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A Collaborative Model of Service Delivery for Individuals with Specific Learning Difficulties

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Abstract

This paper will discuss a collaborative, multidisciplinary approach to service delivery for young people and adults with specific learning difficulties. Influenced by research findings and a gap in service provision, the BUA service has been set up to provide screening, assessment, training and support to young people and adults with specific learning difficulties. The paper will consider the etiology of specific learning difficulties and current practices with particular reference to service provision and best practice models in the delivery of services. The paper will also discuss the BUA Centre's innovative approach with the Institute of Technology, Blanchardstown and the Dyscovery Centre, Wales in the areas of screening, assessment and training, and in developing best practice teaching methods.

The essence of education is becoming*, the gradual discovery of what it means to be human, the search for a personal identity, an identity which brings individual autonomy within a community structure (Ó Súilleabháin, 1986, p.91).*

Introduction

Above are the words expressed by the Irish educationalist, Professor Séamus Ó Súilleabháin (1986), which was used in The Task Force on Autism in 2001, to describe its approach to education. This paper will define specific learning difficulties (SPLDs), identify the etiology and prevalence of the difficulties, and discuss the existence of overlap. It will also look at the advantages and disadvantages of attaching labels to individuals. The current services for people with SPLDs will be described before moving on to look at the type of service that the National BUA Centre offers, which is a multi-disciplinary collaborative model of service for post 16-year-olds. The BUA Centre provides a range of assessment services for adolescents and adults from varying walks of life. The development of a unique screening tool is currently being developed and is being piloted in a range of different settings. The paper will then give some examples of collaborative projects that are currently taking place. A brief

description of a cross border project on specific learning difficulties between Ireland and Wales will be provided before concluding the paper.

Definitions and Etiology

In Ireland, the Disabilities Bill (2004) states that:

> *"special educational needs means, in relation to a person, a restriction in the capacity of the person to participate in and benefit from education on account of an enduring physical, sensory, mental health or learning disability, or any other condition which results in a person learning differently from a person without that condition and cognate expressions shall be construed accordingly"*

'This Act will have implications for' individuals with specific learning difficulties, 'as it includes those who learn differently. This Act, when activated, will have resource and funding implications for all educational services' (National Adult Literacy Agency, 2004).

The term "specific learning difficulties" (SPLDs) is commonly used to refer to Dyslexia. It is not always used to refer to other difficulties, which include:

- Dyspraxia (also known as Developmental Co-ordination Disorder (DCD)) – co-ordination difficulties
- Attention Deficit (Hyperactivity) Disorder (AD (H) D) – attention and concentration difficulties
- Asperger's Syndrome – social and communication difficulties

Individuals who have an SPLD have a specific difficulty in the way they process information which impacts on their ability to achieve their true potential. They learn differently which means that, often, the traditional teaching methods that are used in the classroom may not always work for these individuals.

The Irish Government Task Force on Dyslexia (2002) definition is as follows:

> ***Dyslexia*** *is manifested in a continuum of specific learning difficulties related to the acquisition of basic skills in reading, spelling and/or writing, such difficulties being unexplained in relation to an individual's other abilities and educational experiences. Dyslexia can be described at the neurological, cognitive and behavioural levels. It is typically characterised by inefficient information processing, including difficulties in phonological processing, working memory, rapid naming*

> *and automaticity of basic skills. Difficulties in organisation, sequencing and motor skills may also be present. (p.31)*

In recent years the genetic predisposition for reading difficulties has become increasingly clear. Although the first molecular genetic studies appeared in 1983, specific predisposing genes for dyslexia have not yet been isolated. However, several chromosomal regions have been intensively studied, particularly chromosomes 6, 1, 2, and 15 (Kirby & Kaplan, 2003).

At the BUA Centre, we find that many people still believe Dyslexia is only weakness and lack of ability, but such beliefs are unsubstantiated. "They are myths that have evolved as myths always do when a phenomenon is not well defined" (Fitzgibbon & O'Connor, 2002). As outlined in the definition above, dyslexia is a specific difficulty and it is not caused by lack of intelligence, laziness, or motivation. Dyslexia can cause difficulties in any one or more of the following, reading, spelling, writing, copying, organisation, time management, and direction among others. Often there can be other associated difficulties, which include underachievement, lack of self-esteem, withdrawal, dropping out, disruptive behaviour, bullying, and immaturity. Many adults have learned to hide their difficulties over the years, and have come up with some excellent strategies to overcome the barriers that they face in their everyday lives. If the right or appropriate supports are put in place for individuals with dyslexia, they will be able to succeed and indeed contribute to the success of any college or organisation.

The Report of the Task Force on Autism (2001), defines **Asperger's Syndrome**:

> Asperger's Syndrome *'shows the same kind of qualitative abnormalities of reciprocal social interaction as autistic disorder does with a restricted, stereotyped, repetitive repertoire of interests and activities. In international diagnostic terms, the main difference from autistic disorder has been that there is no clinically significant delay or retardation in cognitive development or in language acquisition (DSM-IV-TR* - an American diagnostic tool that is widely used internationally as a benchmark for specific difficulties). *More importantly, persons with AS have communication difficulties (regardless of structural language skill). The pragmatic aspects of their language are affected, as are all of the paralinguistic features of gestures, facial expressions, intonation meaning and even personal space regulation.*

The difficulties described above affect socialisation of the individual in all situations and result in him or her lacking adaptability and flexibility, especially in new situations. There have been many theories over the years to explain the cause of Asperger's syndrome. One such theory is based on the notion that the male brain is significantly better at systematising than at empathising, whereas the female brain has the opposite cognitive profile. Simon-Baron Cohen (1999) refers to Asperger's syndrome as being an extreme of the normal male brain. Although there is evidence for genetic factors playing a part in Asperger's syndrome, family studies have suggested that the expression and penetrance of the phenotype are variable. However, when examined along with autism and the autistic spectrum, Asperger's syndrome appears in the same families (Kirby & Kaplan, 2003).

The Irish association, HADD (Hyperactivity Attention Deficit Disorder) Family Support Group, **AD(H)D (Attention Deficit Hyperactivity Disorder)** is defined:

> *as a neurobiological disability. It is characterised by inappropriate degrees of inattention, impulsivity and sometimes hyperactivity. (p.2)*

The label for this behavioural syndrome has varied enormously through the ages. The current label from the American Psychiatric Association DSM-IV is ADHD, although the public often continue to use the term ADD. The DSM-IV specifies three subtypes of ADHD:

- Primarily inattentive
- Hyperactive-impulsive
- Combined inattentive and hyperactive-impulsive

ADHD is part of a spectrum of SPLDs. There is no correlation between ADHD and intelligence, and IQ is normally distributed in individuals with ADHD. Memory is not weak in individuals with ADHD. If people with ADHD attend to information, then they can remember it just as well as others do.

ADHD appears to run in families. Strong evidence of genetic involvement has been derived from twin and adoption studies, in which about 50% of parents who themselves had ADHD have a child with the disorder, and 10-35% of children with ADHD have a first-degree relative with ADHD. Although there have been no individual predisposing genes identified for ADHD, molecular genetic studies have focused on chromosomal regions associated with dopamine pathways in the brain (Kirby & Kaplan, 2003). Most symptoms of children with ADHD tend to improve with age, perhaps simply because people learn coping skills, and direct themselves into fields where their attention problems are less of an obstacle. Research

indicates that from 50-80% of children diagnosed with ADHD continue to experience symptoms into adulthood. For many adults with ADHD, as they get older the signs of hyperactivity diminish and they are left with the attention, concentration and organisational difficulties (Kirby & Drew, 2003)

The DSM-IV outlines the diagnostic features of **Developmental Coordination Disorder** as follows:

- **(Criterion A)** A marked impairment in the development of motor coordination.
- **(Criterion B)** The diagnosis is made only if this impairment significantly interferes with academic achievement or activities of daily living.
- **(Criterion C)** The diagnosis is made if the coordination difficulties are not due to a general medical condition (e.g. cerebral palsy, hemiplegia, or muscular dystrophy) and the criteria are not met for Pervasive Developmental Disorder.
- **(Criterion D)** If mental retardation is present, the motor difficulties are in excess of those usually associated with it.

This means that individuals with DCD will have coordination difficulties, which can manifest itself in many activities of daily living. The most typical difficulties identified are with the following: dressing, eating, doing activities under time pressure, riding a bike, and driving a car. In the school or college setting, the most typical problems mentioned include: writing (either copying from the board or taking notes dictated by the teacher), using scissors, and team sports. Many individuals with DCD have insight into their difficulties and feel frustrated at their inability to do tasks that others take for granted. The activities that many of us take for granted require large amounts of attentional resources from an individual with DCD. This often leads to a misdiagnosis of the individual's difficulties. In the past people have been labelled as having ADHD when in fact they had coordination difficulties. Other children were labelled as being disruptive in class when the real issue was that they were unable to hold their attention on a task for the same length of time as another chid in the same class.

The underlying etiology for motor coordination difficulties is not known, although some children who are given the label of DCD may have a neuromuscular or hypotonic problem, and/or a myotonic, myopathic or connective tissue disorder (Kirby & Kaplan, 2003)

Having looked at the various definitions and etiology of specific learning difficulties, the paper will now describe the prevalence of each of these difficulties.

Prevalence of specific learning difficulties

The Dyslexia Association of Ireland estimates that, while no conclusive research has been carried out in Ireland to determine how prevalent dyslexia is, studies in other countries would suggest that 6% to 8% of the population are likely to be affected. The British Dyslexia Association (BDA) in 1989 estimated that there were 10% (4% severe and 6% mild to moderate) of children who have some degree of dyslexia. Some reports suggest that up to four times as many boys as girls are dyslexic. This ratio is questionable, as more recent research appears to suggest that this may be because of the method of referral; for example, when failing, boys tend to be more disruptive in class, and therefore are recognised as needing support from the learning support teacher or psychologist. Asperger's syndrome occurs in approximately 4 per 1000 population, affecting at least four times as many boys as girls. ADHD is one of the most common neurodevelopmental disorders, affecting 3-5% of school-age children. At least three times as many boys as girls are affected, and in clinically referred samples the ratio is often as high as 6:1. 'Developmental Coordination Disorder is a common condition, present in about 5% of school-age children, though a recent comprehensive study suggests that moderate-to-severe DCD may be present in over 7% of 7-year-olds, with a boy: girl ratio of 5.3:1' (Kadesjo & Gillberg, 1998). In considering the type of support required, individuals are often labelled artificially and are placed in a convenient 'box' in order for services to be delivered. It is important to recognise that the functional difficulties seen may commonly overlap for many different conditions.

Overlap

There is evidence to suggest that there is considerable overlap between each of the specific learning difficulties outlined above (Kirby & Kaplan 2003). Too often in Ireland individuals with SPLDs are passed from one organisation to another in order to acquire the help they need, and even still they do not receive the appropriate support. This can take considerable time, energy, and conviction from the individual.

Gillberg's (1998) research alerts us to the fact that conditions on the continuum of specific learning disabilities are more likely to co-exist as the norm with much lower numbers existing with only one label than previously thought. This makes the possibility of a singular diagnosis even more complex. Gillberg states that 50% of those with DCD have ADHD and 87% of children with ADHD have one additional DSM-IV diagnosis with 67% with two. Kirby & Kaplan (2003) report on a population study which showed that 23% of children showed signs of DCD, 8% met the criteria for ADHD, and 19% were categorised as dyslexic.

Nearly 25% of the affected children were found to have all three, while 10% had both ADHD and DCD, and 22% had dyslexia and DCD. Kaplan et al. (1998) sums up this overlap by saying that "co-morbidity (a medical term for overlap) is the rule rather than the exception". Given the diagnostic overlap in SPLDs it would seem important that services be delivered in a model that addresses all of the specific learning disabilities. Research indicates that the numbers of adults exhibiting symptoms that could be attributable to any one diagnosis under the SPLDs umbrella are very small. The SPLD norm is more likely to be that people have a cluster of characteristics with considerable overlap between conditions. Therefore, identification under one heading may lead to other needs not being met.

Labelling

The use of diagnostic labels to characterise a person makes many people uncomfortable. In relation to funding, however, labelling has become a necessity and can be beneficial. For adults in particular, a label often provides a certain amount of relief and allows that person to give an explanation as to why they underachieved in education in the past. A diagnostic label allows for the acknowledgment for some parents that there is a genuine reason for their worries and concerns. It can assist others who work with the individual to focus on the appropriate type of intervention.

On the other hand, labels can be quite harmful, especially for children. Some people may have preconceived ideas about a particular disorder based on their previous experiences of others with the same label, such as a child with ADHD who may have been seen as a difficult child rather than a child with difficulties. Labelling can be particularly harmful if the wrong label is given, or if a person 'views this label as a stigma for life that implies a disability rather than a difficulty that can improve' (Kirby & Kaplan, 2003).

In view of the disadvantages of labelling, and because people do not fit neatly into boxes, people would be better served if we abandoned diagnostic labels and instead provided functional descriptions of a person's strengths and weaknesses. This would probably give parents and others more support in knowing how they can support the individual with their difficulties, for example see table (Kirby & Kaplan, 2003) below:

Examples of diagnostic and functional labels for specific learning difficulties

Diagnostic Label	Functional label
DCD	Difficulty with ball skills, handwriting, dressing, organisation
ADHD	Difficulty staying on task, impulsive behaviour
Dyslexia	Spelling, reading, writing, organisation, time management difficulties
Asperger's syndrome	Difficulty with social relationships, literal interpretation of words and phrases

The labelling debate will continue and there are certainly very good reasons to look at both sides of the argument. Henderson & Barnett (1998) suggest that in spite of recent attempts to standardise the terminology used, variation continues to compromise inter-professional communication and interpretation of research. There seems to have been little change in this since Dewey (1995) spoke about the lack of consensus in relation to developmental dyspraxia in both its definition and description.

Services for people with SPLDs

Services in Ireland in relation to SPLDs have generally been provided and developed by the voluntary sector. Services have almost entirely been in respect of children and there has been little if no provision for adolescents / adults in this area. Services for children are still in the process of development with long waiting lists, huge variability based on geographical location and little integration of service delivery. It has long been thought that children with SPLDs grow out of these difficulties, as they get older. Unfortunately, this is not the case. They still remain to have difficulties but the types of difficulties may change as they move from one educational level to the next.

In recent years there has been an increased recognition of SPLDs in children by health, educational professionals and parents in Ireland. However there remain significant barriers to delivery for appropriate support. Some of the barriers include lack of determination of the specific difficulties, long waits for any support, shortages of professionally trained staff and lack of interdisciplinary communication. In addition to this, there is no central key worker to work with the individual themselves, the family, educators, and vocational supports through a system that straddles different services and uses different terminology. Service provision - if available at all - often varies from place to place magnifying the problems further.

In the past many individuals with Dyslexia, Dyspraxia, (also known as Developmental Co-ordination Disorder), ADHD and Asperger's Syndrome were not recognised as requiring support into adulthood. These conditions affect both children and adults in their activities of daily living and often result in serious barriers to their full integration into society if not recognised and appropriately supported. In addition the labels are used inconsistently by professionals, and this can cause a great deal of confusion, misunderstanding and frustration to both individuals diagnosed, parents and indeed amongst professionals themselves.

While some services exist for adults diagnosed with or seeking assessment in relation to dyslexia, there are currently no services in existence for adults with Dyspraxia (DCD) in particular and little available to those with ADHD and Asperger's Syndrome. In relation to the area of dyslexia, a small number of adults are catered for in specialised adult training. Private assessments are also available through the Dyslexia Association of Ireland.

The National BUA Centre

The National Training and Development Institute (NTDI) has been aware for a long time that there is a gap in service provision for adolescents and adults over the age of 16 years who have specific learning difficulties. Many individuals who train with NTDI encounter difficulties progressing to further education, training, or employment within a mainstream setting because of their specific learning difficulties and the lack of services to cater for their needs. The Institute of Technology Blanchardstown (ITB) encountered similar difficulties in the past, with regards to providing comprehensive services to students with specific learning difficulties who attend courses there.

The National BUA Centre represents the realisation of a long desired goal. Discussions between the Chief Executive Officer of the National Training and Development Institute and the Director of The Institute of Technology, Blanchardstown began three years ago. These discussions took on a tighter and more coherent focus when the Dyscovery Centre Cardiff joined the partnership, with the shared aim of providing a comprehensive and effective service for individuals with SPLDs.

A core staff comprising a Project Coordinator and part-time Administrator moved into premises on The Blanchardstown Campus in May 2003. An interdisciplinary team was sourced, initially on a part-time basis and a full-time Trainee Educational Psychologist joined the staff in August 2003. The appointment of an Educational Support Officer/Dyslexia Tutor has now been formalised so that students entering the college can gain access to

specialist supports immediately after they are identified, rather than waiting for funding approval, which can take a full term, as currently happens in many colleges. The BUA team therefore is made up of a project coordinator, two part-time administrators, an educational psychologist (trainee), an occupational therapist, a speech and language therapist, a medical director, and a clinical manager. All members of the team assess the individuals in order to identify their strengths and areas of difficulty. They then provide practical advice and strategies, which will help the individual to reduce their difficulties and improve their life skills. Where appropriate, blocks of intervention/treatment may be offered in order to give additional and on going help and guidance.

An essential component of the development of the BUA service has been relationship building between mainstream and specialist education providers. The main objectives of this relationship between NTDI and the Institute of Technology, Blanchardstown are:

- To support individual students
- To raise awareness and to support staff in pursuit of the above
- To raise awareness and create a positive ethos towards students with disabilities.

This type of collaboration between a mainstream and a specialist provider is somewhat unique in Ireland and aspires to operate more and more closely within the capacity building model as the service continues to develop.

The BUA Centre aims to create a much-needed model for adults with specific processing issues that involves the individual fully in the process and will, it is hoped, be a more acceptable future vehicle for funding applications. BUA is a centre with expertise in Specific Learning Difficulties for individuals with living and learning difficulties such as: Development Co-ordination Disorder, Dyspraxia, Dyslexia, Attention Deficit Hyperactivity Disorder and Asperger's Syndrome. Individuals may have difficulties in some or several of the following areas:
Reading, Spelling, Handwriting, Study skills, Concentration, Time management, Self-organisation, Prioritising and organising workload, Co-ordination, Social skills and communication, Personal care, Domestic tasks, and Budgeting.

The BUA Centre provides specialist and high quality services, which are tailor-made to suit individual and/or organisational requirements. The approach is very practical and helps people reduce the difficulties they experience in carrying out everyday living tasks, whether

they are home, work or social and communication difficulties. The range of services offered include:

- Assessment / Support
- Transition Planning
- Consultation
- Training

Assessment / Support

The assessment may or may not lead to a diagnosis. However during the assessment a detailed profile of the individual's strengths and weaknesses is built up. Practical, functional solutions, advice and strategies that will help them to improve their living and learning skills are then given and explored.

Transition Planning

Transition planning assists the young person with their move from secondary school to further education or employment, or from further education into the workplace. Practical strategies for planning and dealing with the difficulties encountered are discussed and explored with the individual and their family.

Consultation

This service is offered to meet the needs of those who may have been seen by other professionals in the past and require an opportunity to discuss learning or living problems further.

Training

The Centre offers seminars, as well as tailor-made training and in-service days for employers, educational institutions and health professionals on a variety of topics, e.g. identification and support of individuals with Dyslexia, Dyspraxia, Asperger's Syndrome and Attention Deficit Disorder.

Screening and screening tools

Currently there is no universal system for assessing all individuals for potential difficulties as they enter into training, Further Education (FE) or Higher Education (HE) Colleges.

Individuals may present in four main ways:

- They have already identified difficulties and may have a "label"
- They may think they have problems and want them identified
- They start in the training setting and then others identify they have difficulties
- They start in the training and then they find they are having difficulties

In FE and HE colleges and universities student services may provide a support structure. However obtaining assessments can take time because of a shortage of suitably qualified professionals to undertake the assessments that are required. Until recently these assessments have only looked at the area of Dyslexia and not at the other specific learning difficulties.

Is screening a valuable process?

If suitable support should be put in place an initial screening tool could offer a baseline of information for both the tutor and the student to allow them to have an opportunity to see where strengths and difficulties lie.

There are already computerised screening tools in existence such as ***QuickScan,*** which generates a report highlighting the individual clients' learning style. ***The Dyslexia Adult Screening Test*** offers a batch of sub-tests, which will test possible areas of weakness but is restricted to delivery by trained teachers only. ***The Bangor Dyslexia Test*** runs on a similar vein to DAST. It is a simpler version and requires a teacher with some training for delivery. ***Lucid Adult Dyslexia Screening*** (LADS) tests phonological processing, working memory and lexical access. However none look across all the specific learning difficulties and can be self-administered and the response tailored to the setting (Kirby, 2004).

> *'The Dyscovery Centre has developed an innovative screening tool to identify individuals who may be " at risk" of having difficulties in a training or employment situation and has been developed for post 16 years. It is a computerised programme, which can be used on large numbers of individuals to recognise where difficulties may be occurring and allows guidance for the individual or can be used for planning services within a setting to make sure that all students are having their needs best met.*
>
> *Once screening has been completed looking across all developmental areas, then those individuals requiring a more in depth assessment are offered this service. This one stop screening is potentially both more cost and time effective. This only*

identifies individuals that have been "missed "in their school days. Obviously the best route would be screening at transition points such as school entry and also when starting in secondary school in a way that doesn't make the person feel that they are somehow "lacking" or different in a way that effects their confidence. The child may not have been identified earlier because his needs may have been partially met and it is only when he or she starts to flounder once in a larger school with greater expectation on him or her such as writing at speed, playing sports, and greater need for self organisation that he "tips over" and begins to have problems.

There may also be a need to screen at other stages in life as well, where the adult enters a different type of setting such as into the workplace, or in training settings to identify the type of support required' (Gunne et al. 2003).

Referrals to BUA

There are three referral routes at the BUA Centre, ITB students, NTDI trainees, and a private referral service for anyone over the age of 16 years. In each situation the student meets with a member of the BUA Centre team. This is the initial consultation where information is gathered through a semi-structured interview with the individual. This information usually includes the person's medical, educational, and social and communication history. This gives the BUA staff member a chance to build up a rapport with the individual. When the information is gathered, the clinical team at BUA evaluate the information and decide on the most appropriate type of assessment that will be of the utmost benefit to the person in question. This might be a full psychological assessment, a speech & language assessment, or an occupational therapy assessment. In some cases it might be a multi-disciplinary assessment.

In each individual case, the team focuses on the functional difficulties that the person is experiencing rather than simply attaching a label. What is it that the individual cannot do and what can be done to help the person overcome some of the barriers that they face in their everyday lives whether at home, in college, at work etc? However, in some situations a label is required in order to access funding from the Department of Education & Science.

At ITB students are referred to BUA through a number of different ways:

1. Through the Access Office at ITB
2. Students drop into BUA themselves suspecting that they have a learning difficulty
3. Lecturers can advise students to call into the BUA Centre when they feel that a particular student is not achieving their full potential.

After an assessment, relevant information is passed onto the lecturers so that they can make learning a more enjoyable experience for the student.

NTDI trainees are referred to the BUA Centre through their Regional Psychologist. After the assessment, information and practical recommendations are provided for the resource teachers and instructors who are working with that individual.

Individuals who make enquiries through the private service are sent information about the BUA Centre along with questionnaires. Having read this information she or he may wish to access the service. The centre aims to obtain an accurate and comprehensive picture of an individual, their difficulties and their strengths in a range of settings. Once the questionnaires and supporting documentation are received the team will discuss the information and identify the most appropriate service, which will meet the individual's needs. A team member will then contact the person making the referral to discuss the service being recommended.

With regard to each of the three types of referrals outlined above, all assessments are conducted in a sensitive and client-focused manner and every effort is made to help the individual feel at ease. Generally an assessment at the Centre, per team member may take up to two hours depending on the needs of the individual. The experience may be tiring and some people find it difficult to absorb and retain the information during and after the appointment. Following the appointment a comprehensive report is produced that summarises the assessment findings and outlines practical advice, strategies, and useful information that can help the individual to reduce their difficulties and to improve their living and learning skills.

Collaborative work between BUA & ITB

Collaboration across a variety of disciplines offers potential for new thinking and innovative approaches. Having an interdisciplinary team means that the service user can benefit from a range of skills, knowledge, training and experience of the members of that team. 'People with disabilities should expect nothing less than the highest level of skill and experience from the team. Consequently it should be considered a core function of collaborative teams to build upon the experience of "all" staff members in order to assure that services are delivered with an increasing level of quality, skill and expertise (Sax, Duffin, & Boyle, 2003).

An important policy that BUA has adopted since it opened in August 2003, is that it takes an inclusive approach to education. Members of the BUA team have always been particular about the language they use in reports about individual people. Many different terms and phrases have been used to describe people's difficulties in the past, and most of these have had very negative connotations to them. More recently, the terms 'disability' and 'special needs' have been used to describe people. However, these types of terms direct the focus towards the person rather than towards professional practices or organisational structures. No matter how many times the language has changed over the past hundreds of years '*the focus of attention remains fixed on the particularities of the individual's body or mind rather than on the marginalising and exclusionary practices and structures of society'* (Mc Donnell, 2003).

> *'By defining pupils in terms of 'given' problems, educationalists are then predisposed to regard educational development as having definite limits with certain kinds of pupils. The search for solutions is focused on individual deficits rather than on inequitable social structures'* (Drudy & Lynch, 1993, 59)

Since the BUA Centre opened on the ITB campus in August 2003, it has been working in close collaboration with ITB staff including the academic staff, the Access Officer, and the administration staff. Training sessions are held at regular intervals throughout the academic year. The training depends on requests from particular staff members, for example, 'Dyslexia in the Classroom' or 'Assistive Technology', but the focus is on how the teacher can adapt their teaching styles to meet the needs of each individual learner in the class. From time to time academic staff seek advice from BUA about particular issues that arise within their lectures in relation to students with reading, spelling, writing, language, or communication difficulties among many others. The advice provided by BUA is always one of inclusion. For example, if one student has difficulty taking notes in a lecture, then it is important that he or she is provided with copies of each lecturer's notes in advance of the lecture. But why not provide notes for every student in the class so that no one student stands out as being 'different'. Corbett (2001) asks the question, 'is there a pedagogy for inclusion? If there is, then it needs to be one that connects with the individual learner and their own way of learning, and that then can connect them into the curriculum'. When Lewis & Norwich (2000) investigated the commonality and differentiation of pedagogy for children with learning difficulties, they concluded that what works with most pupils would also work with all pupils.

In light of the above, the Apprentice tutors in particular were very interested in this approach to teaching and learning and requested the BUA team to work collaboratively with them in endeavouring to develop a best practice teaching model within their department.

The Apprentice School in ITB takes on apprentices in carpentry, electrical, brick and stone and plumbing for Phase 4 of their apprenticeship. There are 32 apprentices in each trade and they are only at ITB for 10 weeks. Through interviews and screening of these apprentices, it was acknowledged that many of them had had negative experiences in their previous education. They reported that they did not like the classroom environment and they were not looking forward to being back in a classroom situation for 7 hours each day for 10 weeks. The tutors also find it difficult to motivate the students to learn, and to support students who have particular difficulties in relation to literacy and numeracy. The tutors also expressed concern about getting the course covered in time so that the apprentices are able to sit their exams at the end of the 10 weeks.

Ways of dealing with the above issues are currently being explored between the staff at BUA and the teaching staff of the Apprentice School. This collaborative project is ongoing and there will be a report on the outcome of it at the end of 2005.

Three important questions that are being looked at with the tutors are:

1. How are the learners connected into the curriculum?
2. What strategies are used to ensure that each student learns in a meaningful way?
3. What kind of knowledge or learning is examined at the end of the ten weeks?

Corbett (2001) discussed a case study of a particular school in Tower Hamlets, East London, which had been working at inclusion for about 15 years and has been hugely successful in achieving it's goals. Corbett (2001) talks about the negativity around the issue of inclusion. People are always able to give reasons to explain why inclusion could/would not work, for example, teacher apathy, curriculum rigidity, a competitive market, parental prejudices, shortage of staffing, limited resources, among others. After exploring the school culture, policies and practice, Corbett concludes that there is no great mystery to having an inclusive school. It is all about a shared vision by the school/college team (teachers/tutors/lecturers, students etc.), enthusiastic leadership by committed, experienced and skilled teachers and heads of schools, appropriate levels of resourcing, and an openness to learning new skills and trying out whatever strategies seem useful. Corbett goes on to say that 'an effectively inclusive school can be assessed through comparing the levels of achievement of its learners

with those in comparable schools. In relation to the Apprentice School in ITB, this comparison could be made with other IT colleges who have Phase 4 apprentices attending them. In Corbett's case study school, the average levels of achievement in National Curriculum tests by 11 year-olds showed performance in English below average (D) compared with all schools, but well above average (A) compared with similar schools. Similar results were found with other subjects including Maths and Science. These results are true indicators of the value of inclusive teaching, and there is no reason why this approach would not work in other educational institutions.

Partnership

The partnership, which has been mentioned above, between NTDI, ITB and the Dyscovery Centre teamed together to write a proposal for EU funding, an INTERREG funded project. The agreed name of this project became known as P.A.C.T.S. (Partners Collaborating in Training for Individuals with Specific Learning Difficulties). The PACTS Project has partners from Ireland and Wales. The partners have come together to provide a strong partnership to look at ways of supporting adults with specific learning difficulties and those working with them in the East of Ireland and West Wales areas. In Ireland the Institute of Technology Blanchardstown in Dublin, The BUA Centre, are leading the project. In Wales the Dyscovery Trust is the lead partner.

The aim of the project is to empower individuals with Specific Learning Difficulties, who are increasingly disenfranchised in a society which is ever more dependent on literacy and numeracy, to achieve their potential. This project will increase access to third level education for individuals who may have conditions, which preclude them from achieving their goals academically. The project will focus on developing linkages between Ireland and Wales to build expertise and encourage the transfer of knowledge through joint collaboration.

Specifically, the project aims to ensure the provision of an assessment, remediation and support service for individuals with Specific Learning Difficulties in the designated areas in Ireland and Wales, to assist them in achieving their potential in mainstream education, training and employment settings.

Conclusion

The paper has looked at what the term, specific learning difficulties, means, and how different people have described the different labels that come under this umbrella term. The etiology and prevalence of the conditions were examined which led to discussions around the

impact of labelling, and the fact that there are huge numbers of individuals who have overlapping conditions. People do not fit neatly into boxes and therefore it is important to look at the diagnostic label, but more importantly to look at the functional difficulties that the person is experiencing. In this way the most appropriate remediation and supports can be provided for the individual. With all of these factors in mind the paper goes on to look at how services have developed in Ireland, and in particular the National BUA Centre. The centre provides an inclusive multi-disciplinary approach to education and the living and learning skills of people. It is currently involved in a number of projects and aspires to continue working in this manner. The aim is to continue building its services in a way that respects every individual. The emphasis is on listening to and valuing what people have to say, which is a fundamental aspect of an inclusive model. As Mittler (2000) says,

> *'Inclusion is about everyone having opportunities for choice and self-determination. In education, it means listening to and valuing what children (and adults) have to say,* regardless of age or labels'.

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