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Empowering teachers

Teacher Induction Programme

Module 10: Dealing with diverse students (students with diverse needs)

https://empowering-teachers.eu/

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Date

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EMPOWERING TEACHERS PERSONAL, PROFESSIONAL AND SOCIAL CONTINUOUS DEVELOPMENT THROUGH INNOVATIVE PEER - INDUCTION PROGRAMMES

Dealing with diverse students (students with diverse needs)

A. What is the main idea/goal/objective of this module?

The main objective of this module is to familiarize the nqts with all the main categories of students with diverse needs that may be found among a school population, as well as to make them aware about their specialized needs. In addition, various ways are presented in order to support teachers and the school as a whole in responding effectively to these needs.

B. Expected learning outcomes:

By the end of this module, NQT(s) and mentor(s) will be able to:

- Name the basic categories of students with diverse needs that might be found among a school population
- Become aware about the basic characteristics and needs of their students with diverse needs
- Make appropriate adjustments in their professional practices so as to fulfil the needs of their students with diverse needs
- Identify potential resources of expertise both within and outside the school community for seeking for relevant advice and guidance.

C. Activities, presentations, and other materials included in the module:

ELEMENT	Target audience	Type of resource	Time for resource	Area
10.1 A teacher's self-reflection tool about diversity	NQT	Questionnaire	30 min	Pedagogical/Didactical
10.2 National/regional framework for diverse students	NQT	List	1,5 hours	Bureaucratic/Administrative
10.3 Recognising the main categories of students with special needs among your students	NQT	List with extensive brief presentations	1 hour	Pedagogical/Didactical
10.4 Guide for mentor discussion	Mentor	Guide	1 hour	Pedagogical/Didactical

10.1 A teacher's self-reflection tool about diversity is a questionnaire that offers a departure point into a self-reflection about the awareness and accustomedness as well as aptness in dealing with diversity. It prompts a summarised view based on a series of Likert scale questions.

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10.2 National/regional framework for diverse students is a compilation of legal and other administrative regulations concerning students with special needs.

10.3 Recognising the main categories of students with special needs among your students is an extensive list of a broad array of potential special needs among students. This list details some basic characteristics and refers to a site of a previously funded EU project that in addition to definitions offers also concrete suggestions for proper adaptations and accommodations for these students.

10.4 Guide for mentor discussion is the core of this module and offers the mentor some guidelines for the organisation of a discussion about the realities of the specific local environment of the NQT.

D. Suggestion for the implementation of the module

First, the NQT should fill in the self-reflection questionnaire (10.1) on diversity at school. On the basis of their answers to the questionnaire, the NQT is required to write a short paragraph summarizing and reflecting upon their conclusions in relation to themselves (as persons), their classes, their instruction and their school.

The main activity in this module should be the discussion of the NQT and the mentor. If possible in this case the mentor can organize a group discussion with the participation of the NQT, the school leader, colleagues (teachers or other staff) in the school who have worked in the past with either the same students or students with similar needs and the parents of these students. The purpose of this discussion is for the nqts to devise a realistic action plan for dealing with the needs of diverse students after consulting other experienced colleagues, potential external experts, and the parents of these students. Preferably, this discussion can be conducted in person with all the participants present but alternatively, or if this is not possible, parts of it could be conducted separately with some of the participants either in person or by phone, email, skype, etc. Mentor can use the guide in 10.4 as help in organising the debate.

If possible and appropriate personal aptitudes based on the questionnaire (10.1) can be discussed at the joint discussion, otherwise it would be prudent to hold a 1:1 session prior to the group debate just between the mentor and the NQT. In that discussion they can refer to the questionnaire (10.1), the mentor can present the relevant legal and programme documents pertaining to the area (10.2), and the mentor and the NQT could go through the list of different types of special needs (10.3) as a departure point to talk concretely about specific students that will require NQT's immediate attention.

Alternatively, the NQT can read through the presentation of the main categories of diverse students with a brief presentation of their characteristics independently, focusing more on the categories of students existing in their classes. Both NQT and mentor are invited to read carefully the material included in the i-decide toolkit referenced in *A useful link* below. As a result, they will be able to identify specific ideas either to be readily implemented in the school or specifically in some classes that would require it.

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E. A useful link

Visit the website of the European funded project i-Decide which aimed at providing school directors and teachers with material and ideas for making their schools more inclusive. The project provides teachers and school leaders with practical tips and supportive literature about the characteristics of marginalized pupils. The toolkit focuses on 23 certain categories of decision, which in turn, influence marginalized school populations. While developing the toolkit, 13 broad categories of marginalized populations have been identified and based on them, concrete recommendations have been developed to enable the school staff to give voice to all stakeholders. The toolkit is available in Greek, English, Portuguese and Romanian and is available at: https://www.idecide-project.eu/index.php/en/toolkit/download-the-toolkit

10.1 A TEACHERS' SELF-REFLECTION TOOL ABOUT DIVERSITY

On the ground of their answers to the questions below, the ntqs are required to write a short paragraph summarizing and reflecting upon their conclusions in relation to themselves, their classes, their instruction, and their school. This can be used also in the mentor discussion later in the implementation of the module.

Indicate the level of your agreement to the following statements:
To what extent do you agree with the statement?
1 = Strongly disagree
2 = Disagree
3 = Neither agree not disagree
4 = Agree
5 = Strongly agree

About me

1. I am aware of the assumptions that I hold about people of cultures and groups different from my own.
2. I am aware of how my identity and cultural perspective influence my judgment.
3. I recognize there is diversity **between groups** of individuals based on gender identity, religion, race, ethnicity, language, abilities, sexual orientation, socioeconomic status, etc.
4. I recognize there is diversity **within groups** of individuals with the same gender identity, religion, race, ethnicity, language, abilities, sexual orientation, socioeconomic status, etc.
5. In my own life, I model **respect** for people who are different from me in gender identity, religion, race, ethnicity, language, abilities, sexual orientation, socioeconomic status, etc.
6. In my own life, I model **inclusion** of people who are different from me in gender identity, religion, race, ethnicity, language, abilities, sexual orientation, socioeconomic status, etc.

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7. I take opportunities to put myself in places or situations where I can learn about differences and create new relationships.

About my students and my classroom

8. I am knowledgeable about the diverse **backgrounds** (gender identity, religion, race, ethnicity, language, abilities, sexual orientation, socioeconomic status, etc.) Of my students and their families.
9. I am knowledgeable about the diverse **interests** (gender identity, religion, race, ethnicity, language, abilities, sexual orientation, socioeconomic status, etc.) Of my students and their families.
10. I am careful not to prejudge a student's performance based on cultural or identity differences.
11. I actively facilitate community building in my classroom.
12. My students know each other's names, backgrounds, and interests.
13. My students feel comfortable being themselves in my classroom.
14. My students share personal examples reflective of their **differing backgrounds** in the classroom.
15. My students share personal examples reflective of their differing **interests** in the classroom.
16. I **recognize** conflicts based on differences between individuals and groups.
17. I **constructively address** conflicts based on differences between individuals and groups.
18. I **recognize** how my power and privilege as a teacher impacts my relationships with students of differing backgrounds and identities.

About my curriculum and instruction

19. My classroom materials are inclusive, diverse, and non-stereotypical.
20. I provide opportunities for students to connect concepts of my subject to diversity issues of **local concern**.
21. I provide opportunities for students to connect concepts of my subject to diversity issues of **global concern**.
22. I ensure that classroom responsibilities, activities, and interactions are **inclusive** (e.g., an equitable system for calling on students; gender neutral language).
23. I **respect** diverse behaviors, values, communication styles, and languages in my classroom.
24. The materials I use in class are accessible and appropriate for students with **varying physical disabilities**.
25. I prepare students for future environments that may be different from their current experiences (e.g., college, work).
26. When attempting controversial or sensitive diversity-related lessons and things get uncomfortable, I **persevere**.

About my school

27. I am aware of my school community's diversity.
28. My school celebrates diversity.
29. My school supports diversity in:
Public spaces

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Programs, committees, and student groups
Support services
30. My school policies (e.g., scheduling, and/or prerequisites) disproportionately negatively impact students of differing backgrounds and identities.
31. The membership of the parent groups (e.g., Parent Teacher Association – PTA or Parent Teacher Organization-PTO) reflect the demographics of the school community.
32. My school is open to feedback from families to share insights and experiences related to diversity concerns.

Adapted from:
Https://www.apa.org/ed/precollege/topss/considering-diversity/considering-diversity-tool

10.2 NATIONAL/REGIONAL FRAMEWORK FOR DIVERSE STUDENTS

In translation please list the relevant legal and programme documents that the nqts should be aware of.

10.3 RECOGNIZING THE MAIN CATEGORIES OF STUDENTS WITH DIVERSE NEEDS AMONG YOUR STUDENTS

Category	Subcategory	Brief description
Religious minorities		A minority religion is a religion held by a minority of the population of a country, state, or region. Minority religions may be subject to stigma or discrimination. People who belong to a minority religion may be subject to discrimination and prejudice, especially when the religious differences correlate with ethnic differences.
Roma pupils, Travelling community		The Council of Europe uses 'Roma' as an umbrella term. It refers to Roma, Sinti, Kale and related groups in Europe, including Travelers and Eastern groups (Dom and Lom), and covers the wide diversity of the groups concerned, including persons who identify themselves as Gypsies. Many Roma live in overwhelmingly poor conditions on the margins of society, and face extreme levels of racism, discrimination and social exclusion, even in their daily lives.
Intellectual Disabilities	Cognitive Functioning	Deficits in cognitive functioning and learning characteristics of individuals with intellectual disabilities include poor memory, slow learning rates, attention problems, difficulty in capitalizing what they have learned, and lack of motivation (Heward, 2013)
	Adaptive Behaviour	Adaptive behavior is the collection of conceptual, social, and practical skills that all people learn in order to function in their daily lives (https://aaidd.org). By definition, children with intellectual disabilities have substantial deficits in adaptive behaviour. In particular, children with adaptive behaviour tend to have deficits in the following skills areas: **Conceptual skills**, such as planning and behaviour and the use of abstract concepts; **Social skills**, such as overall behaviour, feelings about themselves, understanding others, solving problems, other people's influence, following rules and obeying the law and **Practical skills** including managing home and personal care, managing money, using the telephone, getting from place to place, staying safe and healthy, following schedules and routines, and maintaining a work life. These limitations can take many forms and tend to occur across domains of functioning. Limitations in self-care skills and social relationships as well as behavioural excesses are common characteristics of individuals with intellectual disabilities. Individuals with intellectual disabilities who require extensive support must often be taught basic self-care skills such as dressing, eating, and hygiene.

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		[Adapted from: Heward, W. L. (2013). Exceptional children: An introduction to special education. Pearson College Div.]
	Down Syndrome	The term syndrome refers to a number of symptoms or characteristics that occur together and provide the defining features of a given disease or condition. **Down Syndrome** is the two most common genetic cause of intellectual disabilities (Roberts et al., 2005). **Down Syndrome:** Caused by chromosomal abnormality. Most often results in moderate level of intellectual disability, although some individuals function in mild or severe range. Affects about 1 in 691 live births; incidence of Down Syndrome increases with age of mother to approximately 1 in 30 for women at age 45. **Characteristics of Down Syndrome**: Best-known and well-researched biological condition associated with intellectual disability; estimated to account for 5%–6% of all cases. Characteristic physical features: short stature; flat, broad face with small ears and nose; upward slanting eyes; small mouth with short roof, protruding tongue may cause articulation problems; hypotonia (floppy muscles); heart defects common; susceptibility to ear and respiratory infections. Source: Heward, W. L. (2013). Exceptional children: An introduction to special education. Pearson College Div
	Social Development	Making and sustaining friendships and personal relationships present significant challenges for many children with intellectual disabilities (Guralnick, Connor, Neville, & Hammond, 2006). Poor communication skills, inability to behaviour the emotional state of others, and unusual or inappropriate behaviours when interacting with others can lead to social isolation (Matheson, Olsen, & Weisner, 2007; Williams, Wishart, Pitcarin, & Willis, 2005). It is difficult at best for someone who is not a professional educator or paid caretaker to want to spend the time necessary to get to know a person who stands too close, interrupts frequently, does not maintain eye contact, and strays from the conversational topic. Social situations that present difficulties for pupils with disabilities can range from the fairly simple (engaging in a conversation with a peer) to the extremely complex: determining whether someone who seems friendly is actually harming you (De Bildt et al., 2005). [Reference: Heward, W. L. (2013). Exceptional children: An introduction to special education. Pearson College Div.]
	Behavioural excesses and challenging behaviour	Pupils with intellectual disabilities are more likely to exhibit 11ehavior problems than are children without disabilities (Dekker, Koot, van der Ende, & Verhulst, 2002). While youth with mild or borderline intellectual disabilities exhibit more antisocial 11ehavior than do adolescents without disabilities (Douma, Dekker, de Ruiter, Tick, & Koot, 2007), in general, the more severe the intellectual impairment, the higher the incidence and severity of problem behaviour. Characteristics: Difficulty accepting criticism, limited self-control, and bizarre and inappropriate behaviours such as aggression or self-injury are observed more often in children with intellectual disabilities than in children without disabilities. Some genetic syndromes associated with intellectual disabilities tend to include atypical and maladaptive behaviour. For example, children with Prader-Willi syndrome often engage in self-injurious, obsessive-compulsive behaviour and pica causes children to be eating non-nutritive substances such as string, hair or dirt (Ali, 2001; Dimitropoulos, Feurer, Butler, & Thompson, 2001; Symons, Butler, Sanders, Feurer, & Thompson, 1999). Adapted from: Heward, W. L. (2013). Exceptional children: An introduction to special education. Pearson College Div.
Learning Difficulties	Dyslexia	"Dyslexia is a learning difficulty that primarily affects the skills involved in accurate and fluent word reading and spelling. Characteristic features of dyslexia are difficulties in phonological awareness, verbal memory and verbal processing speed. Dyslexia occurs across the range of intellectual abilities. It is best thought of as a continuum, not a distinct category, and there are no clear cut-off points. Co-occurring difficulties may be seen in aspects of language, motor co-ordination, mental calculation, concentration and personal behaviourize, but these are not, by themselves, markers of dyslexia. A good indication of the severity and persistence of dyslexic difficulties can be gained by examining how the individual responds or has responded to well-founded intervention" (Rose review, 2009, p.30).

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		[Reference: General signs: Dyslexia Friendly Pack, BDA (2012, pp.4-5)]
	Reading problems (misspelling sounds)	Difficulty in reading is by far the most common characteristic of pupils with learning disabilities. Reading problems of pupils with learning disabilities include difficulty at the word level of processing, for example, inability to accurately and fluently decode single words. Additionally, these pupils present with deficits in the area of phonological awareness of spoken words (Torgesen and Wagner, 1998). Phonological awareness refers to the "conscious understanding and knowledge that language is made up of sounds" (Simmons, Kame'nui, Coyne, Chard & Hairrell, 2011, p. 54). The pupil that faces reading difficulties may exhibit the following characteristics: • Makes poor reading progress • Finds it difficult to blend letters together into words • Is hesitant in reading, especially when reading aloud • Misses out words/lines when reading, or adds extra words • Has difficulty picking out the most important points from a passage (comprehension difficulties)
	Written Language Deficits	Pupils with learning disabilities perform significantly lower than their age-matched peers without disabilities on all written expression tasks, including the transcription of handwriting, spelling, punctuation, vocabulary, grammar, and expository writing (De La Paz and Graham 1997; Englert, Wu and Zhao, 2005). Characteristics: • Pupils with written language deficits tend to demonstrate minimal planning, effort and meta-cognitive control in terms of writing. • Pupils with writing deficits also experience difficulties with spelling, grammar and punctuation • Pupils with written language deficits produce poorly behaviour compositions containing a poorly developed ideas (Heward, 2013).
	Math Under-achievement	Numerical reasoning and calculation pose major problems for many pupils with learning disabilities. Pupils with learning disabilities perform lower than typically achieving children on every type of arithmetic problem at every grade level (Cawley, Parmar, Foley, Salmon, & Roy, 2001). Deficits in retrieving number facts and solving story problems are particularly evident (Fuchs et al., 2010; Geary, 2004). Source: Heward, W. L. (2013). Exceptional children: An introduction to special education. Pearson College Div. Characteristically, pupils with Mathematics Underachievement: • show confusion with number order, e.g. Units, tens, hundreds • are confused by mathematical symbols • have difficulty remembering anything in a sequential order, e.g. Tables, days of the week, the alphabet • have difficulty learning and remembering multiplication tables • may reverse numbers such as 2 and 5
	Social Skills Deficits	Pupils with learning disabilities are also more prone to social problems. The poor social skills of pupils with learning disabilities may be due to the ways they interpret social situations relative to their own experiences and their inability to perceive the nonverbal affective expressions of others (Meadan & Halle, 2004; Most & Greenbank, 2000). Social situations that present difficulties for disabled pupils can be simple or more complex (De Bildt et al,.2005): - engaging in a conversation with a peer - deciding if someone who appears friendly wants to harm you
	Attention Deficit Hyperactivity Disorder	"The essential feature of attention-deficit/hyperactivity disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development" (American Psychiatric Association, 2000a, p. 85). Some pupils with learning disabilities have difficulty attending to a task and/or display high rates of hyperactivity. Children who consistently exhibit these problems may be diagnosed with attention-deficit/hyperactivity disorder (ADHD). Characteristics of pupils with ADHD: Inattention - not attending to details

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		- difficulty sustaining attention to tasks or activities - does not seem to listen - does not follow through on instructions (e.g., starts a task but soon gets sidetracked) - difficulty behaviouri tasks and activities (e.g., work is messy and behaviourize) - dislikes tasks that require sustained mental effort - frequently loses things - easily distracted - Often forgetful Hyperactivity and impulsivity - Fidgeting - Restlessness - runs about or climbs on furniture, often excessively loud or noisy - often "on the go" as if "driven by a motor" - talks excessively, blurts out answers, difficulty waiting to take his or her turn, interrupts others - acts without thinking (e.g., starts a task without reading or listening to the instructions) - Impatient, rushes through activities or tasks, has difficulty resisting temptations. (adapted from American Psychiatric Association, 2011c)
Autism Spectrum Disorders		Characteristics of Autistic Spectrum Disorders (adapted from DSM-5 Autism Spectrum Disorder 299.00 (F84.0) A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text): 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions. 2. Deficits in nonverbal communicative behaviours used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication. 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behaviourto suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers. B. Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive): 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases). 2. Insistence on sameness, inflexible adherence to routines, or ritualised patterns of verbal or nonverbal behaviour (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day). 3. Highly restricted, fixated interests that are abnormal in intensity or focus, such as strong attachment to or preoccupation with unusual objects, with excessively circumscribed or perseverative interest.

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		4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
Comm. And Language Disorders	Communication disorders	A communication disorder is an impairment in the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems. A communication disorder may be evident in the processes of hearing, language, and/or speech. A communication disorder may range in severity from mild to profound. It may be developmental or acquired. Individuals may demonstrate one or any combination of communication disorders. A communication disorder may result in a primary disability or it may be secondary to other disabilities. [References: American Speech-Language-Hearing Association. (1993). Definitions of communication disorders and variations [Relevant Paper]. Available from www.asha.org/policy.]
	Language disorders	A language disorder is the impaired comprehension and/or use of spoken, written and/or other symbol systems. The disorder may involve (1) the form of language (phonology, morphology, syntax), (2) the content of language (semantics), and/or (3) the function of language in communication (pragmatics) in any combination.
	Speech disorders	Three basic types of speech disorders are: (a) Articulation disorders (errors in the production of speech sounds), (b) Fluency disorders (difficulties with the flow or rhythm of speech), and (c) Voice disorders (problems with the quality or use of one's voice).
Sensory disabilities	Hearing impairment	A hearing impairment by definition is "an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance, but is not included under the definition of 'deafness'" as defined by the Individuals with Disabilities Education Act (IDEA). [Reference: http://www.specialeducationguide.com/disability-profiles/hearing-impairments/]
	Visual impairment	"Visual impairment, also known as vision impairment or vision loss, is a decreased ability to see to a degree that causes problems not fixable by usual means, such as glasses." ("Change the Definition of Blindness" (PDF). World Health Organisation. Retrieved 22 May 2022). The most common vision impairments affect: • The sharpness or clarity of vision (visual acuity) • The normal range of what you can see (visual fields) • Colour
Physical disabilities	Congenital malformation of the bones and joints	Congenital malformations are structural, functional or metabolic anomalies, which can manifest from birth or in early childhood. "Different types of pathogenic processes leading to structural abnormalities are indicated by the terms malformation, disruption and deformation. Anomalies can be placed in one of these categories on the basis of developmental stage during which the alteration took place, the process that caused the change, or the end result. (Roger E. Stevenson, Benjamin D. Solomon, David B. Everman, Human Malformations and Related Anomalies, Oxford University Press, 2015). The persons who are assessed with a medium disability are oriented towards professional activities with a reduced physical effort, without travelling long distances or picking up heavy objects. They need behaviourbdevices and recovery treatment to prevent deterioration of the joint functions. The persons who are assessed with a severe disability need compensatory means (prosthesis, orthosis etc.), adapted according to their activity and the affected members. They may also need special means of moving (wheelchair, adapted cars etc.), an adapted living/work space, assistance for daily activities (for the persons with severe deficiencies).
	Scoliosis	Scoliosis is a three-dimensional deformity that occurs when the spine becomes abnormally rotated and curved sideways. The term "is derived from the Greek word meaning 'crooked' and was used for the first time by Galen (AD 131-201) to describe an 'S-shaped' or 'C-shaped' spinal deformity. Although defined as a lateral curvature, as visualised by plane radiography, the deformity is actually three-dimensional and involves changes in the frontal, sagittal and transverse

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		planes of the spinal column. It "can occur in either the upper back or the lower back and very rarely seen in the neck region. The cause for most curvatures of the spine is unknown (idiopathic scoliosis)" (Dolores M. Huffman, Karen Lee Fontaine, Bernadette K. Price, Health Problems in the Classroom prek-6: An A-Z Reference Guide for Educators, p. 275).
	Kyphosis	In general terms, kyphosis is a condition that involves an exaggerated rounding of the back. According to a specialised definition, "structural kyphosis is a posterior convex deformity of the spine that may appear in childhood then worsen with growth, most notably during the pubertal growth spurt. The abnormal curvature may be smooth, defining round kyphosis, or may display a sharp angular pattern. […] Angular kyphosis is the most severe of the two forms. The main causes of round kyphosis are postural kyphosis and Scheuermann's disease. The spontaneous outcome is behaviouri , and round kyphosis is well tolerated in adulthood. […] (Kyphosis: New Insights for the Healthcare Professional, Atlanta, Scholarly Editions, 2013)
	Somatic dysfunction	"Somatic dysfunction can be defined as 'impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures and their related vascular, lymphatic and neural elements' (Educational Council on Osteopathic Principles, 2009)". "Somatic dysfunction is not tissue damage, which the body must heal. Rather, somatic dysfunction is a disorder of the body's programming for length, tension, joint surface apposition affecting mobility, tissue fluid flow efficiency, and neurological balance. […]"(Marc Micozzi, Fundamentals of Complementary and Alternative Medicine, Saunders Elsevier, 2010, p. 244)
	Spinal cord injury	The spinal cord can be generally defined as a group of nerves that runs down the middle of a person's back and carries signals back and forth between the body and the brain, passing through one's neck and back. An injury of the spinal cord, usually referred to as a spinal cord injury (SCI), represents damage produced to the spinal cord that causes changes in its function, changes that may be either temporary or permanent. The respective changes generally involve the loss of muscle function, of sensation or of autonomic function in those parts of the human body served by the spinal cord that are below the level of the lesion. As a consequence, patients with SCI commonly experience permanent and often devastating neurologic deficits and disability.
	Muscular dystrophy	Definition: Muscular dystrophy, usually abbreviated as MD, can be defined as a collective group of inherited non-inflammatory but progressive disorders that affect muscle function (Alan E. H. Emery, Muscular Dystrophy, Oxford University Press, 2008, 3).
	Rheumatoid polyarthritis	Juvenile rheumatoid arthritis is a type of arthritis that causes joint inflammation and stiffness for more than six weeks in a child aged 16 or younger. Inflammation causes redness, swelling, warmth, and soreness in the joints, although many children with JRA do not complain of joint pain. Any joint can be affected, and inflammation may limit the mobility of affected joints.
	Paralysis	The chain of nerve cells that runs from the brain through the spinal cord out to the muscles is called the motor pathway. Normal muscle function requires intact connections all along this motor pathway. Damage at any point reduces the brain's ability to control the muscle's movements. This reduced efficiency causes weakness, also called paresis. Complete loss of communication prevents any willed movement at all. This lack of control is called paralysis. Certain inherited abnormalities in muscles cause periodic paralysis in which the weakness comes and goes.
Lesbian, Gay, Bisexual, Transgender (LGBT)		Lesbian: A lesbian woman is one who is romantically, sexually and/or emotionally attracted to women. Many lesbians prefer to be called lesbian rather than gay. Gay: A gay man is one who is romantically, sexually and/or emotionally attracted to men. The word gay can be used to refer generally to lesbian, gay and bisexual people but many women prefer to be called lesbian. Most gay people don't like to be referred to as homosexual because of the negative historical associations with the word and because the word *gay* better reflects their identity. Bisexual: A bisexual person is someone who is romantically, sexually and/or emotionally attracted to people of both sexes. Transgender or Trans: This is an umbrella term used to describe people whose gender identity (internal feeling of being male, female or transgender) and/or gender expression, differs from that usually associated with their birth sex. Not everyone whose appearance or behaviour is gender-atypical will identify as a transgender person. Many transgender people live part-time or full-time

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		in another gender. Transgender people can identify as transsexual, transvestite or another gender identity. *[Reference:* These definitions are adapted from More Than a Phase (Pobal, 2006), For a Better Understanding of Sexual Orientation (APA, 2008) and Answers to Your Questions About Transgender Individuals and Gender Identity (APA, 2006). Available at: *http://www.lgbt.ie/about/what-is-lgbt]*
Pupils from deprived backgrounds	Single-parent families	A single parent is an uncoupled individual who shoulders most or all of the day-to-day responsibilities of raising a child or children. A mother is more often the primary caregiver in a single-parent family structure that has arisen due to death of the partner, divorce or unplanned pregnancy.
	Poor families	People are said to be living in poverty if their income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantages through unemployment, low income, poor housing, inadequate health care and barriers to lifelong learning, culture, sport and recreation.
	Violent and dangerous families	Domestic violence refers to the abuse and/or assault of children or adolescents by their parents, or adults by their intimate partners. The term is used interchangeably with intimate partner abuse and inter-parental violence. Signs a pupil is having difficulties as a consequence of domestic violence: - physical complaints - tiredness - constant worry about possible danger and/or the safety of loved ones; - sadness and/or withdrawal from others and activities - difficulty in paying attention in class; - outbursts of anger directed toward peers, teachers or self; - bullying [Reference: L. Baker, P. Jaffe, L. Ashbourne, Children Exposed to Domestic Violence, A Teacher's Handbook to Increase Understanding and Improve Community Responses, p. 9]
	Remote areas	Pupils travelling long distances to arrive at school
Migrant, Refugee, Asylum Seeker Pupils	Refugees, Asylum Seekers and Unaccompanied Minors	According to the 1951 U.N Refugee Convention, which is the key legal document that outlines the status and the rights of **refugees**, signed by 144 state parties, "a refugee is someone who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his (her) nationality, and is unable to or, owning to such fear, is unwilling to avail (himself) of the protection of that country". According to U.N Refugee Agency an **asylum-seeker** is someone whose request for sanctuary has yet to be processed. **An unaccompanied minor** is a person who is under the age of eighteen, unless, under the law applicable to the child, majority is attained earlier and who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so (UN, "Refugee Children: Guidelines on Protection and Care", p.121).
	Migrant Pupils	The UN Convention on the Rights of Migrants defines migrants as follows: "The term 'migrant' in article 1.1 (a) should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of 'personal convenience' and without intervention of an external compelling factor."
Pupils with health issues	Asthma	Asthma is a chronic (long-term) lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing, chest tightness, shortness of breath, and coughing. The coughing often occurs at night or early in the morning. Pupils with asthma may at any time: • have flare-ups that cause coughing, wheezing, and serious breathing problems • need to take oral or inhaled medication, usually in the school nurse's office • feel jittery, anxious, or hyper after using their inhalers (also called bronchodilators) • miss field trips that could aggravate their condition • request the removal of allergens in classrooms that can trigger flare-ups

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		• need to be excused from physical education or other activities when they are having flare-ups (NHLBI, 2014).
	Diabetes	Diabetes is a chronic disease in which blood glucose (sugar) levels are above normal. Type 1 diabetes or juvenile diabetes is a disease of the immune system. In people with type 1 diabetes, the immune system attacks the insulin-producing cells of the pancreas and destroys them. Because the pancreas can no longer produce insulin, people with type 1 diabetes must take insulin daily to live.
	Anaemia	Anemia occurs when blood has a lower than normal number of red blood cells, or if red blood cells don't have enough hemoglobin. Hemoglobin is a protein that gives blood its red color and helps those cells bring oxygen from your lungs to the rest of the body. If a person is anemic, the body simply doesn't receive enough oxygen-rich blood, which makes the person feel tired and weak. Severe anemia can damage the heart, brain and other organs in the body, and may even cause death. Overall, iron deficiency is the most common cause of anemia in the developed world (Sills et al, 2016). Iron deficiency needs to exist for a long time before anemia occurs. Iron deficiency is usually caught early by pediatricians in routine screening as it exhibits very peculiar symptoms such as nail-biting and the desire to chew on ice or soil (pica). In the Western world anemia could be the result of prolonged iron deficiency due to malnutrition as seen in anorexia nervosa. Symptoms of anemia Difficulty maintaining body temperature, increased likelihood of infections fatigue, weakness, pale skin, fast or irregular heartbeat, shortness of breath, chest pain, dizziness, cognitive problems, cold hands and feet, headaches and irritability.
	Epilepsy	Epilepsy is a neurological disorder. The brain contains millions of nerve cells called neurons that send electrical charges to each other. A seizure occurs when there is a sudden and brief excess surge of electrical activity in the brain between nerve cells. This results in an alteration in sensation, behaviour, and consciousness. As well as potential difficulties with working memory, pupils with epilepsy may have specific learning problems such as inattention and processing difficulties, or side effects associated with their antiepileptic medication identified as a barrier that can impact on learning (Reilly and Ballantine, 2011). Tiredness, mood swings, irritability and difficulties concentrating could all be attributed to side effects of medication. Disturbed sleep and resulting tiredness as a result of nocturnal seizures is another factor in relation to the impact of epilepsy on learning.
	Cancer	Types of childhood cancer Leukemia is cancer of the blood cells which arise out of the bone marrow and accounts for about 40% of all childhood cancer cases. The most common of these is Acute Lymphoblastic Leukemia (ALL). Acute Myeloid Leukemia (AML) accounts for most of the other cases. Central Nervous System Tumours of the brain and spinal cord are the most common solid tumours in children. Lymphomas originate from cells in the lymph nodes or other lymphatic tissues and include Hodgkins Lymphoma and a number of Non-Hodgkin's Lymphomas. Kidney Tumours are more likely to occur in the first five years of life. Rhabdomyosarcoma is a cancer of the connective tissue that can arise from a number of different locations in the body. Osteosarcoma is the most common childhood bone tumour, and often affects the long bones of the arms and legs. Ewings Sarcoma is a tumour that occurs in the bone or the soft tissue. It often occurs in the pelvis or the leg bones. Neuroblastoma originates in primitive nerve cells in the adrenal gland and a chain of nerves along the spine. While neuroblastoma in infancy usually has good outcomes, in older children it is more aggressive and challenging to treat. Other Cancers: Children may also develop germ cell tumours, which arise from reproductive cells, or tumours that arise in the liver, as well as other rare forms of cancer.

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Pupils with mental health difficulties	Addiction	Addiction is defined by a compulsion to use a substance, or continue with certain behaviour that makes you feel good or avoid bad feelings. There are two types of addiction: physical and psychological. Physical addiction This occurs after a substance is used so much it actually alters the body's chemistry. The body develops a hunger for a particular drug that needs to be constantly fed. If the hunger is not fed, the body goes into withdrawal, leading to a range of unpleasant symptoms until the hunger is fed again. Psychological addiction This occurs when the brain gets addicted to a particular substance or behaviour that 'rewards' it, i.e. Creating a sense of 'feeling good'. The mind is powerful and therefore an addicted brain can produce physical manifestations of withdrawal, including cravings, irritability, insomnia and depression. When it comes to alcohol, nicotine and illegal drugs, it is possible to develop a physical addiction, a psychological addiction, or a mixture of both. What are the signs? Even though different people can develop any kind of addiction, the warning signs are quite similar and include: • An unhealthy focus on pursuing the substance/behaviour • Excluding other activities that are not related to using the substance • Going out mainly with the aim of using the substance • Needing more of the substance/behaviour to get the same feelings of elation • Neglecting other areas of life, including relationships, health, or work. (Reachout.com)
	Depression	Depression "is a common mental disorder, behaviourized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration.
	Eating disorders – Anorexia, Bulimia	The term eating disorder refers to a complex, potentially life-threatening condition, behaviour ized by severe disturbances in eating behaviours. Eating disorders can be seen as a way of coping with emotional distress, or as a symptom of underlying issues. Anorexia Nervosa • A person will make determined efforts to attain and maintain a body weight lower than the normal body weight for their age, sex and height • They will be preoccupied with thoughts of food and the need to lose weight • They may exercise excessively and may engage in purging behaviours. Bulimia Nervosa • A person will make determined efforts to purge themselves of any food eaten, sometimes following a binge, and often following 'normal' food intake. • They will engage in high-risk behaviours that can include fasting, excessive exercising, self-induced vomiting, and/or the misuse of laxatives, diuretics or other medications • They may maintain a body weight within the normal range of their age, sex and height. As a result, bulimia is often less obvious than anorexia and can go unnoticed for longer. Binge Eating Disorder • A person will engage in repeated episodes of bingeing without purging • They will likely gain considerable amounts of weight over time • They find themselves trapped in a cycle of dieting, bingeing, self-recrimination and self-loathing.
	Obsessive Compulsive Disorder	Obsessive Compulsive Disorder (OCD) is a mental health disorder that affects people of all ages and walks of life, and occurs when a person gets caught in a cycle of obsessions and compulsions. Obsessions are unwanted, intrusive thoughts, images or urges that trigger intensely distressing feelings. Compulsions are behaviours an individual engages in to attempt to get rid of the obsessions and/or decrease his or her distress. [Reference: International OCD Foundation]
	Schizophrenia	Schizophrenia is the name given to a group of psychotic disorders associated with significant disturbances in thought, emotion and behaviour. The symptoms most commonly associated with the disorder are the following: - Hallucinations. A person with schizophrenia may see, hear, taste, smell and feel things that simply aren't there. These experiences seem so real that they have difficulty believing otherwise.

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		- Delusions are strange or unusual beliefs that are not based on reality and often contradict real-life evidence. For example, someone with schizophrenia may believe that the reason they're hearing voices nobody else can is that some manner of secret agent is listening to all of their conversations. Another form of delusion could be the belief that someone on a TV show was sending messages to them and them alone, or that passing cars on the street contained hidden messages for them. Delusions can begin suddenly, or may develop over a period of weeks or months. - Disorganised thinking: Someone who is going through a schizophrenic episode may find it difficult to keep track of their own thoughts. Reading a newspaper article or watching something on TV could be difficult because it is difficult to concentrate properly; thoughts and memories might be described as being misty or hazy. - Disorganised behaviour: Unpredictable behaviour and appearance can also be a symptom of schizophrenia, such as suddenly beginning to dress oddly or behave in a completely new way. People with schizophrenia might become agitated, shouting and swearing for no reason. If they believe someone else is controlling their thoughts, they might feel as though they are not in control of their own body.
	Self-harm	Self-harm is when someone deliberately hurts or injures him or herself. This can take a number of forms, including: • Cutting • Taking overdoses of medicines or tablets • Punching oneself • Throwing one's body against something • Scratching, picking or tearing at one's skin causing sores or scarring • Pulling out hair or eyelashes • Burning oneself • Inhaling or sniffing harmful substances • Driving dangerously • Excessive use and abuse of alcohol and/or other drugs
	Stress	Stress is a state of mental tension and worry caused by problems in your life, work, etc. Stress causes strong feelings of worry or anxiety. Stress in pupils may be caused by: • Exams • Problems at school or at work • Sexual, physical or emotional abuse • Relationships • New responsibilities • Moving to a new place • A traumatic event – such as the death of a loved one • New or chronic illness or disability • Peer pressure or being bullied • Unrealistic expectations from themselves, family, friends or culture • Taking on too many activities
	Bipolar Disorder	Bipolar disorder is a biological brain disorder causing severe fluctuations in mood, energy, thinking and behaviour. It was previously known as manic depression, as it causes moods to shift between mania and depression.

Adapted from: https://www.idecide-project.eu/index.php/en/

Consult also the toolkit to not only identify the basic special needs but look into potential adaptations, modifications, resources, techniques and other ideas to accommodate students with specific special needs: https://www.idecide-project.eu/index.php/en/toolkit/download-the-toolkit

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10.4 GUIDE FOR MENTOR DISCUSSION WITH nqts ABOUT DIVERSE STUDENTS' NEEDS

This discussion can be conducted with the participation of the mentor, the NQT(s), the school director, colleagues (teachers or other staff) in the school who have worked in the past with either the same students or students with similar needs and the parents. It can be conducted in person, or if this is not possible, parts of it can be conducted by phone, email, skype, etc.

- Among all the ideas one can find in the i-decide project toolkit (https://www.idecide-project.eu/index.php/en/toolkit/download-the-toolkit) about handling diverse students' needs (focus only on the categories the nts have in their classes) which one could be readily implemented in our school?

The mentor asks the NQT prior the meeting to have studied the relevant material of the i-decide toolkit material and identify in the form of a list all the practical ideas included in it. Then they both assess which of them are readily implemented in the school.

- What is the cost and the procedures we should follow as a school for implementing more of these ideas?

Then, they identify more ideas that could be implemented if the school could make some expenses or follow some administrative procedures. They both devise a relevant action plan including which ideas are worthwhile to be implemented and are the necessary steps to be followed along with a realistic timeline of these steps.

- What is the experience of other colleagues who have worked with the same or similar students in the past? (strengths and weaknesses, practices that worked or not)

The mentor organizes a group discussion with other colleagues who have worked with the same or similar students in the past and the nqts to share experiences and good practices or alternatively he/she encourages the NT to collect this information by conducting similar discussions with other colleagues individually.

- What is the experience of the parents?

Parents are asked to share with the mentor and the nts their experiences with their children at home and identify key needs of them that school should take into consideration.

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- Are there external sources (e.g. Special supporting or counselling services available for schools) of expertise that could provide the NQT with extra help for meeting the needs of diverse students?

The mentor in collaboration with the NQT(s) identify potential sources of external expertise and organize a contact with them for asking advice.

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