



The Changing Perception of Communication Needs—A Litmus Test for the Warnock Legacy

James Law*

Department of Speech and Language Sciences, School of Education, Communication and Language Sciences, Newcastle University, Newcastle upon Tyne, United Kingdom

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*Correspondence:

James Law
james.law@ncl.ac.uk

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Meeting Lady Warnock¹ at the final conference for some work commissioned by the DfEE/NHS in 2001, she said that one of her greatest concerns about her earlier report is the fetishisation of the statement of education needs. It was, of course, true that with the “statement,” as it came to be known, was often equated with her report, and triggered a rather legalistic culture with all the accompanying processes of tribunals and appeals. Nowhere was this more apparent than in the “border disputes” between health and education as to who was responsible for children with speech, language and communication needs (SLCN), a term which only emerged 25 years after her report was published. In this paper it is argued that the nature of disability has changed since Warnock. Communication disability is now one of the most disabling conditions and communication access at least as important as physical access. It is argued that communication should perhaps be seen as a litmus test² for whether the integration of children with support needs in the classroom is achievable. Although Warnock resisted diagnostic labels in favor of “needs” there has been a burgeoning market in measures of cognition, language and behavior since the 1970s. The paper goes on to look at the ways that the term SLCN has played out across health and educational services and ends up comparing the recommendations in the original report with those in the recent (2018) *Bercow - 10 Years On* report.

Keywords: language, communication, speech, child, public health

The Warnock report (Warnock, 1978) was a brave attempt to bring together all the issues associated with the history of special education needs and the modern priorities (in the 1970s) of the children and young people concerned—the first report to do so for half a century. In attempting to capture the needs of all children, the report often lacked specificity—to be fair the authors are clear that this is what they had planned—but this has to be offset against the range of issues that they do cover. The main recommendations or what the report calls their “first priority” are improved provision for children under 5 years, for young people over 16 and teacher training. Of these, the first has made considerable progress, the second and third probably less so. But beyond these first priorities there are a host of other recommendations, some of which look a little strange in hindsight precisely

¹Throughout this piece, reference is made to “Warnock” as if it refers to the individual rather than the eponymous report. In fact, this just reflects a common understanding which takes the name of the chair of the relevant committee as its title. Clearly the findings to which reference are made here were generated by the committee and the research that it commissioned rather than the individual concerned.

²The term “litmus test” refer to the UK understanding of this term which stresses the importance of a single factor in establishing a finding.

because special needs have moved forward so much. We have no mention of inclusion but a highly differentiated version of integration which prefaced later changes. The discussion of children speaking more than one language, a critical educational concern to most modern teachers, is confined to Welsh and Gaelic which might surprise modern readers. Inevitably in such reports there are contradictions but, of these, the most substantive is the tension between belief and practice in the identification of children. On the one hand we have the statement that “*statutory categorisation of handicapped pupils should be abolished*” (para 3.25) but on the other we have a recommendation for what became the lightning rod of categorization in education for many years.

A system of recording as in need of special educational provision those children who, on the basis of a detailed profile of their needs...are judged by their local education authority to require special educational provision not generally available in ordinary schools (para3.13) –

One area which attracts considerable attention nowadays is speech, language and communication (SLC) skills, which pervade the issue of *disability* in general and *access* more specifically. SLCs are seen as critically important both in their own right as far as parents, professionals and children are concerned. They are also critical as an earlier marker of a wide variety of neurodevelopmental disorders (Ek et al., 2012) and in terms of access more generally, access to education, the curriculum, friendship groups and later employment. Indeed, one could reasonably argue that while “handicapped” children experience a great many difficulties in terms of mobility, cognition etc. it is their communication skills which represent the most salient obstacle to their effective inclusion in society and this is getting more prominent as society becomes more technologically sophisticated. There are a number of references to speech and language in Warnock but these are generally in terms of “speech and language disorder” or in terms of “speech and language therapy” rather than as a key dimensions of risk, inclusion and access.

It is argued below that the functional disabilities associated with speech, language, and communication are really one of the best tests for the Warnock legacy. Four issues are identified where this is particularly true,

- the changing nature of disabilities within a changing society,
- the use of thresholds and the increasing definition of the labels for disabilities,
- the tension between education and health approaches to the issue and particularly the role that public health (not mentioned by Warnock at all) has come to play in the process of management and identification of the young child with developmental and/or educational needs
- a comparison of the recommendations from Warnock with those made by the *Bercow 10 Years On* report (ICAN/RCSLT, 2018) which followed up the Bercow report (Bercow, 2008) designed to improve facilities for the children with speech, language and communication needs.

THE CHANGING NATURE OF DISABILITY IN SOCIETY

As Warnock indicates, disability, and indeed special needs and the way that society responds to them, are not static. They change as society changes and, indeed, with the individual’s response to that society. One key aspect is the needs of the workforce and the role that education, although a general “good” in Warnock’s parlance, plays in helping children acquire the necessary skills to enter the workforce. Many disabilities may not have been so apparent in an early industrial society but have emerged as the needs of that society changed. The best example of this is language and communication skills which have become of paramount importance in our increasingly white collar world.

“Before the Forster Education Act (of 1870) the needs of mentally handicapped children were little recognised. Mental disability was for many children, no substantial handicap in coping with the simple demands of everyday life in a largely uneducated and relatively uncomplicated world, and institutional provision was available for those who needed looking after. Their needs first became apparent after 1870 when large numbers of children of below average or poor intellectual ability entered public elementary schools. Many of them made scarcely any progress and their presence hindered normal teaching” (ibid p12 2.16)

Some 20 years on from Warnock, this issue was articulated even more clearly in a paper related to employability and speech and language needs.

The fitness of the person of the 21st century will be defined, for the most part, in terms of his or her ability to communicate effectively. Societal self-interest will drive an increased allocation of resources to optimize the communication ability of its population, for this is how society prospers. Communication disorders will be a major public health concern for the 21st century because, untreated, they adversely affect the economic well-being of a communication-age society. We have seen that manual labor-based employment has diminished, in terms of percentages, in the country during the past century, but massive unemployment has not resulted because those jobs have been replaced by communication-based jobs.(Ruben, 2000 p.243),

Globally, workforces have changed over the past 60 years with a sharp rise in individuals employed in service industries contrasted with a decline in employment in production industries. Thus, in Australia, half of the workforce was “blue collar” in 1966, only 8% in 2001. This inevitably presents new challenges. The Australian Industry Group (2013) reported - “40% of the workforce had communication skills below the minimum standards required to perform their jobs.” And now with the hollowing out of the middle classes (fewer jobs for highly educated people) and widening social inequalities, the salience of oral language skills becomes even more pronounced

During most of human history a person with a communication disorder was not thought of as “disabled.” The shepherds, seamstresses, plowmen, and spinners of the past did not require optimal communication skills to be productive members of their

society, as they primarily depended on their manual abilities. Today a fine high-school athlete—a great “physical specimen”—who has no job and suffers from poor communication skills is not unemployed, but, for the most part, unemployable. On the other hand, a paraplegic in a wheel chair with good communication skills can earn a good living and add to the wealth of the society. For now and into the 21st century, the paraplegic is more “fit” than the athlete with communication deficits. (Ruben, 2000, p. 243)

Ruben was writing in the nineteen nineties but, in many ways, what he said has been amplified by computing in general and artificial intelligence in particular. This puts those with communication needs under even greater pressure, competing with Alexa, Echo and myriad other helpful household items in the internet of things which are starting to dominate our lives. But such implements, for all their convenient wonder, are still relatively crude and function in a very instrumental manner. They provide information or respond to demands but are still not able to interact very effectively. The symbolic imagining of other people's worlds, the capacity to inhabit the shoes of others, remains elusive to the technology. Good effective interactive communication remains at a premium and is likely to become even more so, further handicapping those who struggle with these types of skills. The digital gains of recent years have done much to relieve the disabilities of people who would traditionally been considered “at risk” in society for physical or those gains have done little to help those with functional speech, language and communication needs. This is not just a matter of literacy, as is sometimes assumed, but oral language skills and it is therefore not surprising that many schools are now making this a priority for all children and especially those with more marked, disordered, speech and language—in a way that they may not have done in the late seventies.

THRESHOLDS AND CLASSIFICATION

One of the distinctive characteristics of the Warnock report was the nuanced nature of the discussion of disabilities both in their characteristics and the way in which they interacted with the child's environment. The report highlights that two children, with similar profiles, might be more or less disabled in different family or indeed school contexts. But inevitably the need to decide which children do and which do not need extra funding to support their needs leads to a splitting of the population in one way or another. Warnock draws a distinction between those with major handicaps, many of which have names freely employed by Warnock but difficult for cultural reasons to use nowadays, and those with what the report terms ‘no substantial handicap’. This takes us to measurement and what happens if your assessed performance falls on one side of a designated threshold rather than the other.

Warnock talks about the lack of ability to measure children's abilities. This may have been true at the time but, since the seventies, there has been a considerable increase in the number of cognitive factors and corresponding measures for all sorts of different aspects of a children's abilities (Frazier, 2007; Dockrell et al., 2017). This is to be commended because it

helps with measurement for identification, diagnosis and, indeed, intervention outcomes, although, as Dockrell et al. indicate, many of these measures remain relatively poorly evaluated and are sometimes used interchangeably for diagnosis and outcomes, for example. The challenge is that the increase in the number of measures then allows us to detect differences between groups of children and those patterns are then used to determine a group of children with isolated “specific” problems and this is especially true when general intelligence is involved. Of course, these conditions are only really specific if we are clear that all the other areas have, in fact, been measured and found to be “within normal limits.” In practice, there are high level of comorbidity in all developmental disorders (Bax and Gillberg, 2010) and many are only notionally “specific.” This has long been recognized as a characteristic of developmental language disorders (Hill, 2001; Carpenter and Drabick, 2011; Tomblin and Mueller, 2012). An obvious example would be the organizational and co-ordination difficulties of children with specific reading difficulties or dyslexia and the same would be true of developmental co-ordination disorder, dyscalculia etc. in the way that they have been traditionally characterized (Verhoeven and Van Balkom, 2004). There has, of course, been considerable discussion about whether these concepts are traits or dimensions (Coghill and Sonuga-Barke, 2012), but less on how these can be shown to map onto need or indeed how need should be measured.

A case in point is the identification of children with speech and language difficulties which are *specific* to those domains but otherwise without associated difficulties. First identified in the early nineteenth century (Reilly et al., 2014) these children were a neurological curiosity for many years and it was not until the 1945 Education Act in the UK that they were identified as being potentially in need of special education. A host of different terms have been used to describe the disorder—congenital childhood aphasia, developmental dysphasia, specific language impairment etc. The key components of such conditions are rarely the same and thresholds also differ with some authors identifying children with language levels two or more standard deviations below the mean (World Health Organization, 1992), and others taking more liberal cut-off such as -1.5 standard deviations, the 10th centile (Tomblin and Nippold, 2014), -1 standard deviation (Conti-Ramsden et al., 2001), or with an overall language age (LA) at least 12 months lower than their chronologic age (CA) or their performance mental age (MAP), whichever was the lower (Stark and Tallal, 1981). Consensus amongst academics and practitioners is clearly key. Yet the evidence suggests that academics and indeed those commissioning services are often much happier with clearly defined categories than practitioners who are often much more accepting of “need” as a defining category.

Interestingly in the last 3 years this issue has led to a consensus project pinning down the criteria for *Developmental Language Disorder* (DLD) (Bishop et al., 2016, 2017). While many are happy to work with this broad term (DLD) with its emphasis on functional outcomes many prefer the term Speech, Language and Communication Needs. Only time will tell whether this leads to the term DLD being adopted in the international classifications systems such as the DSM and the ICF or whether it will

follow Asperger's Syndrome and be replaced (McPartland et al., 2012). In many ways Warnock's position, eschewing lower level categories, is probably wise from a pragmatic point of view as can be seen from the report's discussion of terms such as "delicate" which have entered and exited the special needs vocabulary leaving barely a trace. In many ways the academics desire for cognitive specificity is offset against the broader concept of need that practitioners in both education and health have to deal with.

EDUCATION AND HEALTH

Speech, language and communication are, by their very essence, concepts which are relevant to both educational and health services. These skills clearly underpin most of what takes place in the classroom, they are closely linked to literacy, to many aspects of attainment and to social inclusion and, as indicated above, to employment prospects. But equally they are an indicator of healthy development and well-being more generally. Poor communication skills are commonly associated with mental health difficulties and they are also commonly associated with a wide variety of neurodevelopmental difficulties—autism spectrum disorder, cerebral palsy learning disabilities etc. Almost by definition SLCN straddles both services.

Service provision is at the root of the Warnock recommendations as it will always be for those with a focus on improving the experience of "handicapped children and young people" moving through school. Although the context of the report was always the school, there was an awareness of the importance of speech and language, often framed as a speech and language therapy in referencing the Quirk Report (Quirk, 1972) which preceded Warnock and had a considerable impact on the way speech and language therapy services were developed. Although the government of the day did respond to the report, and the number of those qualifying as speech and language therapists increased after its publication, provision for children needing speech and language therapy remain something of a cinderella service relative, for example, to services directed toward literacy or latterly autism. The saliency of services for children with SLCN increased throughout the eighties and nineties. This was partly as the result of pressure from parents from the positive experience of such support in schools and the growing evidence base supporting speech and language interventions.

However, to be fair, these issues were driven by the statement of educational needs and the litigious culture it created. Throughout the eighties and nineties this led to a range of "border disputes" as services squabbled over responsibility for the implementation of recommendations made in the statement and this had its greatest impact for children with what were often considered more moderate difficulties. Nowhere was this more pronounced than in the management of children with speech and language disorders who repeatedly fell between the stools of health and education (Law et al., 2000). The increasing emphasis on parental empowerment, the improving status attached to disability and the way that services were enshrined in law meant that parents began to use the tribunal system and the law to settle

such disputes. In turn, this resulted in a good deal of acrimony, parental stress and wasted resource.

In the end, the Departments of Education and Health in England and Wales came together at the end of the nineties to commission a report on how services should develop (Law et al., 2000). This made a number of recommendations about the common use of terminology, the role that speech and language therapists should play in schools and about the commissioning of these services (joint health/education budgets etc). In turn, this led to a number of papers about different aspects of the services, for example about the role that parents felt that they should play in the process (very much in the spirit of Warnock) (Band et al., 2002 and later Hambly, 2014). But it was soon clear that the pressure within the system required a more substantive initiative to drive the issue of speech language and communication needs forward. This led to the publication of the Bercow report (Bercow, 2008) and then the government's response, the Better Communication Action Plan (Department for Children, Schools and Families, 2008) and the Better Communication Research Programme (BCRP) (Lindsay et al., 2009, 2012).

To a great extent these initiatives shifted the emphasis away from speech, language and communication needs as a health concern to one of central concern to schools. Alongside these initiatives language and communication were increasingly being identified as a key issue by the government's *What Works* centers, notably the Early Intervention Foundation (EIF) and the education Endowment Foundation (EEF) (Law et al., 2017a,b). While educational practice related to communication needs has been an interest in some quarters for many years, such initiatives have moved communication and language to the center of the stage as far as early years education policy is concerned in England at least. Furthermore, they have broadened its application still further, drawing these skills to the attention to a much wider policy audience and to local government officers planning local services. Warnock referenced the Court Report (Court, 1976) and the changes that were taking place with the development of community pediatrics and the need for child guidance clinics to which children should be referred if they had emotional and behavioral problems. Reference is also made to the way that hospitals and schools were historically collocated to facilitate the management of children with both education and social difficulties but the presumption is that education is the focus of the report and that the other aspects just happen because the child has clear medical needs. This picture has clearly changed considerably.

Over the same period there has been a remodeling of the statement of special educational needs which has now been replaced in England by the Education and Health Care Plan (EHCP) (DFE, 2014); (<https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help>). Like the statement this was intended to result in an integrated plan with the child's needs at the center and different agencies feeding in specific details about different aspects of the child's development (i.e., Cognition and learning, Communication and interaction, Social emotional and mental health and Sensory, and physical needs). The criteria for this level of funding was rather stricter than for

the statement and it was not easy for children SLCN to receive such a plan except as part of another condition. Parental feedback on the process has been well-documented (Adams et al., 2017). The number of children with EHCPs is relatively stable at 2.8% (DfE/ONS, 2017) but a further 11.6% are deemed to be eligible for SEN support and of these the second largest proportion after moderate learning difficulty is SLCN. The corresponding figures for 2010 ie when the original SEN statement was still in place was 2.7 and 18.2%, respectively, suggesting the reduced eligibility for support at the less severe end of the distribution. By contrast, the highest proportion of those with EHCP, by a long way, are children with autism spectrum disorders. Yet even with this tightening of eligibility the suggestion is that authorities are not able to cope with the volume of demand and 40% of authorities indicated that they are not able to meet the 20 week target for completion set and over 6,000 cases had taken over a year <https://www.bbc.co.uk/news/education-46658243>. Furthermore, the number of parents having to resort to tribunals nearly doubled to 2000 in the 3 years after 2014 when they were introduced suggesting that many of the problems with the SEN statement are recurring. Interestingly Lady Warnock herself had a number of reservations about the EHCPs when they were introduced (<https://www.tes.com/news/warnocks-5-point-plan-send>) particularly because there was so little transparency about the criteria used by local authorities, mirroring the threshold discussion above.

Although the clinical dimension for children with the most marked “medical” needs remains, there has been a further shift toward a more “population” approach to childhood disability. One of Warnock’s key recommendations is that special education needs to be extended downwards in to the preschool period and upwards into post 16 education. To a great extent this happened as far as the identification of the children with the most marked difficulties were concerned, in collaboration with the developing “child development” services offered by community pediatricians, clinical psychologists, speech, and language therapists etc. In recent years across the UK, national educational systems have increased services to younger and younger children, perhaps best illustrated by the English “two year offer” for more socially disadvantaged children <https://www.foundationyears.org.uk/2011/12/2-year-old-offer/>. The result of this downward extension of activity is that the boundaries between what is a special needs issue and what is developmental variation for which support may be valuable, have become increasingly blurred. In part this is because it means that the purview of the child health nurse or health visitor services effectively crosses over with that of those delivering the new early year’s services. Of course, this emphasis on the very young child, reflecting the increasing awareness of the importance of the home learning environment (Melhuish et al., 2008; Kelly et al., 2011), influences the role played by educationalists because they need to engage with the context in which the child is growing up—i.e., the family—rather than exclusively the performance of the child in class something which is especially salient in the early years. Warnock has very little to say about the social determinants of educational attainment which has been shown over recent years to be so instrumental in terms of the outcomes achieved

(Pfeffer, 2008; Bukodi et al., 2014). Awareness of the gap in attainment by the time children start primary school has fostered an increasing interest in the development and measurement of early skills and thus the identification of thresholds of what is and what is not “typical” development. A corollary of this is a focus on parenting and on promoting “parent child interaction” (Kiernan and Mensah, 2011; Landry et al., 2012). This, in turn, has led to a development, not foreseen by Warnock, but increasingly becoming a driver in the early years is the identification of speech and language as a public health issue rather than just a within-child concern (Beard, 2018). For a condition to be considered a public health problem it must place a considerable burden on society, a burden that appears to be increasing. The burden must be distributed unfairly (i.e., certain segments of the population are unequally affected) and there must be evidence that early preventive strategies could substantially reduce the burden of the condition (Schoolwerth et al., 2006). Increasingly there is an awareness that child language does fulfill these criteria (Law et al., 2013, 2017c; Wylie et al., 2014).

Nowhere is this seen more clearly than the concept of school readiness. Over the last few years a series of documents have highlighted the importance of very early child development and school “readiness” as core life skills. These have been shown to lead to a host of later benefits in education, socialization and employment (Bercow, 2008; Gross, 2008; for examples see: Allen and Duncan Smith, 2008; Field, 2010; Marmot, 2010; Allen, 2011; Save the Children, 2014a,b,c). A child’s ability to understand and use oral language is arguably the most important element of school readiness. The crucial transition to literacy in the first 3 years of school is not likely to be successful without well-established language skills (Law et al., 2017a,b).

In terms of the burden to society it is clear that many children with limited language skills are already in receipt of additional resources in school. In particular, when their difficulties are associated with poor school achievement and mental/health behavioral difficulties (Cohen et al., 1998; Law and Elliott, 2009), often leading to long term consequences (Beitchman et al., 2001; Hartshorne, 2006; Schoon et al., 2010). Children with DLD are also likely to struggle with transitions between schools and into the workforce (Snow, 2016). Low literacy levels impose a range of direct and indirect costs on governments, industry and communities and are difficult to rectify (Industry Skills Council of Australia, 2011). Approximately 8 per cent of children at school entry may have DLD (Norbury et al., 2016), making it as prevalent as childhood obesity (reported to be 7% Australian Bureau of Statistics, 2009) although this figure is likely to be much higher once children with less pronounced difficulties are included (Locke et al., 2002; Law et al., 2011) and when children across from across the social spectrum are compared (McKean et al., 2018). Access to services was an issue not directly addressed by Warnock but it is clear that it is not easy for all children to access the services they need and it is often the families who are most in need of these services who access them the least (Moore et al., 2015) and cost, availability and accessibility may also be issues (Ou et al., 2011; Morgan et al., 2016). A recent Australian study by Reilly and colleagues mapped the distribution of speech pathology services across metropolitan Melbourne and examined

the level of need in these areas according to language vulnerability and social disadvantage (Reilly et al., 2016). There were three times as many private speech pathology services (requiring the client to pay a fee) as there were public (free) services for 0–5-year-olds and overall, poorer availability of services in some of the most vulnerable areas. Evidence from the UK is less easy to come by but a recent study has suggested that such inequalities may not be as marked in London at least (Pring, 2016). All children have access to schools in the UK but not all of them have equal access to the necessary support and more socially advantaged parents are more likely to have the skills and knowledge based on their education and experience to be resourceful and access the services their children need.

The field of intervention research and evidence based practice has moved on apace since 1978. Indeed, Warnock, by her own admission, had little to say about it. Much has been written about the evaluation of interventions to promote child social and emotional development in general (Asmussen et al., 2016) and about interventions to promote the language skills of young socially disadvantaged children (Warr-Leeper, 2001). Most of the intervention studies concerning DLD have been carried out by specialist clinicians and could be described as “targeted-indicated” interventions whereby children are identified by a diagnostic process prior to attending the service (Law et al., 2003). Rather less often they focus on universal (the whole population) or “targeted selective” interventions—i.e., where a subset of the population was deemed to be “at risk” and therefore received the intervention, usually for reasons of socio-economic disadvantage (Law et al., 2017a).

Interestingly although she did consider early identification, deeming it to be a health concern managed at a local level, Warnock did not consider the public health dimension. This has now moved into the mainstream in much of the UK as witnessed by the universal use of the Ages and Stages Questionnaire in Scotland and England (Squires and Bricker, 2009) and the recent announcement from the UK Education Minister Damian Hinds and the joint Public Health England and the Department of Education in England working together (<https://www.change.org/p/rt-hon-damian-hinds-mp-secretary-of-state-for-education-fair-funding-for-children-and-young-people-with-speech-language-and-communication-needs>) and more recently still by Nadhim Zahawi Children and Families Minister who announced additional funding to help identify children with language difficulties at 2 years. <https://www.gov.uk/government/speeches/children-and-families-minister-announces-new-early-years-funding>.

WARNOCK AND BERCOW 10 YEAR ON (BTYO) – WHERE HAVE WE GOT TO?

It is important to see Warnock within the current policy context. Specifically it is instructive to compare some of the Warnock recommendations with those in the most recent report on provision for children with speech language and communication needs namely the Bercow 10 years on report (ICAN/RCSLT, 2018). One would hope, given the passage of time, that

recommendations would have moved on as some are achieved, others move out of focus and new ones come in. It is important, of course, to acknowledge that the terms of reference for the two reports were very different and so trying to speak across the generations is likely to be a challenge. Rather than making direct comparison between all the recommendations of both reports some, interesting similarities and differences can be identified. Understandably BTYO was much less concerned with the formal process of identification or the specific educational provision that is made although its authors do express concern about the perceived lack of funding without EHCPs. It was not trying to draw together what is known about services but rather point in the direction of future developments. Raising public and teacher awareness about speech and language disabilities particularly. As already indicated, public health was not mentioned in Warnock whereas it comes through very strongly in *Bercow 10 years on*. Similarly it references the Department of Education’s role in contributing to the government’s “social mobility strategy” tackling health inequalities: to their Joint Health & Wellbeing Strategy and in their contribution to Integrated Care Systems, such broad policy linkage was far beyond what was said in the Warnock report. The report highlights the role of evidence based practice and sharing best practice, both modern mantras which one could say were implicit but rarely explicit in Warnock. In relation to young people with communication disabilities the report says

The Department for Education should ensure that communication skills, specifically those identified as needed for the workplace, are appropriately recognised in the criteria for the Functional Skills qualifications. The Education and Skills Funding Agency should revise their apprenticeship funding rules for training providers and employers, to include training for communication skills development. (ICAN/RCSLT, 2018 paragraph 1.4 p.40)

These last two recommendations are interesting for two reasons. The first is that the disability issue is fused with employment more generally and the second is the employment significance of communication skills, to which Warnock does not refer at all. There is a recommendation for OFSTED, the mechanism in England by which school performance is monitored, which, of course, did not exist in the 1970s, to audit communication issues in the school and classroom. The Warnock report separates out psychiatric problems and what it prefers to call emotional and behavioral problems from speech and language disorders. An extensive body of research evidence over the last forty years suggests that these two domains are closely linked and *Bercow 10 years on* recommends that this be recognized in the provision of Children and Young People’s Mental Health Services and the Mental Health Support Teams. An extension of this, demonstrating the ambition of the second report, is that there is a recommendation that the Youth Justice Board should introduce mandatory communication skills training for all justice professionals as part of their initial training.

BTYO focuses on the need for accessible and equitable services for all families something to which, as noted above, Warnock

does not pay any attention. Prevalence especially from the Isle of Wight study (Rutter et al., 1976) is referenced in Warnock but there is no sense that specific subgroups of the population received greater or lesser access to the services they need. BTYO indicates that what are now called *Local Offers* need to include clear statements about who is responsible for funding and providing support for children with SLCN from 0–25 years. Furthermore, the report talks about the need to commission support for children and young people's SLCN on the basis of outcomes not outputs reflecting the need to get away from measurement of process (waiting lists, attendance etc) to whether the interventions made a difference. Early identification—a concern for Warnock—was also picked up in BTYO but the focus on current systems and how to improve them (notably the Ages and Stages Questionnaire) suggesting that the processes need developing within the context of the English Healthy Child Programme. Training is highlighted in BTYO but this time it is the health visitors (not considered in more than a passing manner by Warnock) who are considered central to the process of identifying special needs.

In short, the topological landscape has changed considerably in the 40 year since Warnock but many of the items, important now, were referenced in the earlier report. There are plenty of examples of real progress. In many ways the modern concerns are refinements which have schooling at their center but overlap with other services Child and Adolescent Mental Health (erstwhile child guidance) services and employment services with a strong public health dimension speaking to the nature of the populations identified and the service access available to them.

CONCLUSIONS

Returning to the key arguments in this paper, it is clear that the nature of disabilities changes as society changes and the society about which Warnock was writing was very different from our own. Yet definitions, labels and thresholds will always be an issue as different groups of professionals seek to define their populations for study, provision etc. It is clearly helpful, not least to parents and practitioners, that the views on what is a case coincides, but there is still a lot of progress that needs to be made in the science underpinning these judgements. “Need” sounds as if it is more meaningful as far as the child is concerned but, of course, this remains a relative concept. Does the parent's concept of need reflect that determined by the therapist or the authority commissioning the services. Communication has a number of characteristics which makes it relevant for those providing both health and educational services (in the UK context at least) and this has led to tensions as to who should take responsibility for these services. The argument here is that a public health approach in many ways mitigates this problem given the universal nature of educational provision. As demands change so it has become increasingly clear that pressure to develop services for children with SLCN has become better articulated over time so that those demands are better defined now than they were in 1978.

Warnock's recognition of the importance of the functional aspect of disabilities rather than their classification categories has meant that certain aspects of a child's development have become especially salient in measuring whether the system has succeeded in supporting the child. Many aspects of disability, physical access, sensory adjustment etc. have progressed substantively since the 1970s, because of increased awareness and new technology, but one aspect to which this paper has been devoted is *communication access*, the ability of the child to understand what is going on in the classroom and the home, with family and friends and to actively participate in discussions and decisions, in the curriculum and in making and sustaining friends.

Amongst its nuanced discussion and detailed analysis, the statement of educational need will always been seen as one of the key initiatives that came out of the Warnock report. Rather than engaging with some of these difficult concepts, people latched on to the statement as a way of identifying and ultimately helping the child. In fact, it ended up as an instrument in its own right with resultant tussles with parents about labeling on the one hand (bad) and access to funding on the other (good) or a more nuanced combination of the assessment of need (Resch et al., 2010; Watson et al., 2011). The good intentions to enshrine the process in law ended up with a rather litigious process with border disputes between health and education as to who was responsible (Lindsay et al., 2005) a tension that remains to this day (<https://specialneedsjungle.com/call-to-action-lets-work-together-stop-send-tribunal-nightmares/>).

Nowhere was this more pronounced than language and communication skills which underpin many of the core activities that Warnock identified. Indeed, these skills are amongst the most important aspects of inclusion which go far beyond co-location and physical modifications to active engagement with peers and others. Warnock identified the importance of participation but did not discuss the issues in terms of specific abilities. Similarly she did not identify the liminal space between health and education where speech, language and communication needs have tended to reside in the UK, at least until relatively recently. Perhaps when her report is repeated fifty years on, it will be the better understanding of the role of such skills and the way that teachers respond to them which will be a focus. Warnock saw the influence of her report reaching “to the end of the century and possibly beyond” (p.325) and it has certainly done that. Expectations of parents have increased as have the numbers of staff and indeed the training for staff (Bercow, 2008). The argument here has been that the extent to which children's speech, language and communication needs are addressed will be critical to the practical implementation of many of the child focused recommendations in the Warnock report and this will remain the case for the foreseeable future, whatever new technology may bring.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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