

# Capturing the voices of children in the Education Health and Care plans: are we there yet?

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### *Conflict of interest statement*

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest

### *Author contribution statement*

OP and SC have conceptualised and written the whole paper in collaboration, and the ideas provided are the result of shared reflection. CG and VE contributed to conducting the study and drafting and revisiting the intellectual content of the paper.

### *Keywords*

special educational needs (SEND) Code of Practice, Voices, Children, International Classification of Functioning, Disability and health (ICF), Education, Health and Care (EHC) plans

### *Abstract*

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The focus on the voice of children with special educational needs has received increased recognition internationally both in policy and research. In England, this was depicted in the new special educational needs framework introduced in 2014. As part of this new policy, children with disabilities and/or additional needs can receive an Education Health and Care (EHC) plan. The EHC plan is a single document that should describe the children's strengths and needs in a multi-disciplinary and holistic way. Section A of the EHC plan should describe the child's own perspective. In this context there is much need for evidence on the quality of these new plans and in particular on the quality of the depictions of children's voices. The aim of this study was to address this knowledge gap by analysing the depictions of children's voices and the process by which these were gathered in 184 EHC plans of children with SEND attending mainstream and special schools in the Greater London area.

The content analysis of the section concerning the children's voices was conducted using the categories of a multi-dimensional classification system, which includes aspects relating to the child herself, but also to her environment and relationships - the International Classification of Functioning, Disability and Health (ICF). The findings revealed high levels of variability in the way the voices of children were captured, including the methods used to ascertain their views. Additionally, the type of school that the child was attending seemed to play a significant role on how his/ her voice was captured, favouring mainstream schools. The findings of the present study provide the first set of evidence-based data concerning the quality of the content of the newly introduced EHC plans and are discussed in the light of the implications they have for policy and practice.

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### *Ethics statements*

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*Ensure that your statement is phrased in a complete way, with clear and concise sentences.*

The study was approved by the Ethics Research Committee of the University of Roehampton, which adheres to the British Psychological Society guidelines. Written parental opt-in consent was provided by all parents of children that their plans were received and analysis for the purposes of the current study. All plans included in the analysis were anonymised. Confidential information regarding the name of the Local authority, parents or schools contact details was only accessed by the core members of the research team. This data was permanently kept in password-protected files on the university computers (when in online format) and in locked cabinets in the teams' research office.

In review

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### Abstract

The focus on the voice of children with special educational needs has received increased recognition internationally both in policy and research. In England, this was depicted in the new special educational needs framework introduced in 2014. As part of this new policy, children with disabilities and/or additional needs can receive an Education Health and Care (EHC) plan. The EHC plan is a single document that should describe the children's strengths and needs in a multi-disciplinary and holistic way. Section A of the EHC plan should describe the child's own perspective. In this context there is much need for evidence on the quality of these new plans and in particular on the quality of the depictions of children's voices. The aim of this study was to address this knowledge gap by analysing the depictions of children's voices and the process by which these were gathered in 184 EHC plans of children with SEND attending mainstream and special schools in the Greater London area.

The content analysis of the section concerning the children's voices was conducted using the categories of a multi-dimensional classification system, which includes aspects relating to the child herself, but also to her environment and relationships – the International Classification of Functioning, Disability and Health (ICF). The findings revealed high levels of variability in the way the voices of children were captured, including the methods used to ascertain their views. Additionally, the type of school that the child was attending seemed to play a significant role on how his/ her voice was captured, favouring mainstream schools. The findings of the present study provide the first set of evidence-based data concerning the quality of the content of the newly introduced EHC plans and are discussed in the light of the implications they have for policy and practice.

**Key words:** special educational needs (SEND) Code of Practice, voices, children, International Classification of Functioning, Disability and Health (ICF), Education, Health and Care (EHC) plans

## 1 Capturing the voices of children in the Education Health and Care plans: are we there yet?

### 1. Introduction

Capturing the voices of children with special educational needs and disabilities (SEND) has increasingly been recognised as a key element of relevant policy initiatives internationally (United Nations Convention on the Rights of Persons with Disabilities, 2006; Porter, 2014). In England, there is increased emphasis on participation of children and young people in the decision-making process through the new SEND Code of Practice, which was introduced following the enactment of the Children and Families Act (CFA) 2014 (DfE and DoH, 2015). These reforms have been described as the most substantial ones in the UK over the last two decades (DfE, 2014; Norwich & Eaton, 2015; Curran, Mortimore & Riddell, 2017). The CFA introduced the Education, Health and Care plans (EHC plans) to replace previous statements of Special Educational Needs. The EHC plan is a single document that should describe the children's strengths and needs, in a multi-disciplinary and holistic way and portraying the child's own perspective. Although capturing the views of children is a key element of the new SEND policy, there is limited systematic evidence to date on how the voices of the children are depicted in the EHC plans and on the methods used to ascertain their voices. To the authors' knowledge, this is the first study which aims to address this knowledge gap by systematically analysing the EHC plans of children attending mainstream and special schools in order to examine how their voices are being captured.

#### 1.2 The new special educational needs framework in England

Some of the changes introduced by the new SEND framework concerned the definition of SEND; the emphasis on multi-agency team work in achieving an integrated, holistic assessment of the child or young person; the extension of the age range for the provision of SEND from birth to 25 years of age; the emphasis on a child-centred approach, in which eliciting the voices of the children and young people themselves was considered a key element of their assessment and intervention. Additionally, as part of this SEND policy framework, Education Health and Care (EHC) plans replaced the Statements of SEN.

The EHC plan is a single document that should describe the children's education, health and care strengths and needs, in a multi-disciplinary and holistic way and portraying the child's own perspective. The Code of Practice provides a description of the elements that each section of the EHC plan should contain (DfE & DoH, 2015). Section A of the EHC plan should describe the child's own voice. It should be noted that the EHC plan is drawn up by the local authority (LA) following an education, health and care assessment which has concluded that an EHC plan is necessary in order for the child's needs to be met and also following consultations with relevant teams of professionals, parents and the children themselves. Therefore, the new SEND policy highlights the principle of child *participation* in decision-making. Additionally, it points out the legal duty of local authorities to enable children and young people through the development of appropriate processes to express views, to be consulted and to take an active part in decision-making on ways of achieving the best possible outcomes.

### 1.3 The voices of children with SEND

The notion that the voices of children and young people with SEND should be heard and that they should be actively involved in decision making about their education, health and social care is not a new one and has been described and pointed out before in policy and legislation documents both in the UK and internationally (Children Act, 1989; United Nations Convention on the Rights of Persons with Disabilities, 2006; Gray et al., 2006; Palikara et al., 2009). Policy changes have taken place with the voice of the child in the centre (Children Act, 1989; Individuals with Disabilities Education Act, 2004), but there still appears to be a gap between policy and practice (Porter, 2014). Although the values and ideologies of these policy documents are important, the empirical evidence on the effectiveness of these legislation documents in capturing the voices of children is still rather scarce. For example, in England, there is no systematic evidence on the quality of the methods by which the voices of children and young people were captured in previous legal documents describing their needs - the Statements of SEN, although critiques on Statements do exist (Warnock & Norwich 2010). The evidence concerning the effectiveness of the EHC plans in capturing the voices of children since the reformed system was introduced are even narrower. In 2017, the Department of Education published the findings of a commissioned study examining the views of parents and children on EHC plans (Adams et al., 2017). It was reported that two thirds of the children that took part in the survey were satisfied with the process followed for obtaining their EHC plan and that this would help to achieve the outcomes agreed on the actual plan for the child or the young person. Interestingly, it was reported that only 44% of the children and young people were being directly *asked* if they wanted to take part and it was much less common for them to be given *choices of how* to take part (19%) in the Education, Health, Care assessment process. It was also noted that the chances of child/ young people being actively involved in the process seemed related to the child's age and whether they previously had a Statement of SEND. In the same line, two other recent reports (Scott, 2016; National Autistic Society, 2016) described the level of satisfaction of parents and children since the introduction of the reformed system but both provided no evidence deriving directly from the children's EHC plans documents.

The process or methods for eliciting the views of children and young people do not come without particular challenges. Previous research has highlighted that capturing the voices of children and young people is not unproblematic and requires use of appropriate methodology, meticulous planning and care in eliciting and interpreting valid responses (Palikara et al, 2009; Whitehurst, 2007). Whitehurst (2007) argued that this is particularly challenging when eliciting the views of children with profound and complex needs and called for the need of developing appropriate methodologies and strategies to meaningfully engage in such process with the children themselves. Palikara and colleagues (2009) examined the views of adolescents with a history of Specific Language Impairment during transition from secondary education to post-16 and argued that the young people were aware of their history of SEND and were able to offer valid accounts of the effect that these difficulties had on different aspects of their lives including education. The findings of this study also highlighted important methodological issues in eliciting the views of children with SEND including the value of professional experience and the use of 'narrative coherence' (Hauser et al., 2006) as a useful methodological tool in ascertaining the views of these children. Although the above studies provided some valuable evidence concerning the challenges and the opportunities related to eliciting the views of children with SEND, it should be noted that none of them has examined ways by which the voices of these children are actually being depicted in official legal

1 documents, such as their Statements of SEN, or EHC plans, which usually accompany the  
2 children and young people throughout their whole educational path and play a significant role  
3 in determining outcomes, aspirations expectations and provision among other things.

4

5 In order to address some of the gaps identified in the literature above, we aimed to gather some  
6 novel data by investigating the quality of the newly introduced EHC plans specifically  
7 regarding the ways by which they capture the voices of children with SEND. In particular, we  
8 aimed to address the following four research questions:

9

- 10 1. Have the children's voices as presented in the Section A of the EHC plans been  
11 obtained directly from the child?
- 12 2. What methods were used in order to elicit the views of the children on the EHC  
13 plan?
- 14 3. In the Section A of children's EHC plans was the focus on abilities, disabilities or  
15 both?
- 16 4. Where there any differences in the depictions of children's voices in EHC plans  
17 from mainstream schools when compared to those from special schools?

18

19 In order to address the research questions above, the International Classification of  
20 Functioning, Disability, and Health for Children and Youth (ICF-CY), was used as a theoretical  
21 framework and coding system. In 2007, the WHO published the ICF-CY), which followed the  
22 publication of its adults' version (ICF) in 2001. The ICF, which is considered to provide a third  
23 viewpoint, beyond the medical model and the social model of disability in the conceptualisation  
24 of SEND, acknowledges that the source of the disability is the complexity of individual and  
25 social factors interacting to result in a unique individual functioning profile (Simeonsson,  
26 2006). This ICF was selected as a theoretical and analytic framework for the purposes of the  
27 specific study because the multidimensional conceptualisation of disability as described in the  
28 ICF-CY is closely aligned with the definition of the SEND in the new SEND policy. Although  
29 the ICF-CY is not mentioned directly in the new policy, a rationale concerning the possible  
30 links between the two has been presented elsewhere (Castro & Palikara, 2016). Castro and  
31 Palikara (2016) have also argued that the body functions and the activities and participation  
32 codes introduced by the ICF-CY could be used to document the children's SEND in the EHC  
33 plans. Similarly, the environmental factors' codes could be applied to describe the  
34 environmental influence of contextual features on the child's participation or to document the  
35 Local Offers across LAs, using a common language. The approach to disability as briefly  
36 described above was key for the adoption of the ICY-CY as the taxonomic system to serve the  
37 purposes of the present study.

38

## 39 **2. Materials and methods**

40

### 41 **2.1 Recruitment and data collection**

42

43 In order to proceed with the analysis of the Education Health and Care plans of children with  
44 SEND, a formal invitation letter was sent to a number of Local Authorities in close proximity



1 with the University of Roehampton. Once the support of the Local Authority was obtained,  
2 formal invitation letters with informed consent forms for head teachers, Special Education  
3 Needs Coordinators (SENCOs) and parents were sent to all schools within the Local Authority  
4 that have expressed their interest in participating in the study. Meetings were held with the  
5 representatives of the schools that expressed interest in the study, in order to explain the scope,  
6 process and ethical standards of the project and how the results would be reported.  
7 Additionally, meetings were held with parental associations in some local authorities where  
8 the project was presented and parents invited to participate. For each school that agreed to  
9 participate, the key contact person liaised with the parents to obtain opt-in consent from them  
10 to release the EHC plan of their child/children. Both online and physical informed consent  
11 forms were issued and accepted; the content of the online form was strictly the same as the  
12 physical form. When parents expressed their interest to participate directly to the team, signed  
13 informed consent forms were sent to us, without school mediation. As an incentive to  
14 participate in the study the team made the commitment of feeding back the general results of  
15 the study to both parents and professionals. Once the informed consent forms were received by  
16 the team in either online or physical format, the team would contact the parent/key professional  
17 for the anonymised EHC plan to be sent to us in password-protected format.

18

## 19 **2.2 Participants**

20

21 The EHC plans included in the analysis describe the education health and care needs of 52 girls  
22 and 132 boys in 92 mainstream and 92 special schools, across 9 London Local Authorities. The  
23 date of birth was made available for 175 of the 184 children; mean age was 11.21 years, with  
24 a standard deviation of 4.04; the youngest participant was 3 years old oldest participant is 21  
25 years old and the

26

## 27 **2.3 Ethical issues**

28

29 The study was approved by the Ethics Research Committee of the University of Roehampton,  
30 which adheres to the British Psychological Society guidelines. Written parental opt-in  
31 consent was provided by all parents of children that their plans were received and analysis for  
32 the purposes of the current study. All plans included in the analysis were anonymised.  
33 Confidential information regarding the name of the Local authority, parents or schools  
34 contact details was only accessed by the core members of the research team. This data was  
35 permanently kept in password-protected files on the university computers (when in online  
36 format) and in locked cabinets in the teams' research office.

37

## 38 **2.4 Data analysis**

39

40 The content of section A of the plans included in this study was analysed through a process of  
41 systematic content analysis. Two types of content analysis were included sequentially. First,  
42 an inductive process of content analysis was adopted to ascertain whether general themes  
43 would emerge from the reading of section A of the plans. As a result of this analysis, it was  
44 noted that this section contained information on *abilities/strengths* of the child and on

1 *disabilities/functioning issues* of the child; similarly, some plans use the first person ('I') while  
2 others refer to the child using the third person. However, in many of the plans using the first  
3 person, there were indications of the fact that maybe the child herself did not provide the  
4 information conveyed, as it was often characterised by a rather complex discourse in cases  
5 where children were reported not to have the functional abilities to express their view in such  
6 complex way. Therefore, as a first step and as a result of an inductive content analysis,  
7 frequencies were run for all plans regarding the following categories: number of plans that use  
8 the first person in section A; number of plans that report the process by which the  
9 voice/perspective of the child was obtained; number of plans with section A focusing on  
10 abilities, disabilities or both.

11

12 The second and following type of content analysis adopted was a deductive content analysis  
13 using the International Classification of Functioning, Disability and Health for Children and  
14 Youth (WHO; ICF-CY, 2007). This is a classification system regarded by the WHO as the gold  
15 standard for classifying disability in children and it has been extensively used in other studied  
16 to support the exploration of disability-related content (e.g. Castro, Pinto & Simeonsson, 2014;  
17 Osborne et al., 2016; Klang et al., 2016). Using the ICF-CY categories as pre-defined codes  
18 for deductive content analysis supports a deeper examination of the nature of the content  
19 included in section A of the plans. This second phase of analysis followed specific steps: 1)  
20 identification of units of meaning within the text relating to either abilities/strengths of the child  
21 and those referring to disabilities/ functioning issues and also those referring to environmental  
22 issues; meaning units are hereby defined as the constellation of words or statements that relate  
23 to the same central meaning (Graneheim & Lundman, 2004); 2) all meaning units in all three  
24 categories (abilities, functioning issues and environmental issues) were coded using the ICF-  
25 CY system and following coding procedures used in previous studies, namely the ICF linking  
26 rules (e.g. Cieza et al., 2005; Cieza et al., 2016; Castro, Pinto & Simeonsson, 2014); the linking  
27 rules were developed for the specific purpose of linking content with the ICF, and include  
28 specific notations for each type of content that cannot be linked to the classification and  
29 guidelines on how to choose the ICF code to be linked to the meaning unit under analysis; 3)  
30 all meaning units were firstly coded by an experienced researcher with training on the ICF-CY  
31 system; 4) 5% of all meaningful units regarded as 'abilities' and 5% of all meaning units  
32 regarded as 'disabilities' were double-coded by a second independent researcher also trained  
33 on the ICF-CY to ensure reliability of criteria when coding. The choice of units to be double-  
34 coded was made through random selection of numbers on a computerized web-application;  
35 each number randomly selected would correspond to one EHC plan and the first 2 meaning  
36 units of that plan would be double-coded until 5% of the total was reached. Frequencies of  
37 meaning units were computed per ICF-CY component, abilities, disabilities and environmental  
38 issues and per category within these components. Demographic variables regarding date of  
39 birth, gender, age, local authority and type of school (special or mainstream) were also recorded  
40 and included in the analysis.

41

42 We also tested whether there were differences between local authorities and types of school in  
43 regard to: the use of the first person in the section A, the focus on abilities or disabilities and  
44 also regarding the content of the plans as coded by the ICF-CY system. These analyses were  
45 performed using non-parametric tests with *R studio*.

46

### 3. Results

A total of 184 plans were included in the analysis. Twenty-six plans that were received with parental consent were not included in the analysis because the content of section A (the child's perspective) was missing – the section was either not completed or the content was extremely limited. The plans included in the analysis describe the education health and care needs of 52 girls and 132 boys in 92 mainstream and 92 special schools, across 9 London Local Authorities. The date of birth was made available for 175 of the 184 children; mean age is 11.21 years, with a standard deviation of 4.04; the oldest young person is 21 years old and the youngest is 3 years old. Table 1 describes the number of EHC plans included in the analysis per Local Authority. Because some Local Authorities provided very few plans, only the first four were included in the inferential analysis.

[Table 1 here]

The Local Authorities included in the inferential analysis differ substantially in terms of their demographics. According to the 2015 Indices of Deprivation (Department for Communities and Local Government, 2015), Local Authorities 2 and 4 are within the 10% least deprived in the country, while Local Authorities 3 and 1 are in the 50% more deprived. More details about the socio-economic characteristics of these boroughs cannot be included for preservation of confidentiality and anonymity.

#### 3.1 Results of the induction analysis

As a result of the inductive content analysis performed with the 184 EHC plans included in this study, it was observed that 117 plans (63.6%) used the first person in section A of the plans. However, amongst these, many show some indication that the voice of the child was not directly obtained, as the first-person discourse seems rather complex for the pattern of needs described in the child's profile. For example, '*I enjoy interacting with people including strangers*' (participant 57, characterised in the plan as having a global developmental delay, performing way below age related expectations and needing visual cues to communicate at 6 years of age) and '*I can give an answer from 2 or 3 choices, point to what I want or show what I want*' (participant 56, who is described in the needs section of his plan as 'not engaging without support' and just 'beginning to understand routines and expectations in school at 6 years of age). Therefore, it is difficult to ascertain whether the use of the first person in the great majority of the plans actually represents the real number of children there were indeed heard. Only 31 plans of the 184 (16.8%) report the methods by which the voice of the child was obtained. Often, there is mention to the fact that the parent filled in the section of the plan in representation of the child, but there is no indication in the great majority of these plans on how the child's views are understood by the parent or other representing adults. When Looking at whether the plans focus on abilities, disabilities or both in section A, it was observed that the great majority of plans focus on both (91.3%); For example, participant 197 'turns the pages by himself' but 'doesn't like others being in his personal space and can become upset when this happens'.

### 3.2 Results of the deductive analysis

From the deductive content analysis performed using the ICF-CY categories as a pre-defined classification of domains to link with the content of section A of the plans, the following was observed: 709 meaning units were identified as relating to abilities or strengths of the children and 1010 meaning units were identified as relating to disabilities or functioning issues of the children; therefore, even though the great majority of plans focus on both abilities and disabilities as described above, there a majority of content units focusing on functioning issues rather than strengths. Additionally, 277 meaning units were identified as relating to environmental issues.

Figure 1 shows the frequency of plans and the total number of occurrences of each meaning unit, within the ones classified as abilities/strengths of the child. The figure shows that most abilities identified in section A of the EHC plans refer to Activities and Participation aspects, followed by Body Functions; some aspects were classified as *non-definable* for being rather vague and consequently not susceptible of being classified with a specific system such as the ICF (for example, participant 33 was described as having said that she needs help with 'gross motor skills' in section A). Table 2 discriminates the specific aspects of functioning that were most commonly mentioned as abilities/strengths of the child: *motivation functions* appear 191 times (occurrences) in 141 plans (records). It is very common that the child or representative describes what the child enjoys doing. These were all classified as motivational aspects. The second most common aspect identified as abilities of the children was temperament and personality functions (children being described as 'loving', 'sociable', etc; these appeared 81 times in 58 plans Other aspects identified as abilities were observed in a minority of plans, including interactions with peers, communicating through gestures, speaking, eating and calculating.

[Figure 1 here]

[Table 2 here]

Figure 2 shows the frequency of plans and the total number of occurrences of each meaning unit, within the ones classified as disabilities/functioning issues of the child. Once again, Activities and Participation are the most common type of functioning issue observed, followed by Body Functions; there are only 8 occurrences corresponding to 8 records of Body Structures identified as functioning issues; 55 occurrences in 45 records were *non-definable*.

[Figure 2 here]

Table 3 shows the specific type of content assigned to functioning issues. The most common functioning issue observed was emotional functions (often linked to emotional regulation issues, such as aggressive outbursts or tantrum behaviours). Speaking is the second most

1 common functioning issue. Non-definable issues due to their vagueness and lack of clarity were  
2 the third most commonly identified.

3

4 [Table 3 here]

5

6 Figure 3 shows the frequency of plans and the total number of occurrences of each meaning  
7 unit, within the ones classified as environmental factors relevant for the child. The majority  
8 of meaning units link to *support and relationships*, followed by *products and technology*. The  
9 specific environmental aspects most commonly included in section A were the *support of the*  
10 *immediate family*, which was mentioned in the great majority of plans (151); products and  
11 technology include *medication* and *communication aids*.

12

13 [Figure 3 here]

14

### 15 **3.3 Results of the inferential analysis**

16

17 Series of non-parametric tests (Mann-Whitney and Kruskal Wallis) were run to test differences  
18 between Local Authorities and type of school regarding the inclusion of specific abilities,  
19 disabilities and environmental issues in section A of the EHC plans. Non-parametric tests were  
20 used given the categorical nature of the variables under analyses. In fact, the Kruskal-wallis  
21 test ( $H$ ) '*is approximately chi-square distributed, meaning that the probability of getting a*  
22 *particular value of  $H$  by chance, if the null hypothesis is true, is the P value corresponding to*  
23 *a chi-square equal to  $H$* ' (McDonald, 2014, p.157). No differences were found between local  
24 authorities or type of school in this respect.

25

26 Similar analysis was run to test the difference between Local Authorities and type of school in  
27 relation to the use of the first person in section A of the plans, the quality of the report on how  
28 the voice of the child was obtained and regarding a stronger focus on abilities, disabilities or  
29 both. It was found that Local Authority 1 uses the first person significantly less than local  
30 authorities 2 and 4 ( $H(8) = 39.41, p < .05$ ). Local Authority 3 describes the method for  
31 obtaining the child's voice significantly more than the other Local Authorities ( $H(8) = 72.31,$   
32  $p < .05$ ). Mainstream schools report the method for obtaining the voice of the child  
33 significantly more often than special schools ( $U = 11.81, p < .001$ ).

34

## 35 **4. Discussion**

36

37 To our knowledge, this is the first study which aimed to provide systematic evidence  
38 concerning the quality of the newly introduced EHC plans, in relation to how the voices of  
39 children with SEND attending mainstream or special schools were captured. The content of  
40 184 EHC plans of children with SEND attending mainstream and special schools in the Greater  
41 London area were analysed using the ICF as theoretical and analytical framework. The findings

1 of the study showed great variability between LAs in the way that they were capturing the  
2 voices of the children and also in the methods employed to ascertain their views. Although  
3 most of the EHC plans included some information on children's abilities/strengths, the analysis  
4 of these units showed that they were rather limited in scope and revealed little about what the  
5 child was good at. Significant differences were found in the way the voices of the child were  
6 captured depending on the type of school attended, with mainstream schools providing more  
7 detail.

8

9 The results of the study highlight the high level of variability observed in the way different  
10 LAs were capturing the children's voices. The data collected in this study was gathered  
11 between 2015 and the end of 2016 and therefore cannot represent the current national trend;  
12 this is still to be known upon completion of conversions of statements into EHC plans.  
13 However, the present study includes a variety of EHC plans, developed within Local  
14 Authorities that differ substantially regarding their ways of operating and availability of  
15 resources. As mentioned in the sample description, the areas included in the main analysis  
16 differ in terms of their deprivation indices (Department for Communities and Local  
17 Government, 2015). This is interesting if we consider the observation that some of the quality  
18 aspects of the plan (section A) differed significantly between Local Authorities; these  
19 differences might reflect different procedures in designing and implementing the EHC planning  
20 process, but also the resources (and often the lack of them) available to support these  
21 procedures. These differences between Local Authorities may also reflect the lack of national  
22 guidelines for the development of EHC plans, placing the accountability for the quality of the  
23 process within the Local Authority only. Given that their resources differ substantially, the lack  
24 of such guidelines is directly affecting the quality of the EHC plans that will be made available  
25 for children and families in more deprived areas. Future research should endeavour to provide  
26 evidence to support the development of guidelines to improve the quality and comparability of  
27 the EHC planning process across the nation. Although Statements of SEN have been criticised  
28 in the past on how useful they were as tools in meeting the needs of children (Audit  
29 Commission, 2002; Norwich 2005), the evidence base for the effectiveness and usefulness of  
30 EHC plans for children, young people, families and professionals remains to be seen. The  
31 findings of this study revealed that mainstream schools tend to report significantly more often  
32 the methods used in obtaining the child's voice when compared to special schools. This is an  
33 interesting result as one could deduce that special schools would master techniques of accessing  
34 the children's voices better than mainstream schools that often do not have the specialised staff.  
35 However, it may also be the case that special schools support children with more severe  
36 functioning issues than mainstream schools and therefore find the process of accessing their  
37 voices even more challenging. Indeed, previous research in the area of ascertaining the voices  
38 of children with complex needs has underscored the particular challenges that professionals  
39 may experience during this process (Palikara et al., 2009; Whitehurst, 2007). Additionally, it  
40 should be noted that the results of the current study may not be generalizable in terms of the  
41 differences found in the quality of the EHC plans between mainstream and special schools; this  
42 would not be achievable considering the currently observed delay in the completion of  
43 Education Health and Care plans. In fact, between January 2016 and January 2017, only 32.7%  
44 of the children and young people with statements had received a converted EHC plan (DfE,  
45 2017), which is illustrative of the slow pace of the conversion process. Perhaps national  
46 guidelines for the development of EHC plans should also include a range of evidence-based  
47 methods and strategies to use with children of various functioning levels in order to gather their  
48 views. Future research should address the link between the quality of the EHC plans developed  
49 and the pattern of needs of the children in receipt of those plans.

1 The findings of the present study illustrated that even though the majority of EHC plans  
2 included some information on the abilities/strengths of the child, this seemed to be much more  
3 often related to what the child *likes/enjoys* doing, than to what the child *is good at*. Even though  
4 the information on motivational issues is regarded as of great importance, it might be equally  
5 relevant to include actual aspects of functioning that can be linked to day-to-day successes,  
6 things that the child *is good at*, to support educational interventions. These issues could  
7 integrate national-wide guidelines on how to develop high quality EHC plans. Similarly,  
8 temperament and personality functions are often mentioned as abilities/strengths of the child.  
9 This happens as in most cases there is a description of the child's general behaviour (using  
10 terms such as 'loving', 'caring', 'sociable' or 'cute'), more than actual behavioural dimensions  
11 that can be prompted and measured as the basis for educational interventions and monitoring.

12

13 Regarding the specific types of disabilities identified in the analysed plans, it is worth noting  
14 that the code *non-definable* was the third most frequent code linked to these meaning units.  
15 The reason for this was the rather vague nature of many of these statements. For example, 'has  
16 issues around language development' or 'needs to be more independent' are rather general  
17 statements that do not support potential interventions and do not illustrate the highly specialised  
18 work of a multi-disciplinary team of experts that should have developed the plan bringing  
19 together their expertise. On the contrary, these are general, not specialised statements that could  
20 apply to many children with or without education, health and care needs. Non-definable  
21 statements identified in this study also refer to diagnostic data which is often presented as a  
22 way of describing a general *need*, but not necessarily informing educational intervention, or  
23 actions to take place in an educational setting (for example, 'has epilepsy', but no information  
24 is available on the frequency and severity of seizures and functional consequences for the  
25 child's *participation*). The issues of quality observed in these plans suggest that there might be  
26 other factors influencing the quality levels of the EHC plans developed and these might be the  
27 training and specialisation characteristics of those involved in EHC plan development. To date  
28 there are no national guidelines, standardised procedures or minimum requirements to be met  
29 by those who are involved in the process. The data observed in this study might be a reflection  
30 of such dearth of specialisation.

31

32 In the present study, the use of the ICF was a valuable theoretical and analytical framework to  
33 enable the identification of quality issues with a greater level of specificity, looking at the actual  
34 nature of the content included in the plans. The biopsychosocial nature of this classification  
35 system split into Body Functions and Structures, Activities and Participation and  
36 Environmental Factors seems to be a good fit when trying to analyse the quality of documents  
37 that aim to be holistic in their descriptions of education, health and care aspects. This suggests  
38 that perhaps the use of such system as a supporting tool in the developing stage of the EHC  
39 plans could potentially help to improve their quality – by reducing vague statements,  
40 introducing standard levels of information of social and individual nature as well as by  
41 providing a common language between professionals from different areas of intervention. The  
42 ICF is of particular relevance for the English context as it has the potential to address key issues  
43 in the current SEND policy including: ensuring parent and child access rights to an adequate,  
44 relevant and user-friendly assessment; adopting an interactive causal model and holistic model  
45 of disability, which is relevant to a range of areas of functioning; covering personal strengths,  
46 not just difficulties; and supporting inter-professional collaboration (Castro & Palikara, 2016;  
47 Norwich, 2016).

1 This study examined how the voices of children with SEND attending mainstream and special  
2 schools were captured on their EHC plans. However, it should be noted that the pattern of  
3 needs that the child experiences was not taken into account in this analysis. This was a  
4 deliberate decision in order to allow for the emergence of themes that they may be universal  
5 concerning the quality of the EHC plans, regardless of the type of SEND. However, future  
6 studies should consider whether there are significant links between the children's patterns of  
7 needs and the quality of their EHC plans. Additionally, it would be useful to consider whether  
8 capturing the voices of children with profound and complex learning issues or rare  
9 developmental disorders, may affect the quality of how the voices of these children are being  
10 captured, because of the difficulties inherent with eliciting the views of these children  
11 (Whitehurst, 2006). Furthermore, research aimed at examining the quality of how the voices of  
12 older young people with SEND are being captured, especially in preparation for adulthood is a  
13 noteworthy area for future research with important educational and clinical implications.

In review



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Table 1

*Frequency of plans per Local Authority*

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<u>Local Authority</u>	<u>Number of EHC plans obtained</u>
1	66
2	36
3	27
4	37
5	3
6	8
7	4
8	1
9	2
Total	184

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In review

FREQUENCY OF ABILITIES/  
STRENGTHS PER ICF-CY COMPONENT

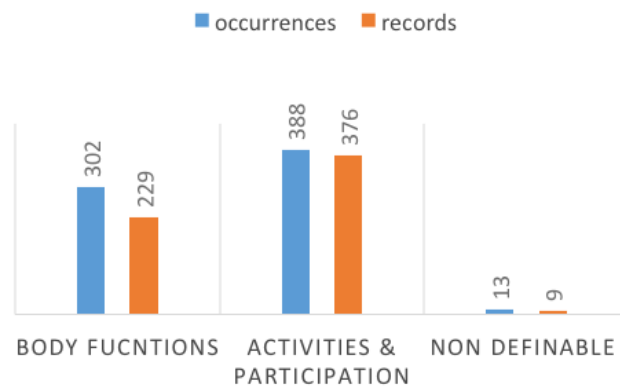


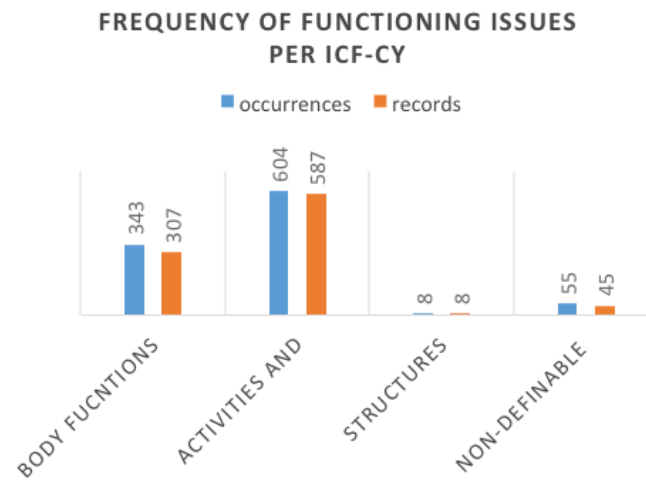
Figure 1. Frequency of strengths/abilities in section A of the plans, matched with the ICF-CY classification system

In review

Table 2

*Most common ICF-CY codes used to describe abilities/strengths*

ICF-CY code	Occurrences	Records
Motivation functions	191	141
Temperament and personality functions	81	58
Interactions with peers	39	38
Communicating with gestures	24	20
Speaking	20	19
Eating	18	18
Calculating	14	14
Non-definable	13	9



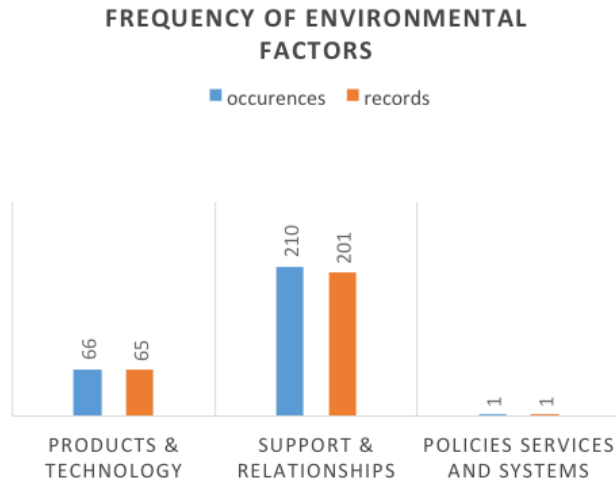
*Figure 2.* Frequency of functioning issues in section A of the plans, matched with the ICF-CY classification system

In review

Table 3

*Most common ICF-CY codes used to describe functioning issues*

ICF-CY code	Occurrences	Records
Emotional functions	82	62
Speaking	60	59
Non-definable	55	45
Accepting novelty	38	32
Eating	37	35
Dressing/undressing	34	34
Regulation of emotions	31	25
Toileting	31	31
Sensory functions	29	28
Writing	27	27
Directing attention	26	26
Reading	24	24



*Figure 3.* Frequency of environmental factors in section A of the plans, matched with the ICF-CY classification system





Figure 1.JPEG

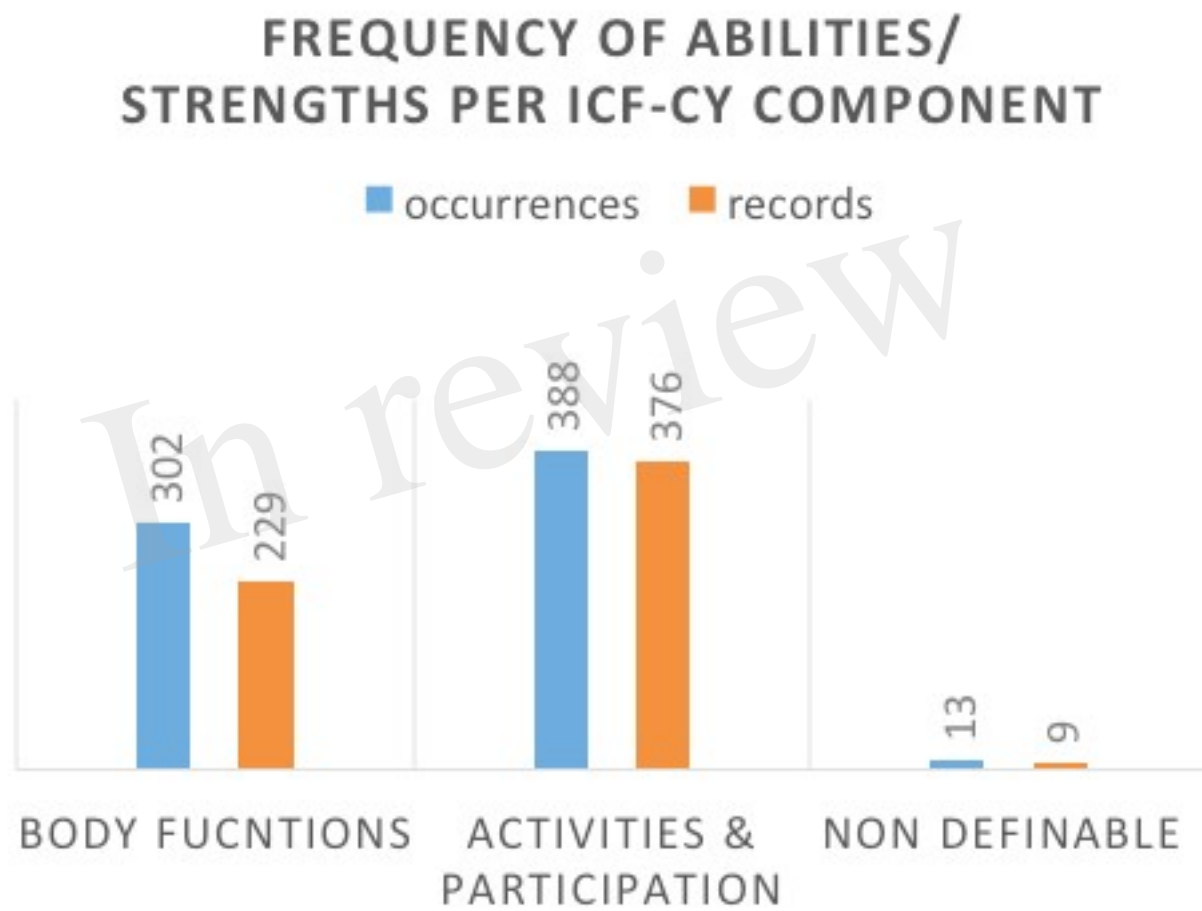


Figure 2.JPEG

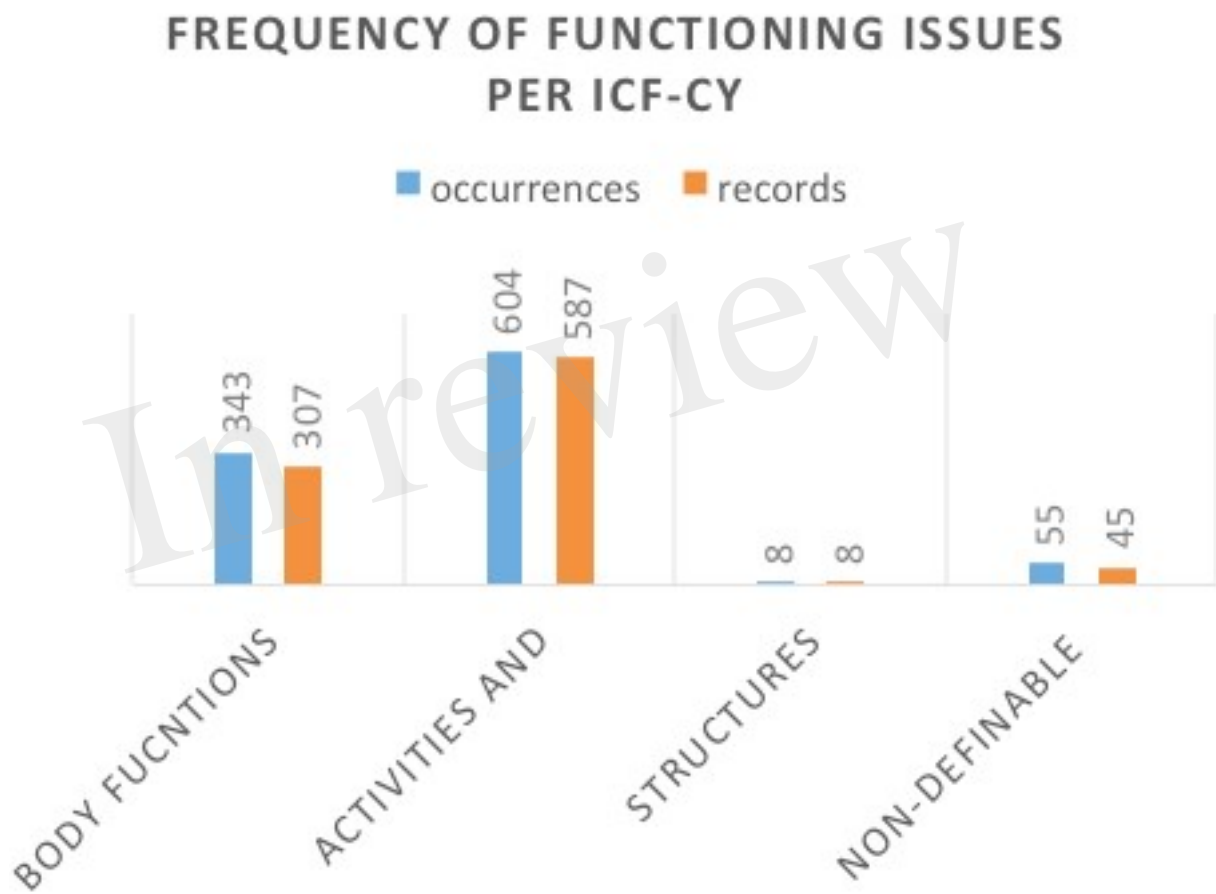


Figure 3.JPEG

