., 2012).

The Alder Centre has a number of links with other agencies, charities and support services. Within their own service they provide a Child Death Helpline, Spiritual Care, Patient Advice Liaison service and counselling sessions if required. They also hold direct links with Winston’s Wish, which is a charity specifically designed to help young people who are dealing with bereavement, CRUSE bereavement care, the Samaritans and many more. This ensures continuity of care as the right service can be provided for the individual and information sharing can consistently occur. ‘Many bereaved individuals adapt to their loss with minimal assistance from health-care professionals’ but by providing all information and support away from a hospital setting the correct aid could be found for that person in particular (Faull et al., 2012). The most obvious link to other agencies is the link with the hospital itself. This includes with any doctors or nurses that may have previously worked with the family as well as any other key individuals around the hospital environment. This is a fundamental way to ensure that there is an effective change-over from health care professional to bereavement support worker and a bond can be built with the family immediately.

The main area in which the Alder Centre need to provide a service is within schools and for education for parents who often find that the most difficult part of dealing with bereavement is how to tell the people closest to them, especially if another child is involved (Rolls et al., 2007). This could be provided in conjunction with a service for schools in order to provide education on how to deal with a child who is coping with bereavement. Some children find themselves being ‘bullied or taunted at school’ as they are different to their peers and it can often be difficult to provide the correct support without having all of the required information and training (Rolls et al., 2007). Ninety-two per cent of children under sixteen will lose somebody close to them and ‘around 70% of schools have a bereaved pupil in their care’ and so it is imperative to ensure that teachers are educated in bereavement support in some form (Drabble, 2013).

Within a Special Needs High School bereavement is a common topic, with many children losing friends frequently due to the vast array of disabilities within the school. It has therefore been absolutely necessary for teachers to be able to deal with difficult questions from their pupils and be able to tackle the topic as openly and honestly as possible, as it has been suggested that there is ‘no formula for dealing with grief, but being open and honest goes a long, long way’ even if that means admitting that all of the desired answers cannot be given (Drabble, 2013).

The hospital Bereavement support service is a clear example of multi-agency working as the centre is directly linked to the hospital. This means that information is frequently shared between hospital staff such as doctors and nurses and the support service in order to provide the best care available for the grieving family. The bereavement service is introduced to the family within an hour of their child’s death and this early intervention is vital in order to form a bond with the family and to let them know that support is immediately available. It is vital that the support worker has all of the information required in order to gain trust from the family and maintain a professional stance (Barker, 2009). By ensuring that there is this link the team can feel much more supported which can in turn increase morale of the staff. It would also be integral for the bereavement support worker to establish who the lead professional may have been if the child had ongoing problems or illnesses, and liaise with them to gain further details about the child, this could be a teacher, nurse or any other support service. Charlton (2002) suggests that it may sometimes be more efficient to appoint more than one lead professional to ensure continuity of care and enable information sharing to be carried out more effectively. This can often be an extremely time consuming process and something that may not be possible when dealing with such a delicate matter and it has been suggested that a confusion of roles can often occur due to this not being outlined sufficiently (Barker, 2009).

When focusing on a bereavement support service it is important to remember that ‘each person’s grief journey is totally unique to them’ and that one form of support may work for one individual but may not for another (The Operational Bereavement Group, pg. 3). James (2008) states that grief models such as the Kubler Ross Model, which present grief as five simple steps, are ineffective as every person is different and there is very little empirical evidence to support this theory. The model suggests that a person will go through denial, anger, bargaining, depression and finally acceptance but there is no suggestion of how long each step will last for and dealing with the loss of a child is a very different process than losing an adult (James et al., 2008, pg. 420). Other models such as Schneider’s growth model, which allows for growth after bereavement in eight stages and Bowlby’s attachment theory which suggests that grieving is integral when losing somebody close to you, do not allow for individual difference and the fact that some individuals do not actually take any time at all to grieve (James et al 2008., pg. 421).

The Alder Centre have been praised for their work with families and the comments that they receive from the families of children that have died show how much good work is being carried out with each patient. One of the comments stated that the team do ‘an amazing job in extremely heart-breaking circumstances’ and another suggested that the support received was better than they could have hoped for from any other hospital (Pauline and Paul, 2013). The main area in which this service could improve is by liaising more with teachers and school staff to allow for training when a pupil dies, whether this is through training days or the support staff themselves going in to local schools to talk to the child’s peers. The multi-agency working with the likes of Winston’s Wish allows for siblings to be supported, even though this is not part of the Alder Centre’s expertise and means that the whole family can gain a support system. By acknowledging that every person is different and therefore every person will require a specific and unique support system a truly amazing service has been produced in order to continually provide support for the family as a whole.

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Anorexia Nervosa

This essay will discuss an overview of the nature of anorexia and focus on causes and influencing factors that an individual can experience with the condition. It will also look at any possible agency involvement and how to identify anorexia.

There are many perspectives on how to define anorexia nervosa. According to the National Health Service (NHS) (2012) anorexia is ‘an eating disorder and mental health condition that can be life-threatening’, whereas, Stegier and Bruce (2009) define anorexia as ‘a relentless pursuit of thinness and a phobia of the consequences of eating.’

Anorexia existed in medieval Europe. This was when extreme fasting was linked with holiness, humility and purity. Religious women were often suffering with “holy anorexia” (Remedy Health 2014). According to Russell (1985) ‘the nature of the psychopathy of anorexia has been the subject of interest since the earliest descriptions of the illness.’ The fear of becoming overweight was considered as a characteristic of the psychopathology of anorexia and it was used as one of the diagnostic criteria’s in 1970. Some people believe that anorexia is a ‘profound biological solution to existential problems’ (Crisp 2006:147).

Anorexia is an emotional disorder that focuses on food, however according to the University of Maryland Medical Center (UMMC) (2013) many researchers believe anorexia is an attempt to deal with perfectionism and gain control. The eating disorder has three key features that are; the refusal to maintain a healthy body weight, an intense fear of gaining weight and a distorted body image. There are two different types of anorexia; the restrictive type and the purge type. According to Lask and Bryant-Waugh (2007) the restrictive eaters will eat a normal range of food but do not eat very much. This can affect children’s puberty, and their height and weight should be monitored. The purge type is when the person is regularly engaged in binge eating or purging behaviour which includes self induced vomiting or the misuse of laxatives (Yeo and Hughes 2011).

According to Falkner-Wiley (2001) anorexia is commonly associated with teenage girls and young women. Giordano (2005) supports this as he says anorexia affects young people between sixteen and nineteen years old. There are an estimated ten per cent of eating disorder suffers who are anorexic. Psychologists at the University of British Columbia found that the ratio of women to men is 9:1 and 10 per cent of males die with anorexia. This percentage doubles to 21% for men over the age of forty-five. This is higher as it is said that it is easier to hide if you are elderly (Usborne 2012).

According to the NHS (2012) there is no single cause for anorexia. Experts believe that anorexia is caused by a combination of psychological, environmental and biological factors. This then leads to a destructive cycle of behaviour.

People who develop anorexia share certain psychological factors, which include; low self-esteem, lack of control in life depression, anxiety, stress or loneliness (NEDA 2013). Wozniak, Rekleiti and Roupa (2012) supports NEDA (2013) that anorexia is caused by psychological factors as they believe that anorexia is the reaction to the demands of adolescence for more independence and increased social and sexual activity. This is so they can be more concerned

about food and controlling their body weight more than adolescent goals.
Environmental factors can influence anorexia as according to the NHS (2012) due to the Western culture and society girls are exposed to different media which reinforces the message that ‘being thin is beautiful’. Magazines and newspapers focus on celebrities’ minor physical imperfections this includes; gaining a few pounds or having cellulite. This can be a major cause of anorexia as people can look at celebrities as role models and believe that they should look like them. Other environmental factors that may influence anorexia is if someone has experienced bereavement, physical or sexual abuse or a stressful life event. According to Bupa (2014) people can experience anorexia if they do a job like modelling, dancing or were a very lean body type is desirable.

There are many different biological factors that influence anorexia. Starvation affects the chemical levels on the brain (Freeman 2002); this extreme dieting can make anorexia symptoms worse as the normal functions of the brain are being disrupted. This is due to the brain not getting a healthy and nutritious diet to function. The change in hormones can be affected by malnutrition which can lead to sensitivity to tryptophan which is found in most foods, this can cause people to feel anxious when they eat. An ‘appetite-reward pathway’ can become scrambled in someone who had anorexia. This means that feeling full after a meal does not give them a sense of reward, but a sense of anxiety, guilt or self-loathing (NHS 2012).

There are many implications of anorexia that people can experience. According to National Eating Disorders (2013) anorexia is a potential life-threatening condition that can affect someone’s emotional and physical health. The earlier the person seeks professional help the greater the likelihood of recovery. Anorexia can affect the: reproduction, nervous system, cardiovascular, skeleton and teeth. It can also result in death and psychological problems (Ogden 2003). As a result of self-starvation the body cannot have the nutrients to function properly; this can cause risk of heart failure as there will be a slow heart rate and low blood pressure. Anorexia can cause a reduction in bone density which results in dry, brittle bones. Someone with anorexia may experience severe dehydration which can cause kidney failure (National Eating Disorders 2013).

According to Duker and Slade (2003) there are two different ways of recognising anorexia, any physical symptoms of under nutrition or starvation and the sufferer’s individual attitude towards food and body control. Anorexia can be identified if a person’s BMI is equal to or less than 17.5. A person may also refuse to maintain their body weight in the normal weight range for their height and age, even though there is no physical or mental disorder (Abraham 2008:24).

There are many symptoms of anorexia these can be: rapid weight loss, fear of gaining weight, dry or yellowing skin and frequent illness. If these symptoms are present then the doctor will perform a medical and physical examination, to rule out any physical illness. If no physical illness is found then the person may be referred to health care professionals to diagnose mental illnesses (Cleveland Clinic 2014).

There are many different agencies alongside the General Practitioner (GP) that are involved with someone who has anorexia; they are known as the care team. The GP identifies the eating disorder and plays a key role in the management of the disorder. The GP also provides support for the families and carers and has relevant links to the access of specialist services and psychological therapies to help the person with anorexia (Hay 2013). The dietician who is specialised in nutrition supports someone with anorexia. According to Hay (2013) the dietician provides expertise for meal planning and nutritional care in the re-feeding phase as their treatment goal is to improve nutrition. Counsellors provide psychological treatment for someone who has anorexia. A specialised counsellor may specialise in psychodynamic or cognitive behaviour therapy, which they will be effective in when working with the patient. There are also counsellors that are not specialised which will have experience in more than one therapy type and they are able to use the one that is more suitable for the individual (Freeman 2002).

To conclude, anorexia is common in teenage girls and there are a number of factors that can cause this. In this research however there is evidence of lots of support systems set up for people with anorexia so that they do not have to fight the illness alone. With this information the future could be bright for people with anorexia who want to change their ways and defeat the illness.

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Selecting a Mainstream or Special School setting for a child who has special needs?

The educational provision for children has radically changed throughout the years where previously children with special needs were categorised by their disabilities and placed in separate schools under the Education Act (1944). Many children with severe disabilities were considered to be uneducable, labelled into categories and placed in institutions within the health authority. The Handicapped Children Act (1970) came into force and demanded that all children were to be educated, and to become responsibility of local education authorities. The Warnock Report (1978) and the Education Act (1981) significantly changed the conceptualisation of special educational needs (SEN) by introducing the idea of special educational needs statements and an inclusive approach based on educational goals for all children regardless of their abilities and disabilities (Alcott, 2002).

The DfES (1997) defines inclusion within the Green Paper as,

> ‘‘seeing more pupils with SEN included in mainstream primary and secondary schools. By inclusion we mean not only that pupils with SEN should wherever possible receive education in a mainstream school, but also that they should join fully with their peers in the curriculum and the life of the school’’.

Similarly, Farrell (2003, p.27) emphasises that inclusion is where pupils belong to and be welcomed by and participate in the school and the community. Their range of interests, abilities and attainments are welcomed as an enrichment to the school. However, other writers have the view that policies based on inclusion should not be restricted to the education of pupils with special needs, (Ballard, 1995). Booth and Ainscow (1998 cited in Farrell and Ainscow, 2002 p.3) supports this by looking at ‘‘inclusion as a process in which schools, communities, local authorities and governments strive to reduce barriers to the participation and learning for all citizens’’.

The Salamanca Statement (1994) developed a dynamic statement on the education of children with disabilities which called for inclusion to be internationally considered as the norm rather than the exception. The guided principal for the new framework for action advocated that ordinary schools should accommodate all children regardless of their physical, social, emotional, intellectual or other needs (Hodkinson and Vickerman, 2009). The percentage of pupils with statements of Special Educational Needs placed in mainstream schools was 54.3 per cent in 2009 compared to 54.8 per cent in 2010 (Department of Education, 2011). Whilst the number of children with statements in mainstream schools has grown, a significant proportion continue to be educated in special schools (Audit Commission, 2002).

Controversy has risen amongst educators and parents due to the continuous debate about the inclusion of children with special needs within mainstream and special schools. Placing children with SEN in mainstream schools has benefits for the child and also the school community as a whole. It enables children with SEN to integrate with others within the class and can also improve their communication, language and social skills (Smith, 2007).

According to Gonzalez (2012) children with disabilities who are mainstreamed show improvements in social and play skills, increased social engagement with their peers and increased motor involvement in play. It also gives pupils an opportunity to get to know the child for the person inside the body and not the outward disability which helps to improve the social acceptance of children with SEN (Smith, 2007).

On the other hand, others may argue that children placed in mainstream schools are often excluded from lessons due to being withdrawn from class for specialist services and extra support. Large pupil to teacher ratios often create a problem when a child with SEN requires one-on-one assistance (Jenkinson, 1997).

Lightfoot (2004) further supports this by stating that ‘children often work alone on inappropriate tasks under the supervision of classroom assistants, instead of being included and engaged in lessons. In some schools they are taught separately by assistants in small groups, resulting in feelings of isolation, and in others they are put in the lowest ability set, with resultant damage to their self-esteem.’

Many people argue that mainstream schools are not inclusive as they often do not have the adaptions, skills and resources to make effective provision for all children with SEN. However, the Disability Discrimination Act (2001) requires schools to make reasonable adjustments to prevent pupils with disabilities from being at a disadvantage and to plan in order to improve their access to the curriculum. Consequently, this often raises the question ‘‘is teaching pupils separately from their peers and not providing the required resources really inclusion?”

Gonzalez (2012) claims that many teachers receive little if any training in SEN which can lead to children underperforming in school. Maddern (2010) emphasised that in a recent survey only 39 per cent of teachers and support staff had any qualification in SEN.

The Code of Practice (2001) acknowledges that although the needs of most children with SEN can be met within a mainstream school, there will still be children whose needs will be best met within a special school setting. Many parents see a special school as a setting ‘where the child is not set up to fail’ (Jenkinson, 1997).

According to Joseph (1999) special schools provide students with individual attention that they would likely not receive in a mainstream school. As a result learning and development occurs more rapidly as children are not ignored due to not being able to keep pace with the rest of the class. Special schools have the advantages of having specialised teachers and support staff, high staff ratios, specialist equipment, small class sizes and personalised learning (Alcott, 2002). However, Jenkinson (1997) has the view that placing children within special schools categorises them separately from society and often places a disability ‘label’ on them.

Joseph (1999) disagrees as he believes that special schools promote a sense of inclusion among the students, as the children can bond with others with similar disabilities rather than feeling segregated. The national curriculum within special schools is often adapted specific to the children’s needs and specialised resources are used to access it. Teachers also offer different means of teaching which is relevant to each child’s needs. Special schools also have the disadvantage that they do not usually offer elective courses such as art or music due to the focus being on teaching students with basic skills (Jenkinson, 1997).

I feel that all children should have the opportunity to be educated in an inclusive setting in order to achieve their maximum potential. Personally, I believe that parents should be given the choice as to whether to send their child to a mainstream or special school rather than the local educational authority. Mainstream schools implement some aspects of inclusion; however I feel that there are still various obstacles in way of ‘full inclusion’ and that many schools currently find it difficult to meet the wide range of individual needs. After visiting a local special school setting my perception of special schools changed, as the school had an excellent range of extra circular activities, facilities and resources for the pupils as well as onsite health provision.

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‘The Role of the Special Needs Coordinator (SENCO) is broad and varied and requires numerous skills.’

This paper will examine in depth the role of SENCO and investigate the practice, legislation and theory surrounding this role. SENCO is a Special Needs Coordinator which is recognised by Hornby et al (1995) as being the central, designated person who is responsible for the care and support of Special Educational Needs (SEN) provision within schools. A SENCO is also known as *“the champion of all the vulnerable children”* in their school and are relied upon to understand their needs, recognise how to meet those needs, have the skills to help colleagues to make effective, correct provision for these children (Evans, 2007, p.5).

This is a role which is shaped by government strategy, workforce and putting into practice new initiatives. Being a SENCO is a very demanding and time consuming role, which needs an organised and concentrated individual who will assess and ensure the correct support for every child under their care. It is identified by the DfSC (2008) that the SENCO role should be taken by a qualified teacher with further knowledge and experience with Special Educational Needs or disabilities, and should be part of a senior management team or role. There are many skills that being a SENCO requires and one of these is management skills, the ability to strategically manage and assess children, their abilities and needs, and being able to process that information to propose a better way of learning which will allow that child to gain the most out of the educational provision he/she needs.

Being a SENCO is much more beyond the status within the school. Yes, gaining respect and admiration is a necessity for the success of the role. There are a mass of responsibilities that come hand in hand with the title. The Children Act (2004) states that *"SENCOs must be aware of how meeting the needs of children with SEN fit into the overall framework"* (Cited in Cowne, 2008, p.6.) Complete accuracy at all times is compulsory, especially within writing and academic skills when keeping detailed records and SEN registers current and up to date. Another responsibility it carries is the obligation to provide realistic individual learning plans which enables the child to reach the best possible success through the best possible support system. As well as supporting the children, it is a necessity to support fellow teachers and staff to complete their accountability to their pupils. The Code of Practice (2001) (cited in Gillie, 2012) states a SENCOs responsibilities consists of *"liaising with and advising fellow teachers", "contributing to the in-service training of staff".* Sharing their knowledge and professionalism by advising and contributing to others to secure the best approach is a duty.

The National Standards for Special Educational Needs Co-ordinator (1998, p.5) declares that a SENCO should have "*the ability to make points clearly and to listen to and understand the views of others."* Strong communication skills is certainly a necessity, the appropriate language and approach that must be used with parents, must differ from the formal, professional language used in LEA Common Assessment Frameworks and with other professionals. Upholding professionalism is a necessity, but also an empathetic supportive approach is needed with parents of a child in need. SENCO's will often find themselves in a dilemma between the requirements of legislation and the practicality and reality of the process. Wedell (2012) provides an example where an SEN Statement states that a pupil should be in a special school; whilst the parent insists on the pupil being educated in the mainstream. Their role here is to be empathetic and supportive of the parents' opinions; but also keep in mind the official regulations and what is best for the child. Another necessity is the ability to communicate with children, to ensure that the teacher- pupil relationship is strong and effective which leads to better understanding of the child's needs and then to be able to meet them successfully.

Several restrictions and issues are raised by the amount of responsibility upon a SENCO and the insufficient allocation of time given to carry out the role. Many SENCO's also have a full time teaching timetable with the duty to educate and care for their own class, which indefinitely limit's their capability to meet the SENCO requirements as well. Time management is very problematic and causes great anxiety for many teachers. There is currently no officially agreed time frame, allocated for the role. However in the Draft Revised Code of Practice (DfEE, 2000) professional members of education such as head teachers and governors are asked to review the amount of time available in context and structure of their school policy and time. On the other hand, Crowther et al (2010, p.86) shows that this is not the reality and that *"65 per cent of SENCOs reported that they had no timetabled time for their role and a further 17.7 per cent reported that they had a half-day or less for their role."*

Through researching towards this paper it became evident that theory and practice more than often create many barriers and concerns for an individual carrying the responsibilities of a SENCO. Yes, there is great pressure and expectations on a SENCO to support the schools' pupils to the best of their ability but there are also roles and responsibilities that should be approached as a whole-school. Cowne (2008, p.9) argues that whilst the coordination of the day-to day policies and practice of SEN is the duty of the SENCO, there are responsibilities that lies with the *"governing body and the* *head teacher, who carry out the strategic planning of the school's development."* It is important to regard the SEN Coordination solely as a whole-school approach, which conclusively allows the SENCO to achieve the best for all of their pupils.

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Discussing the barriers within society that may impact upon the individual with a disability/need.

Definitions of disability normally focus on any situation where a person is unable to execute everyday activities or is restricted in participating in everyday activities as a result of a bodily limitation; this could be physical, cognitive or psychological. Disability reflects a relationship between features of a person's body and features of the society where they live (Johnstone, 2001 and Shakespeare, 2006). The Equality Act 2010 states that someone has a disability if the physical or mental impairment has a long term and negative effect on the person's capability of performing normal everyday activities (Lawson, 2011) .The World Health Organisation (WHO) describes a disability as a restriction or lack of ability to perform an activity in the way that is considered normal for a human as a result of an impairment (Barnes and Mercer, 2003). Both these definitions focus on the medical model of disability as it sees the person's disability as a 'problem'.

The medical model is the most widely used way of defining disability; however disabled people prefer the social model of disability. One criticism of the medical model of disability is that it supports the misunderstanding that disability is due to ill health and disabled people need care from medical professionals (Disabled Living Foundation, 2001). The social model however looks at the way disabled people's lives are affected by the barriers imposed by society. The social model changed the view of disability; disability was seen as a form of social exclusion that should not be tolerated. In the 1980's the social model of disability was behind disability equality across a range of different organisations. The social model played a big part in the disability movement (Oliver, 2004 and Thomas, 2004). As stated by Finkelstein (2004, pp 16) ‘the social model of disability has provided the disability movement with an invaluable tool that has strengthened our insight into the struggle of emancipation’. The United Nations Convention on the Rights for Disabled people would support the social model of disability; it believes that the social model identifies solutions to the barriers disabled people experience in day to day life. It tries to encourage the removal of these barriers within society, rather than trying to fix an individual’s impairment or health condition (Office for Disability Issues, 2011).

In ancient Greece people believed that the mark greatness was unison and beauty. People with a physical or mental difference were seen as evil and weak, as a result of this prejudice, disabled people were usually blamed for natural disasters such as famine, sometimes they would be killed and used as scapegoats (Kendall, 2012). In the nineteenth century people with disabilities were used in ‘freak shows’. These shows were exhibitions of people who were seen to have a physical, mental or behavioural difference at circuses, fairs and carnivals (Barnes and Mercer, 2003). In western societies during the 20th Century, disability was seen as a fault with the body or mind. It was seen as misfortune and a burden to others in society. In the 1960’s disabled people wanted change, they wanted to live independently. The issues of environmental and social barriers to disability where highlighted. Examples included buildings and public transport being inaccessible and the discrimination faced by people with disabilities (Barnes and Mercer, 2003).

However even in today’s society people with disabilities face difficulties leading a ‘normal’ life and discrimination from other members in society. According to Barnes and Mercer (2003, pp 1) ‘disabled people are viewed as ‘unfortunate’ because they are unable to enjoy the social and material benefits of a contemporary society’. Some buildings are still not accessible, in 1991 new building regulations were put in place to try and ensure accessibility for everyone. However this regulation was for new buildings only, therefore if a building was built before 1991, it may be hard to access (Disabled Living Foundation, 2001). Cultural and social influences can also play a part in how much a person is affected by their disability. Income can play a big part in this; not being able to afford high quality equipment may disable a person more than if they can afford top specification equipment to help aid them. Lower income could mean that a person is living in poorly modified housing. Gaining employment can help solve this; however it can be difficult for people with disabilities to be employed. As stated by Shaw Trust (2009) in a survey they conducted ‘half of disabled people where in work, compared with 80% of non-disabled people and 23% of disabled people have no qualifications compared to 9% of non-disabled people’.

The Disabled Persons Act 1944 required companies with more than twenty staff members to have a minimum of 3% of employees with a registered disability. However this piece of legislation is widely ignored and there is no prosecutions for failing to follow it. The Access to Work program (ATW) was set up in 1994 by the Placement, Assessment and Counselling teams (PACT) to give financial support to allow disabled people to work. The employers pay 20% of the cost of equipment needed and the ATW scheme pay the rest. The aim of the program is to provide support to overcome work-related obstacles resulting from a person’s disability, enabling disabled people to work equally with their non-disabled colleagues and encourage employers to recruit disabled people by offering practical and financial help (The Greater London Association of Disabled People, 1994 and Job Centre Plus 1994). However new figures show a big drop in the numbers of people receiving money from the ATW scheme since the new coalition government came into power. In 2010-11 there was a drop of 15% and 25% in 2011-12 (Pring, 2012).

For some disabled people it is not their impairment that is disabling it is the terminology used by members of society. People that use wheelchairs should not be seen as bound to them as if this is the case then able-bodied people could be seen as shoe-bound. Some wheelchair users can walk for short periods of time and lead a fulfilling life. Often people with disabilities begin to get known by their impairment for example people with dyslexia are called dyslexics. The person’s disability is not their most important feature and should not be used to describe them. Campaigners are now calling for the Government and media to watch their language when they speak about disabled people. Disability Rights UK believes that it is the language that the government and media uses which results in negative press coverage for disabled people, leading to discrimination (All Together Now, 2012).

A survey was carried out by the Grass Roots Group that showed many shops and businesses in the UK need to improve their services for disabled people (Employers Forum on Disability, 2001). Improvement has been made, however the research reveals that services still need improving. The research focused on fifty of the UKs top companies. It was undertaken by a group of mystery shoppers, they visited two hundred and eighty nine building societies, high street shops, supermarkets and telephone call centres. The team had a wide range of different disabilities from being blind to using a wheelchair. A group of non-disabled shoppers were used to compare the service they received. Four out of five companies visited could not provide standard forms of information in different formats other than written. 40% of wheelchair users had difficulty entering premises and forty 44% with mobility problems found that counters were too high. 70% of deaf people in the study said that customer service staff could not meet their needs. However eight out of 10 perceived staff to be confident in dealing with their needs. Lack of knowledge was a problem. Access to food retailers was harder than other places (Employers Forum on Disability, 2001). In 2010 a survey was carried out by the Office for National Statistics, this survey was called the Life Opportunities Survey, 18,000 people were asked to identify eight key areas of life with the most common ‘social barriers’. The results show that 19% of adults with some sort of impairments see ‘anxiety and lack of confidence’ as a barrier to employment, whereas only 4% for adults without impairments believe this (Guardian, 2010 and Office for National Statistics, 2010). Both of these studies highlight the difficulties faced by disabled people on a daily basis, the studies show that although steps have been made towards having a society accessible for everyone, this has not yet been reached. It shows that disabled people still face attitudinal and environmental barriers throughout their lives.

In today’s society technology is one of the major influences for improving access to employment and education for disabled people. Technology facilitates communication, such as voice output communication aids and text. Technology has been recognised for a long time as a potential way to help children with disabilities have the best opportunity for an extensive, vigorous, and socially engaged life (Johnstone, 2001). Technology has been used for children with disabilities for many years, were the focus was on strategies aimed at correcting a child's specific impairment. It could be argued that technology supported the medical model of disability as its main use was to ‘correct’ the person’s disability. Although disability support and the development of the social model of disability has expanded the use of technology to include a wide variety of that are seen to be necessary in optimising health, development, and social engagement for children and adults with disabilities, for example electric wheelchairs. Technologies have played a significant role in the premature diagnosis of potentially disabling conditions. Therapeutic interventions have also reduced the impact of disability in daily activities (Wise, 2012). Nevertheless as stated by Johnstone (2001, pp146), "No matter what sort of electronic or technological equipment is available it is only ever as good as the human support that lies behind it". Technology is an environmental tool to enable disabled people to lead a 'normal' life, however if attitudinal barriers still exist then disabled people will never feel fully integrated in society.

Legislation has been put in place to try and prevent discrimination faced by people with disabilities. Under the Disability Discrimination Act 1995 discrimination for a disabled person means being treated unfairly because of a person's disability (Disability Rights Commission, 2001). There are two types of discrimination. The first type is direct discrimination; this is when someone treats another person less favourably due to them having a certain characteristic. Indirect discrimination is when a policy or practice is put in place that seems to be equal for everyone however leads people to be treated less favourably to another person (University of Leads, 2012). The Disability Discrimination Act aims to end discrimination against disabled people. In the UK disabled people cannot be discriminated against in employment, access to goods and services, transport, insurance services and education. The Act was updated in 2005, one of the major changes was the definition used for disability. The 2005 changes included people who have Cancer, HIV infection or Multiple Sclerosis; they were now also seen to have a disability from the point of diagnosis, not from when the disease had a long term or adverse effect on their ability to carry out normal day to day activities. The Disability Equality Duty (DED) was also introduced by the Disability Discrimination Act which required public authorities to think about how their policies and practices affect disabled people. The Duty was set up in 2011 and has three main aims: eliminate discrimination, harassment and victimisation that have been made illegal by the Equality Act 2010, progress equality of opportunity between people from different groups and promote good relationships between people from different groups (Office for Disability Issues and Harris and Simon, 2010). The National Disability Council advises the government of issues relating to the elimination of discrimination (Johnstone, 2001)

In conclusion disability affects a large proportion of society. Through legislation and people’s attitudes to disability, the inequalities faced by disabled people could be stopped, however for this to happen all members of our society need to believe that opportunities available for disabled people and non-disabled should be equal. However even though extra resources such as the access to work scheme are available to disabled people, it does not make up for the fact discrimination, whether indirect or direct still takes place in the 21st century. For disabled people to feel fully integrated into society environmental barriers, such as access to public transport and attitudinal barriers, such as the type of vocabulary used to describe disabled people, need to be changed. People with disabilities are not usually ashamed of their disabilities; others should not feel uncomfortable living and working with them, or talking about disabilities in their presence.

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