



# Must Try Harder?

Meeting the educational  
needs of children after  
an acquired brain injury.

This booklet and accompanying DVD are given to parents of children who have survived acquired brain injury, to show to their teachers, SENCO'S and others involved in meeting their educational needs. It provides an understanding of why educational difficulties can arise after acquired brain injury, and of appropriate compensatory strategies.

The booklet contains suggestions for further reading and a list of relevant organisations.

# **Must Try Harder?**

## **Meeting the educational needs of children after acquired brain injury**

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# Ben's story

Ben was 9 years old when he was hit by a car while out riding his bike. He was taken by ambulance to his local hospital and then transferred to the regional hospital, which had more specialist facilities for managing his acquired brain injury. He was in a coma for two weeks. As he regained consciousness he was confused and aggressive but these problems resolved. With a lot of help and therapy in hospital Ben gradually regained his motor and communication skills. He made excellent progress and when he was discharged everyone said what a remarkable recovery he had made.

Ben and his parents were very enthusiastic about his return to school and looking forward to the whole family being able to get back to normal. His friends and teachers made a fuss of him at first; they were very relieved to see he had made a complete recovery, and pleased to see him back at school. He just needed to catch up with the work he had missed.

But there have been changes in Ben that are hard to understand. It takes him much longer to get things done and he often doesn't finish them. He is easily distracted and has trouble remembering information, even very simple instructions. He seems to forget what his teacher tells him from one minute to the next.

Ben can't always find the words he wants to use and reading is much harder for him now. He gets easily tired and irritable. His friends are not spending much time with him now; he can't keep up with the things they like to do and to talk about. They laugh at his silly comments and behaviour and think he is stupid. They also don't like the way he gets angry. He never used to be like that. Ben's teachers and friends are beginning to think that he is different from the Ben they knew before the accident.

It is going to take a long time for them to understand the changes they see.

# A note for parents and carers:

## Why this booklet?

This booklet and the accompanying DVD are about life, and particularly school, for your child after acquired brain injury (ABI). Of course no two families will have the same experience of ABI, but certain stories are all too familiar. This booklet covers a wide range of problems that can emerge, sometimes quite a while after ABI. As such, it may seem quite negative. Obviously, we hesitated before putting such material in a booklet for parents, but in talking with families we were assured that they understood not all these things would necessarily happen, but wanted to know what *might* happen so that they could be prepared. The justification for the booklet ultimately is that we believe that understanding can lead to real benefits for the children with ABI: there are things that can be done in the classroom that will make a real difference.

School is important to children with ABI and ABI is an important issue for schools. However, children with ABI pose particular problems to teachers and educators and we have spent some time thinking about why this is as a prelude to producing this booklet and DVD. Part of the problem is that you need a long-term view to appreciate what is happening as the needs of a child with ABI emerge and change. Teachers looking after your child now may have too brief an involvement with your child for them to appreciate how the situation is changing.

Until recently, the educational needs of children with ABI have not received a great deal of attention. You may find your child's teacher, even your school's SENCO\*, relatively unfamiliar with these matters.

And because at least some of your child's teachers may be new each year, you may find yourself having to explain about your child, and about ABI each September.

No one else knows more about your child's needs following his or her ABI than you do. We believe that a parent or carer who feels able to speak up for their child is probably the single greatest asset a child recovering from ABI can have. We want to help you as you seek the best for your child at school and hope you will find this DVD and booklet helpful.

In giving the DVD and booklet to you as a parent or carer, we hope that you will share these with teachers and other school staff to familiarise them with the issues that often face children after ABI. We have included some general advice pages we hope you and your child's teachers find helpful starting points. Feel free to copy this booklet.

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\* Special Educational Needs Coordinator: the teacher in your school with special responsibility for coordinating help for children with special educational needs.

# What is acquired brain injury (ABI)?

Acquired brain injury is the most common cause of new disability in childhood. It refers to any injury occurring to the brain after the period immediately around birth. This may result from a number of different causes, including:

**Road traffic accidents**

**Falls**

**Brain tumours**

**Strokes**

**Encephalitis and other neurologically based diseases.**

ABI arising from causes such as road traffic accidents or falls, rather than illnesses, is sometimes called **traumatic brain injury (TBI)**. Of the million people who attend hospital each year in the UK as a result of TBI alone, over half are under 16 years of age. TBI is recognised as the most common cause of death and acquired disability in childhood. In a large secondary school with 1,500 pupils, for example, another child will acquire new significant disability as a result of TBI at least every other year, (although this may not always be recognised) – and this is just one cause of acquired brain injury.

Overall ABI results in at least 3,000 previously healthy children acquiring significant disability every year in the United Kingdom. There are many more with less serious problems that may nevertheless affect them at school.

# A note to teachers

A child who has suffered an acquired brain injury (ABI) gets back to school and the many anxieties of those days or weeks in hospital seem over. It is only natural to hope for the child's sake that the whole episode can now be put behind them and after a period of catching up they can pick up where they left off: that they will have "recovered". Unfortunately, this is overly simplistic. The effects of even quite subtle **learning problems after ABI can tend to compound** over the remainder of a child's education; and educators need to remain mindful of a child's previous ABI through the remainder of his or her educational career.

Meeting the educational needs of a child after ABI can pose a challenge for many reasons. We do not wish to give the impression that a few quick tip cards and an informational DVD will address the very real resource and other pressures you face. However, we do believe improvements can be made, and we hope this DVD and booklet can assist in that process.

The DVD suggests these strategies that can help, and the remainder of the booklet expands on some of them:

## **Familiarise yourself, as an educationalist, with the needs of children after ABI.**

Recognise that the educational needs of children after ABI are unique. Needs differ between individual children, of course, but the consequences of ABI can result in quite complex problems with "deep" processes that are difficult to get a handle on without some theoretical understanding. Areas of special educational need can be patchy, and the combinations and profiles unfamiliar. Consequences are regularly under-recognised, and underestimated.

**Recognise the limitations of routine assessments. Consider seeking specialist assessment and advice.**

Encourage good communication and teamwork. ABI is a major challenge to inter-agency working.

**Listen to parents.**

The needs of a child with ABI emerge with time, often quite slowly. Often the parents are the only ones with a perspective on the whole story. Without knowledge of the child as he was prior to injury, or even after the injury but a few years ago, you may not appreciate how much has changed.

**Recognise that needs change over time.**

What worked before may not be appropriate now. Expectations change, too, and a child who was coping before may suddenly start to struggle for reasons that may not be initially apparent.

## Looking good so far...

Children with ABI return to school at various stages in their recovery. Most return directly from an acute hospital setting. Others may have participated in a rehabilitation programme and some may have been at home for extended periods, with or without the benefit of home tuition.

ABI is remarkable for an ability to cause **invisible injury**. Children walk and talk and may “look good” but have new problems with learning, behaviour, concentration or organisation that, because they may not be immediately obvious, are **under-recognised and underestimated**. Physical problems, such as difficulties with walking or fine hand movement, weakness on one side of the body, headaches or seizures, can be a problem early in the recovery period after injury. For some children these physical problems may persist. The danger however is that these may be focussed on at the expense of the less visible cognitive problems.

## ...but it's not over yet

The DVD explains that injury often occurs to the structures involved in new learning. The combination of **impaired new learning but retained previous skills and knowledge** is often misinterpreted. A child with ABI may seem to be “back to normal” soon after initial recovery. He may be able to perform misleadingly well on formal tests (e.g. reading assessments), which essentially tap skills acquired prior to injury. However, it is then often the case that he **fails to make age appropriate progress from that time onwards** and falls gradually further behind his peers.

Children are continually developing. Neurological development continues until approximately 20 years of age. Damage to specific areas of the brain may not be apparent until skills mediated by those areas would normally develop and this could be years after the initial injury. For example, areas of the frontal lobes are involved in so-called executive functions: the ability to organise and direct your own actions. These will not be fully evident until adolescent years in any child. If a five year old child has sustained frontal lobe injury, the full consequences for executive function will not be known for several years. Apparently “new” problems may, therefore, appear many years later. Unfortunately, the teachers involved with a child by this stage may be unaware of the ABI several years ago if the child was deemed to have “recovered”, and the connection may therefore not get made. This is sometimes termed the **sleeper** (or delayed) **effect**.

**The special educational needs (SEN) of children with ABI are likely to change more significantly throughout the course of their school careers than that of other children and they need even more vigilant monitoring.**

# **What makes children with ABI different from others with SEN?**

At school, teachers may observe behaviours in brain-injured children that are similar to those of children with specific learning disabilities, attention disorders or emotional and behavioural difficulties. While many characteristics may be shared by the brain injured child and other developmentally impaired groups, the problems are different for the child with an acquired brain injury.

The following points demonstrate the common characteristics often shared by children with ABI which, in combination, may distinguish them from children with other problems. The child with a brain injury may:

- **Have a history of academic successes prior to the injury**
- **Demonstrate an uneven learning profile consisting of some intact high-level skills and some weakened or lost skills**
- **Have a need for compensatory and adaptive strategies to offset specific cognitive losses (e.g. memory, organisation)**
- **Exhibit problems generalising and organising new information**
- **Demonstrate inconsistent patterns of performance including much variability in the rate at which progress is made.**
- **Retain a base of previously learned information**

- **Demonstrate poor self-control resulting in inappropriate behaviours, impulsivity and distractibility**
- **Demonstrate inefficient problem solving and inability to learn from mistakes**
- **Exhibit loss of emotional control (e.g. frequent mood swings, increased irritability) and limited facial expression**
- **Experience difficulty adapting to changes in routines, the unexpected etc.**
- **Not recognise changes from pre-injury abilities, personalities and behaviours.**

The frequently unusual combination of these physical, cognitive and behavioural components set children with acquired brain injuries apart from children with other learning difficulties.

Despite the fact that general good practice in relation to the identification of SEN and the ways of addressing them will, of course, also apply to these children, their significant differences must be taken into account.

# Common areas of difficulty following ABI

When children return to school after ABI they may have limited physical and cognitive endurance. They may no longer be able to complete work to the level, or at the speed, that they did previously. They may appear withdrawn, irritable or easily frustrated. They may be unaware of changes in their social and/or academic performance caused by the injury, even though it may be obvious to others.

Specific areas of difficulty commonly reported after acquired brain injury can include the following:

## Physical

To reiterate, children often make good physical recoveries following ABI. However, significant difficulties may result in some cases e.g. quadriplegia (weakness or coordination problems affecting all four limbs) or hemiparesis (weakness on one side of the body). They may have generally poor co-ordination (affecting fine or gross motor control, or both) or lose visual or hearing skills. They may also suffer from ongoing problems, including: headaches, seizures, dizziness, blurred vision, fatigue, muscle pain in the neck or back and ringing in the ears. Any of these can interfere with a child's general level of activity and functioning.

Epilepsy can be a complication of ABI in children. Seizures may vary, for instance from severe generalized tonic-clonic seizures to absence seizures (with brief staring) or partial seizures involving uncontrolled movements or actions. Anticonvulsant medication may control or prevent the seizures, but occasionally can produce unwanted side effects, which can include changes in behaviour, motor activity or levels of alertness.

## **Fatigue**

Unusually high levels of fatigue are frequently experienced after ABI, and this can obviously affect everything a child does. Children returning to school may need to start with a shortened day and require frequent rest periods throughout the day, being unable to sustain a continued level of performance.

Fatigue can often be an ongoing, long-term difficulty for young people following ABI and can be characterised by sudden onset, in contrast with a gradual difficulty faced by those without such injuries.

## **Language and communication**

The majority of children with ABI regain the ability to speak in understandable sentences and this can belie more subtle but significant difficulties with language. As with other areas affected by ABI, a “patchy” profile of communication skills can often be seen. Children with communication problems caused by ABI almost never show the communication profiles typical of developmental speech and language disorders.

Communication is dependent on a wide range of complex skills any or all of which can be affected by ABI. Skills necessary for language and communication are mediated by different parts of the brain and very dependent on other skill areas (physical and cognitive) which may be impaired. For example, memory difficulties may result in word finding problems or an attentional deficit or slow speeds of processing information may affect the ability to participate in a group discussion in class or socially.

# Attention and concentration

Attention and concentration difficulties are commonly experienced after ABI and this can have a profound effect on a child's learning and behaviour. The ability to focus and sustain attention is an essential skill that is fundamental to learning; when it is impaired many other cognitive skills can be affected e.g. what may appear to be the result of memory problems can sometimes be due to poor attention, but the two are very closely linked. Inevitably, failure to attend to information results in incomplete storage in memory.

There are different levels of attentional skill and a child may be able to direct their focus to one particular activity but have difficulties shifting their attention to another, or be unable to divide or alternate their attention between two tasks, or two parts of the same task, e.g. following directions and information in a text book together with making a written response. The child's ability to attend will be influenced by the demands of the task; how alert, tired or interested the child is; and how distracted he is, even by his own internal thoughts.

## Memory

Like other processes that may be affected by ABI, memory is very complex. We all tend to take our ability to remember for granted, even if we do not consider it to be good. All too often the memory problems suffered by people with ABI are dismissed by others who say, "Oh, my memory's really bad, too!" This, of course, is a very thoughtless comment when made to someone who actually has memory impairment.

There are many processes involved in memory, which may be selectively affected, and the whole process is also dependent on other skill areas, which may be impaired. It is important to be aware of and to consider these before attempting to address any functional difficulties.

Broadly, the process of remembering can be divided into three main composite parts: encoding (“taking in” information); storage (“filing” it away) and retrieval (recalling it). Memory processes themselves can be roughly categorised into working, short-term and long-term memory.

Any of these aspects of memory can be affected, whilst others may be relatively spared. There may also be weaknesses in one or more modalities e.g. remembering visual information more readily than verbal information. Memory is one of the most commonly affected areas of functioning following ABI.

## **Speed of information processing**

It is common after ABI, even after a mild injury, for the sufferer to experience a reduction in the speed that they are able to process information. This, in turn, affects general communication skills, social skills and the completion of all academic tasks in school e.g. a child may initially understand what is required, or what is going on, but rapidly lose the thread as the amount of information accumulates. By the time information has been taken in, processed and a response formulated by the child, the classroom issues have moved on and therefore the response is inappropriate. Children who are slow to respond frequently find themselves left behind – sometimes it is easier not to try and the child may find himself becoming increasingly isolated from his peers. Assessments that do not record speed of performance may give an unrealistic picture of a child’s ability to function in the classroom.

## **Perception**

In basic terms, our perceptual skills allow us to take in information from our senses and automatically to interpret it, based on what we know already, in order to make it meaningful.

Our attention and cognitive skills are, therefore, closely linked with perception. Perceptual skills relating to any of our senses can be affected but problems with visual perception are most commonly reported after ABI and can impact on academic progress. These may be specific, may just represent “disorganised” perception or may result from more general cognitive deficits.

Specific areas of visual perception include form constancy (ability to recognise shapes regardless of the form in which they appear); figure ground (recognition of shapes or objects as distinct from a background); position in space (awareness of, for instance, reversals and rotations); and spatial relations (awareness of objects/figures in relation to oneself and to each other)

## **Executive functioning**

The executive system of the brain is responsible for the control, planning and organising of behaviour. This system can be easily affected after ABI, often resulting in difficulties with goal setting and following activities through to completion e.g. packing a school bag with the things needed for the day or planning the steps required for carrying out a school project.

Other areas of difficulty can include initiating actions, flexible problem solving, self monitoring and being able to make adjustments to behaviour. A child with ABI may not be able to demonstrate what he knows in an organised way e.g. he may work haphazardly, starting in the middle of an exercise with no planned direction or understanding of the expected outcome.

# Behavioural and psychosocial difficulties

Children with ABI may exhibit behaviours that are problematic inside or outside the school. As the injury has occurred to the developing brain, some behavioural changes may not be evident until months or years later due to the nature of the damage itself and to subsequent developmental demands. Common changes in behaviour may include dramatic mood swings, irritability, frustration, impulsivity and poor emotional control. The brain-injured child may make loud, inappropriate comments, may strike out at peers and get upset easily. Behavioural problems experienced beforehand can become magnified following an injury to the brain. Disinhibited or impulsive behaviour can occur. Conversely, a brain-injured student may be withdrawn, appear unmotivated and lack initiation.

Inappropriate behaviour may be a direct result of damage to areas of the brain responsible for behavioural control, or as the secondary effects of frustration resulting from acquired cognitive or social impairments.

With increasing age, children are expected to control their behaviour, to learn from past mistakes and to develop a good self-image. Following ABI a young person's inability to control behaviour may be interpreted as wilful non-compliance. It is essential to remember that such control may be impaired and loss of cognitive skills, such as the inability to reason, to problem solve or adequately to express oneself may result in inappropriate behaviour. A child's behaviour could also change due to prescription drugs.

# Interpretation of acquired difficulties

The effects of these various problem areas are frequently interlinked and can be difficult to identify. However, it is important to understand the relationship between cognitive and behavioural deficits and the child's school performance. Impaired cognitive skills affect abilities to learn, to interact with the environment and to develop appropriate social relationships.

Any number of cognitive processes can be disrupted or spared following a brain injury and problems relating to areas mentioned above may be demonstrated in a variety of ways, which may not immediately be clear. For instance, failure to hand in some class work may indicate a child's inability to start a task; to sustain attention; to move from one problem to another in an organised way; to finish work in the allotted time; or to remember to hand in the work when it is completed. These are to name but a few possible explanations and to highlight the importance of considering underlying factors for inappropriate behaviour.

**These considerations demonstrate the limitations of general tests of educational attainment for children with ABI. Specialist neuropsychological assessment can help to provide invaluable insight into the causes of a particular child's problems. Such expertise may be linked to regional paediatric neurology centres or related specialist services. Enquiries about local availability and referral arrangements should be made through school, community or other paediatricians who may be involved.**

# What teachers need to know

Assessment of the educational needs of brain-injured children is a multifaceted process, relying on both formal and informal (functional) measures.

It is important to remember that standardised tests measure a sample of the student's abilities on a certain day in a given setting. Global standardised test scores {e.g. IQ} may over or under-estimate the child's specific deficits or strength areas, or indeed may give no indication of the impaired underlying cognitive processes that will have a profound effect on the child's ability to make progress at school. Some of the traditional, or well known tests may only attempt to measure skills and information acquired prior to the child's injury. If possible, it is helpful to include assessment and advice from a psychologist experienced in working with children with ABI in order to help clarify the child's learning difficulties.

An integral part of the evaluation is observations by the classroom teacher. A teacher's day-to-day contact with the child identifies the effect of factors such as decreased stamina, weakened organisational skills, situations that a child finds particularly stressful, their interactions with children and staff, as well as other details not available from standardised measures.

Another component of a comprehensive assessment is the comparison of the child's pre-injury academic performance with his present performance. This comparison helps to identify cognitive, physical and behavioural changes that are unique to this child.

Appropriate assessment may identify the child's unaffected areas of retained knowledge and help to define complex learning problems that may be experienced. The compilation of all assessment materials will help the teacher to formulate appropriate differentiation and compensatory strategies for the brain injured child in the classroom.

If you believe that a child who has suffered a brain injury is experiencing difficulties in the classroom, it may be beneficial to consider whether the following problems are present. This list is not meant as a diagnostic instrument, but can be used as an aid for identification of needs within the classroom. All these questions refer to age appropriate expectations, compared with peers.

	Yes	No
Is he able to focus attention on a given task?		
Can he shift his attention easily from one task to another?		
Is he easily distracted?		
Can he work independently?		
Can he organise (sequence) a task efficiently?		
Can he remain on task without prompting?		
Can he solve problems?		
Can he learn from his mistakes?		
Can he follow written instructions?		
Can he follow verbal instructions without multiple repetitions?		
Can he retain new information?		
Can he use language to express thoughts clearly?		
Does he respond in class within expected time limits		
Can he organise his work area e.g. desk, materials?		
Is his behaviour age appropriate?		
Does he interact appropriately with his peers?		
Does he accept changes in routine?		
Does he maintain stamina throughout the day?		
Does he perform and behave consistently?		
Is he aware of his strengths and weaknesses?		

# Addressing SEN resulting from ABI in schools

No two brain-injured children or adolescents share the same combination of strengths and difficulties. There must be consideration of the child's individual needs when planning classroom intervention. Brain injured children returning to school are often **inefficient learners**, requiring support to compensate for reduced cognitive abilities. A child who experienced learning problems prior to a brain injury will retain his difficulties, but these are likely to be exacerbated. The school should provide the pupil with necessary strategies to facilitate learning.

Prior to school return, it is helpful if the SENCO (Special Educational Needs Co-ordinator) is identified as a point of contact for other professionals who have been and may continue to be involved with the child and for the parents. An IEP (Individual Education Plan) for a child with a brain injury requires ongoing modification, with flexibility and development of compensatory strategies.

There are many strategies that are used with other groups of children with SEN as part of good practice which are often not considered for these children, for instance because they are either more able, or are working to a low level which is thought to be commensurate with their potential. However, strategies that teachers have found helpful with brain-injured students, whatever their ability, to support their learning and behaviour include:

- Structuring the classroom environment as much as possible.

- Breaking tasks into component parts and presenting gradually increasing levels of difficulty.
- Providing repetition for consolidation whenever possible.
- Allowing extra time for the child to process information and to respond.
- Integrating compensatory technology such as computers, digital recorders or smart pens into the child's classroom activities.
- Establishing prompts or cues such as gestures, reminder cards and written classroom rules.
- Provision of a buddy system to help navigate the school building and to follow a timetable.
- Help from a teaching assistant to clarify instructions or record work.
- Adjustment in the level of expectations to take into account the child's physical deficits, e.g. headaches and fatigue.
- Help for the child to develop organisational systems for books and equipment.
- Not relying solely on standardised or formal testing measures.

# Attention and concentration

- Get the child's attention by using a predetermined signal before presenting material.
- Reduce unnecessary environmental distractions, such as background noise.
- Remove unnecessary distractions, such as pencils, books and papers from the child's table. Or, for some children for whom manipulating something in their hands facilitates concentration, agree an acceptable object.
- Limit the amount of information presented.
- Reduce the number of individual tasks on a printed page.
- Reduce the amount of copying from the board and textbooks.
- Provide a window that frames small amounts of information to remove distractions on the page or use a highlighter to focus visual attention.
- Avoid asking a child to do more than one thing at a time, e.g. answering a question while carrying a lunch tray.
- Pace the child's work. Shortened tasks enable the student to sustain attention, encouraging completion.
- If the child is off task, make a specific task-related comment or direction that will help the child re-focus; a simple command to get on with work may not be helpful as he may have forgotten what it is he is meant to be doing.
- Say, for instance, "look at your book" rather than "pay attention".

# Memory and organisational skills

- Establish a routine. Consistency provides the child with stability and security.
- Develop a memory book to include daily timetables, notes regarding ongoing work and things to remember. Some children may also need information such as classroom seating charts, teachers' names or room numbers.
- Present information in a variety of ways - starting with the child's most intact modality. For example, give a child who has intact visual skills written directions, diagrams and directional cues, such as arrows.
- Pre-teach information. For instance, supply parents with materials to introduce concepts to the child and supply pupils with advance outlines of material to be covered.
- Give cues to encourage independent work. These cues may consist of an index card attached to the child's desk as a reminder to hand in or to complete work. Colour code textbooks and notebooks. For multi-step tasks prepare an outline (organiser) to be used as a guide.
- Use multiple-choice tests when possible. It is usually easier for a brain-injured child to recognise correct information than to recall it.
- Numerous repetitions and rehearsals of information are necessary. Encourage the child to manipulate information and to use it in more than one setting to assist encoding and to promote generalisation of learning.
- Allow the child to use compensatory tools such as an electronic organiser, calculator or computer.
- Link new information with old learning.
- Ask the child to repeat information to make sure that it is understood and encoded.

# Auditory and receptive language skills

- Reduce background noise by moving the child away from groups with which he is not involved, high traffic areas and environmental noises such as radiators.
- Speak at a slower rate.
- Present verbal information in small “chunks”.
- Reduce the complexity of verbal and written instructions.
- Repeat instructions.
- Accompany verbal directions with written ones, pictures or symbol cues.
- Allow extra time for the child to process verbal or written information.
- Allow use of compensatory tools, e.g. note taker.
- Provide the child with as much feedback as possible.
- Encourage the child to identify and request clarification of specific information or vocabulary he has not understood (self monitoring).
- Be aware that the child may have difficulty following and participating in group discussions.
- Do not use figurative or idiomatic speech. Children may take such phrases as “pull your socks up” literally, which may lead to confusion.
- Accept that the child may not understand humour or sarcasm.

## Expressive language skills

- Allow extra time to express himself if the child needs this.
- Be aware that the child may not be able to sequence oral or written language and provide appropriate visual or auditory prompts to help the child to structure his thoughts.
- Utilise appropriate special needs software to assist the child to organise thoughts and written work.
- Use question prompts to help the child expand expressive language. Asking who, what, where, why and how questions may help the child to structure his responses.
- Provide the child with examples of appropriate communication through modelling or role-play in PHSE lessons. Social Skills groups can benefit brain injured pupils.

## Visual skills

- Present material in the child's field of vision.
- Allow extra time to process visual information.
- Remove unimportant visual distractions when possible.
- Enlarge printed materials, e.g. text books or worksheets and reduce the amount on one page (using photocopying).
- Provide cues to encourage left to right tracking. These cues may be arrows, coloured dots, or highlighting of the top and/or left side of the text.

- Help the child to organise written work by utilising pre-folded paper, graph paper, pre-numbered pages, outlines and boxes for answers etc.
- Present information in an appropriate place if the child has a visual field deficit, such as not being able to see one side or edge of the page.

## **Reasoning and problem solving**

- Help the child who is unable to do so to identify problems.
- Help the child to think about alternative solutions to problems often encountered in the classroom and in the school setting.
- Help the child to predict consequences and point out cause and effect relationships.
- Assist the child in setting goals.
- Be aware of the child's inflexibility and inability to alter plans.
- Provide additional structure and organising templates, such as written steps to complete maths problems.
- Help the child to generalise rules or learning in each situation. For example, a child who learns to place appropriate headings on pages in one class may also need to be cued to use the same format for written work in all subjects.

## Social and behavioural skills

- Provide the child with social skills training and practice.
- Set clearly defined boundaries and teach routines.
- Provide alternatives for inappropriate behaviour rather than just telling the child not to do something.
- Give frequent and consistent positive reinforcements and provide feedback regarding behaviour and consequences.
- Redirect the child as soon as behaviour begins to be inappropriate, such as removing him from the situation or involving him in another task.
- Avoid drawing attention to inappropriate behaviour.
- Prepare the child for any change in classroom routine.

## Speed of processing

- Recognise that as the student becomes tired his speed of processing decreases.
- Eliminate timed measures to assess learning, whenever possible.
- Whenever possible, reduce the amount of work required.
- Provide the child with someone to take notes for him.
- Allow extra time for the completion of tests and assignments.
- Frequent breaks allow the child to “recharge.”

# Suggested reading

We hope the information in this booklet has helped to highlight the unique and often complex needs of children with acquired brain injury. Understanding these needs and difficulties is crucial to enable effective support to be delivered. Members of school staff play a critical role in providing that support in order to optimise recovery and to teach new strategies and skills to compensate for those that may be lost.

Parents, education and health staff working together can increase the understanding and communication, help to provide a consistently and closely monitored programme, and achieve the best outcome at each of the ages and stages through which a child develops.

This booklet may provide helpful starting points to increase understanding. The impact of an acquired brain injury occurs over a very long time and it is important to gather additional information and support structures to help a child succeed. The following publications may be useful.

Appleton R, Baldwin T (eds) 2006. *“Management of Brain Injured Children”*. Oxford University Press

Blosser J L, DePompei R 2003. *“Paediatric Traumatic Brain Injury – Proactive Intervention”*., 2nd edition Delmar: Thompson Learning

Middleton J A 1997. *“You’re not the only one: Having a brother or sister with a head injury”*. Child Brain Injury Trust publication

Middleton J A 2001. *“Psychological Sequelae of Head Injury in Children and Adolescents’* Journal of Child Psychology and Psychiatry 42, 2, 165-180.

Oddy M 1993. “*Head Injury during Childhood*”  
Neuropsychological Rehabilitation, 3, 301-31.

Powell T 2001. “*Head Injury – A Practical Guide*”.  
Speechmark Publishing.

Singer G H S, Glang A, Williams J M 1996. “*Children with Acquired Brain Injury. Educating and Supporting Families*”.  
Brooks Publishing

Walker S, Wicks B 2005. “*Educating Children with Acquired Brain Injury*”. Taylor and Francis

Wicks B, Walker S 1999. “*Choosing a School for your Child with Acquired Brain Injury*” Trust-Ed publication.

Ylvisaker M 1998. “*Traumatic Brain Injury Rehabilitation*”.  
Butterworth-Heinemann.

Special Educational Needs Code of Practice (2001) DfE  
(Department for Education)

**<http://www.education.gov.uk/schools/pupilsupport/sen>**  
(Please check the disclaimer on the website)

Access to Education for Children and Young People with  
Medical Needs ref: 0732/2001

**[www.education.gov.uk](http://www.education.gov.uk)**

Acquired Brain Injury, National Service Framework for  
Children, Young People and Maternity Services (Jack’s  
Journey). Search for ‘acquired brain injury exemplar’.

**[www.dh.gov.uk](http://www.dh.gov.uk)**

# Other resources

## “Don’t judge a book by its cover”

Workshops for Education Professionals provided by the Child Brain Injury Trust.

The Child Brain Injury Trust’s training on childhood acquired brain injury aims to provide a no-nonsense, jargon free approach to childhood acquired brain injury. This is a CPD opportunity and can be seen in full on the Teachers Development Agency CPD website.

<https://cpdsearch.tda.gov.uk/>

The workshop is suitable for anyone who works within the Education sector.

### Workshop Objectives

By the end of the workshop delegates will know and understand:

- How to define an acquired brain injury
- The impact an acquired brain injury can have on the family
- Why acquired brain injury is a hidden disability
- How this is likely to affect the support that a child requires in school
- How to implement practical strategies for supporting children and young people in the school and college environment

# Useful organisations



## **ACE (Advisory Centre for Education)**

[www.ace-ed.org.uk](http://www.ace-ed.org.uk)



0808 800 5793



## **Brain and Spine Foundation\***

[www.brainandspine.org.uk](http://www.brainandspine.org.uk)



0808 808 1000



## **Child Brain Injury Trust\***

[www.childbraininjurytrust.org.uk](http://www.childbraininjurytrust.org.uk)



01865 552 467



## **Contact a Family\***

[www.cafamily.org.uk](http://www.cafamily.org.uk)



0808 808 3555



## **Different Strokes\***

[www.differentstrokes.co.uk](http://www.differentstrokes.co.uk)



0845 130 7172



## **Encephalitis Society\***

[www.encephalitis.info](http://www.encephalitis.info)



01653 699 599



## **Headway\* - the brain injury association**

[www.headway.org.uk](http://www.headway.org.uk)



0808 800 2244



## **HemiHelp\***

[www.hemihelp.org.uk](http://www.hemihelp.org.uk)



020 8672 3179



## **Meningitis Trust\***

[www.meningitis-trust.org](http://www.meningitis-trust.org)



0800 028 1828



## **NCYPE (National Centre for Young people with Epilepsy)\***

[www.ncype.org.uk](http://www.ncype.org.uk)



01342 832243

**I.P.S.E.A. Independent Panel for Special Education Advice**



[www.ipsea.org.uk](http://www.ipsea.org.uk)



0800 818 4016

**SKILL, National Bureau for Students with Disabilities**



[www.skill.org.uk](http://www.skill.org.uk)



0800 328 5050

**The Children's Trust\***



[www.thechildrenstrust.org.uk](http://www.thechildrenstrust.org.uk)



01737 365000

**National Brain Injury Centre\***



[www.stah.org](http://www.stah.org)



01604 616692

**Trust-Ed\***



[www.trust-ed.org](http://www.trust-ed.org)

\*Member of the Children's Acquired Brain Injury Interest Group (CABIG), a consortium of charities concerned with acquired brain injury in children.

# Afterword

The justification for the booklet is that we believe that understanding can lead to real benefits for children with ABI: there are things that can be done in the classroom that will make a real difference.

Someone once wrote that the unique tragedy for parents of a child with an acquired brain injury was the daily reminder of the child they had lost. For some families with less severely injured children this may seem an exaggeration. For others, however, the situation is doubly cruel: society cannot see and may not even acknowledge that they have lost a child they once knew.

We hope this booklet has gone some way to help parents and (in this case) educationalists understand how this can arise, and in doing so to understand each other (and the child at the centre) better. Damage has been done that cannot be undone. But whilst the brain cannot replace damaged areas, it is remarkably flexible and adaptive, and can be helped to “work around” new difficulties.

**Undoubtedly, the single greatest asset a child recovering from ABI can have is an empowered parent advocating for them. We hope that this booklet makes a small contribution towards this goal.**

# Acknowledgements

The “Must Try Harder?” project was originally funded by Tyne & Wear Health Action Zone. The project team members were:

Kieran Breen, CBIT; Dr Rob Forsyth, Consultant and Senior Lecturer in Child Neurology, Newcastle General Hospital; Dr Tom Kelly, Consultant Paediatric Neuropsychologist, Newcastle General Hospital; Sue Walker, Educational Psychologist; Beth Wicks, Education Consultant.

Feedback on the content of the “Must Try Harder” package will be welcomed, and should be directed to: Children’s Acquired Brain Injury Interest Group, c/o Encephalitis Society, 7B Saville Street, Malton, Yorkshire YO17 7LL.

This booklet and accompanying DVD are given to parents of children who have survived acquired brain injury, to show to their teachers, SENCO'S and others involved in meeting their educational needs. It provides an understanding of why educational difficulties can arise after acquired brain injury, and of appropriate compensatory strategies.

We hope this package goes some way to help parents and educationalists understand:

- That there are things that can be done in the classroom that will make a real difference.
- That although the brain cannot replace damaged areas, it is remarkably flexible and adaptive, and can be helped to “work around” new difficulties.

**Funded by**



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