

Shaping the Future of Policy on Learning Disorders: A Comparative Analysis of the US, Canada, UK & Sweden

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Abstract

Learning disabilities (LD) arise out of neurological differences in structure and function that impede an individual's ability to receive, process, retain, and retrieve information. Similar disruptions in learning manifest in autism, a highly complex neurodevelopmental disorder. For these individuals, learning disabilities are concrete and permanent, resulting in lifelong difficulties in learning, employment, and social recognition. Cases of delayed LD identification are often associated with debilitating incapacitation, resulting from low self-esteem, underachievement, and underemployment.

Government policy needs to stand at the forefront of knocking down the many barriers that hinder individuals with LD from becoming confident, independent members of society. Policies from North American and European nations contain respective strengths, and thus international discussions and comparative research should be conducted on LD policies. This article examines national policies of the US, UK, Canada, and Sweden, focusing on identification, funding, and core focuses of learning disability policy.

I argue three main points within each respective category of diagnosis, funding, and goals of LD policy. First, educators need to play larger roles in the identification of LD, and government policy should facilitate this role. Second, funding for LD and autism support is largely channelled towards educational initiatives, but such initiatives are currently too broad to promote concrete outcomes. Funding needs to go towards specific categories of support – including assistive technologies, assessment protocols, or extracurricular/pre-professional activities. Finally, the foremost focus of policy should be placed on addressing employment disparities for individuals with LD/autism. Such policy would go the furthest ways in promoting the “normalization principle” and “social role valorization,” which are two guiding principles that can help increase opportunities for persons with disabilities, equip them with socially-valued roles, and bring them towards a greater level of social equality.

Part 1: Diagnosis & Identification

Section 1.0: Introduction

In addition to clinical definitions provided by the DSM-IV and ICD-10, the diagnosis of learning disabilities is largely conducted by psychiatrists, psychologists (i.e., school, counselling, and clinical), neuropsychologists, and disability specialists through a combination of intelligence, academic achievement, social aptitude, and cognitive (i.e., memory, attention, language, visuo-spatial) tests. Three basic categories exist for learning disabilities: dyslexia, dysgraphia, and dyscalculia. Dyslexia involves difficulty with words. Dysgraphia involves difficulty with writing. Dyscalculia involves difficulty with mathematics (“What Are the Types of Learning Disabilities?”, n.d.; “Learning Disabilities,” n.d.). Similarly, autism diagnoses involve two steps: developmental screening and comprehensive diagnostic evaluation by generalized or specialist doctors (“Screening and Diagnosis of Autism Spectrum Disorder,” n.d.).

At the same time, educators and school systems can play a critical role in helping to identify students with learning disabilities or autism at an early stage. The four countries discussed have varying levels of focus applied to utilizing school-based diagnostic and identification LD methods. While the US and Canada have increasingly implemented early intervention-oriented educational programs (i.e., specialized interventions occurring before clinical diagnosis) for students in elementary/secondary school, legislative efforts for LD support in the UK and Sweden are comparatively less focused on early-stage, educational LD identification and intervention. Instead, the UK and Sweden put increased legislative emphasis on later, post-secondary school support.

Section 1.1: US

Within the past decade, LD diagnosis methods in the United States have changed dramatically, leading to a 18% decline in total number of students placed into the LD category from 2002 to 2011 (National Center for Learning Disabilities, 2014). This drop has been correlated with, and potentially results from, earlier LD intervention within the primary to secondary school systems.

In addition to the DSM-IV clinical definition of LD, the American federal definition of “learning disability” is largely shaped by the Individuals with Disabilities Education Act (IDEA), which establishes procedures for identifying LD and addressing needs for special education services. Significant changes in 2004 and 2006 have drastically ameliorated both clinical and social outcomes for LD individuals in the States. In 2004, IDEA eliminated the previous “discrepancy” requirement – defined as a “severe” discrepancy displayed between intellectual ability and academic achievement – in determining LD (GreatSchools Staff, 2016). This “ability versus achievement” discrepancy approach (established in 1977) resulted in later identification of LD, as it

necessitated that students fail over a long period of time to show sufficiently “severe” deficits in academic achievement before students could receive special education and disability services. The requirement was also often misdiagnosed students for whom English was a second language or students living in poverty.

In 2006, IDEA required all states to develop new criteria for LD identification, based largely on research-based interventions as part of the diagnosis procedure. One such intervention that has been adopted in many states and proved largely successful is the treatment-oriented diagnostic process: Response to Intervention (RTI) (National Center for Learning Disabilities, 2014). RTI is a data-based approach to providing early identification and support. Instead of waiting for students to meet diagnostic criteria, RTI places struggling students into research-based intervention programs before diagnosis. The approach begins with a universal screening of all children in the general education classroom (i.e., pre-K to high school) and proceeds with increasing-intensity interventions provided for struggling students to accelerate their rate of learning. Interventions are conducted with a Multi-Tier System of Supports (MTSS) model that includes data-driven decision making, curriculum, instruction, assessment, professional learning, and leadership services provided by teachers, special educators, or specialists (National Center for Learning Disabilities, 2014).

Ultimately, this refined educational diagnosis procedure has allowed for earlier, personalized assistance for struggling students in general education, more accurate diagnoses of LD, and more effective early-stage interventions that translate into improved long-term clinical, social, and professional outcomes. A final diagnosis, however, is made with medical testing conducted by a specialist team, usually involving a psychologist, special education expert, and speech-language pathologist (“How are learning disabilities diagnosed?,” n.d.).

Section 1.2: Canada

In the past in Ontario, the diagnosis of LD was performed only by qualified members of the College of Psychologists and the College of Physicians and Surgeons. This may have resulted from the Learning Disabilities Association of Ontario’s official definition of LD emphasizing that the condition is caused by genetic, congenital, or acquired neurobiological factors instead of cultural, socio-economic, or language-based ones (“Official Definition of LDs,” 2019). In addition to clinical diagnoses, Ontario’s Identification, Placement, and Review Committee (IPRC) identifies educational needs of students and recommends type of placement for instruction at the request of school principals (officially) but also by parents and teachers.

Four criteria formed the basis for clinical LD diagnoses in Ontario (Learning Disabilities Association of Ontario, 2001). First, a clinically significant discrepancy must exist between thinking/reasoning abilities

and one of the more specific psychological processes related to learning. The second criterion is low academic achievement relative to an individual's thinking/reasoning abilities or academic achievement sustained within expected levels only by extremely high levels of support and effort. This criterion parallels the now-defunct US "discrepancy" model comparing academic performance and cognitive ability. The third criterion is evidence that learning difficulties are related to deficits in specific psychological processes. Finally, evidence for LD diagnosis cannot be accounted for by developmental delays, physical difficulties, environmental factors, cultural/linguistic diversity, ADHD, or anxiety.

Just like their American counterparts, Canadian LD diagnosis methods have moved towards incorporating more treatment-oriented education initiatives for early-stage LD identification within primary and secondary schools. While Ontario's previous diagnostic models for LD were mostly conducted by psychologists and specialists working on a more clinically-defined model of LD, in 2014, the Ontario Ministry of Education introduced a new memorandum (Policy/Program Memorandum No. 8, aka. PPM 8) formally establishing requirements for school boards to identify and aid students with LD (Ontario Ministry of Education, 2014). PPM 8 provides the ministry's official definition of LD and also requires that the IPRC use this new definition in LD identification of students. This new intervention-focused diagnostic model established required protocols for early and ongoing LD screening (i.e., compulsory school board procedures to identify learning abilities and needs of students), holistic assessments (based on parental, educational, and medical information), and program planning using a tiered approach enhancing personalized support and care. By developing early intervention-targeted LD diagnoses with larger roles for educators and school boards, Ontario is spearheading efforts to improve outcomes for students with LD (Learning Disabilities Association of Canada, n.d.; Dubé, 2016). However, across Canada as a whole, there remains a lack of consistency in the delivery and allocation of resources for supporting LD (D'intino, 2017). Ontario's diagnostic and educational resources for LD support can serve to inform future policies in the standardized identification, support, and accommodation of students with LD in Canada.

Section 1.3: UK & Sweden

Learning disabilities in the UK, defined by the Department of Health as "a significant impairment of intelligence and social functioning acquired before adulthood," are generally made using psychometric assessments of intellectual functioning and direct clinical observation of adaptive/social functioning (Miller & Scully, 2015). Focus has been placed by the British Psychological Society on three core criteria for LD diagnoses: 1) significant impairment of intellectual functioning, 2) significant impairment of adaptive/social functioning, and 3) age of onset before

adulthood (Webb & Whitaker, 2012). In Sweden, dominant LD diagnoses are based on neuropsychiatric methods that focus on psychological-medical language, with an emphasis on categorizing ADHD (aka., ADD), dyslexia, dysgraphia, dyscalculia, and autism in particular (Mehan, 2014; Hjerne & Saljo, 2012).

Thus, the UK and Sweden are currently largely reliant on traditional clinical definitions (mostly ICD-10) and medical diagnoses for official identification of LD; neither currently enforces or requires nationally-integrated programs of school-based assessment and educational intervention similar to RTIs in America or “Program Planning” in Ontario. In September of 2016, the UK Department for Education introduced Education, Health and Care (EHC) plans for children and young people (up to 25) with learning disabilities whose behaviours are described as “challenging.” (“Developing EHC Plans,” n.d.) These plans – which provide special educational needs support to meet students’ personal, educational, health, and social needs – are conducted by local councils, but do not require school boards to adopt formal procedures for early and ongoing LD identification in students (Government Digital Service, 2014).

Section 1.4: Extrapolations

In America, with the use of RTI combined with the Multi-Tier System of Supports (MTSS), educators play a large role in providing early assistance to children before they experience significant failure. Further, the tiered organization of RTI and MTSS allows for a high degree of personalized care. This personalized care can significantly benefit clinical and social outcomes, as cognitive differences with LD are usually not noticed until students’ early school years. Thus, schools and educators are in an optimal position to provide the earliest, and potentially most effective, identification and intervention procedures for early manifestations of LD. However, the inability of such RTI-based identifications to account for individual neuropsychological factors and specific cognitive processes is a significant weakness for both diagnostic and educational purposes, as it fails to inform educators about the student’s strengths and weaknesses.

Overall, the importance of incorporating treatment-oriented diagnostic models that can be implemented in schools for early LD identification (e.g., RTI, MTSS, and Program Planning) should be emphasized. These models can provide early-stage and ongoing screening, deliver personalized intervention, and bypass the delay-periods that often appear before clinical diagnosis wherein students can fall further and further behind their peers. When implemented in addition to the traditional roles played by specialists and psychologists, these models can help create a holistic clinical diagnosis and allow for effective early intervention of LD.

Part 2: Funding for Education

Section 2.0: Introduction

Funding opportunities for individuals with learning disabilities primarily fall into two primary categories of support: educational and vocational. Here, I focus on funding for systems of educational welfare that equip individuals with learning disabilities with the resources and skills necessary to achieve their long-term educational goals.

Currently, federal and state sources of funding for LD provide educational support in broad categories; this large scope may not promote concrete action and does not lend itself well to tracking where funds end up and how effective the support is in practice. Countries would benefit greatly from government funding of specific categories of support, such as early screening, assistive technologies, or special disability support boards.

Section 2.1: US

Federal funding in the US for the education of individuals with LD is governed by the Individuals with Disabilities Education Act (IDEA), which provides six main elements: 1) an Individualized Education Program, 2) free and appropriate public education for students aged 3-21, 3) least restrictive environment (i.e., spending time in the general education classroom to the maximum extent possible), 4) appropriate evaluation, 5) parent and teacher participation, and 6) procedural safeguards (National Center for Learning Disabilities, 2014). IDEA's federal special education funds are the most specific among the surveyed four countries and are distributed through three state grant programs and several discretionary grant programs for pre-K to Grade 12 students (Individuals with Disabilities Education Improvement Act of 2004). At every point in IDEA, individuals with LD and their parents are given Procedural Safeguards, which are rights and protections that must be upheld throughout educational decisions made by schools in the provision of special education.

Critically, however, IDEA is not “fully funded.” When the Act was first passed, Congress promised to pay 40% of the extra cost of special education (i.e., the estimated excess cost of educating children with disabilities). Yet, in 2014, IDEA federal funding covered only 16% of the estimated excess cost of educating disabled students.

In sum, the Act does delegate a combination of general special education funds and discretionary grant programs and critically includes procedural safeguards to give individuals and their families a say in provided educational services. However, the six main grant provision categories can benefit from more specific classifications and the amount of funding for IDEA is disappointingly insufficient to cover the bare excess costs of special education.

Section 2.2: Canada

The Ministry of Education in Ontario funds elementary and secondary public schools along with Catholic schools through two grants assisting students with LD (Government of Ontario, n.d.-b). The primary source of funding is the Special Education Grant (SEG), which provides additional special programs, services, and equipment for students with disabilities. The Special Education Per-Pupil Amount (SEPPA) grant provides further health and safety support for students who require more than two full-time staff (Government of Ontario, n.d.-c).

A particularly well-specified category of funding provided by the Canadian Federal Government exists in their national post-secondary funding grants (“Educational Technology Funding for Students with Learning Disabilities”, n.d.). For instance, the Canada Student Grant for Services and Equipment for Persons with Permanent Disabilities (CSF-PDSE) funds the cost of accommodations and assistive technology for students with disabilities who are enrolled in post-secondary institutions. In addition, the Canada Student Grant for Persons with Disabilities provides \$2,000 annually for tuition, travel, accommodation, and supply expenses (“Educational Technology Funding for Students with Learning Disabilities”, n.d.).

Section 2.3: UK & Sweden

In the UK, executive agencies, with sponsorship from the Department of Education, are primarily responsible for funding post-secondary education for LD individuals. The Education Funding Agency (EFA) provides students aged 16-19 with an Education, Health and Care (EHC) plan; EFA and local authorities can fund education for disabled students up to the age of 25 (Education Funding Agency, 2015). In addition, the Skills Funding Agency (SFA) funds colleges and training providers who offer further education for LD students aged 19 years or older.

Similarly, in Sweden, the National Agency for Special Needs Education and Schools (SPSM) provides general government funding to education providers in primary, secondary, and special needs schools (National Agency for Special Needs Education and Schools, n.d.). SPSM also provides a Special Interventions in Schools grant to encourage schools to develop appropriate learning environments for students with LD. For students with severe disabilities, Swedish municipalities offer programs known as *särskolas* that provide both theoretical studies and practical training (“Country Information for Sweden,” n.d.).

Section 2.4: Extrapolations

While all four countries have federally funded programs in place to support primary and secondary education for students with LD, each nation would benefit from more precisely defined categories of funding. Examples of more specific categories of funding include funding in assistive technology, pre-professional programs, or early psycho-educational assessment for LD support. An increase in specification would

facilitate definitive actions taken to improve educational support, thus channelling government funding into more effective and concrete benefits for individuals with LD. Further, narrower categories would allow funding to be tracked more precisely, which could in turn inform policy makers on the efficacy of each initiative and help refine strategies of support.

Part 3: Current Directions

Section 3.0: Introduction

Two of the most influential principles guiding current LD and autism disability policy around the world are the “normalization principle” and “social role valorization,” two terms coined by Wolf Wolfenberger in the 1980s. The normalization principle prioritizes social integration of people with disabilities. Social role valorization (SRV) supports the establishment, enhancement, and maintenance of socially valued roles for these individuals. In turn, both terms have shaped social services emphasizing deinstitutionalization, community support, and employment services, which form the three core foci of international policy surrounding LD today.

Section 3.1: Normalization Principle

Reacting against previous 19th century reliance on institutions for supporting people with disabilities, legislators and other powerful actors consider that principles of decentralization, integration, and normalization best promote choice and freedom for disabled individuals. The normalization principle has propelled deinstitutionalization efforts across the US, UK, Canada, and Sweden.

In the UK, the detrimental effects of institutionalization on disability support has been recognized for several decades, but effective action promoting deinstitutionalization has yet to be taken. Thus, the normalization principle was a significant component of Sir Stephen Bubb’s 2014 report “Winterbourne View – Time for Change.” (Transforming Care and Commissioning Steering Group, 2014) Following a failure to meet the 2014 Concordat pledge to reduce the number of hospital placements for people with LD and to close inpatient services on a large-scale, Bubb proposed that a mandatory commissioning framework for local providers of health and social care services be created to reduce reliance on inpatient care. Bubb urged the UK’s National Health Service (NHS) to further decommission inpatient services and focus on building systems of community support for individuals with LD and autism.

Out of the four countries examined, Sweden has embraced the normalization principle most effectively. Results include that residential institutions have been dissolved and community-based services have been developed across the country (Murphy, 2014). There are officially no Swedish institutions for individuals with functional impairments, but residential arrangements still exist for special service, which are regulated

by the Act Concerning Support and Services to Persons with Certain Functional Impairments (LSS).

Section 3.2: Employment & SRV

Samhall is a state-owned, government-sponsored agency in Sweden responsible for creating meaningful jobs for people with LD and autism (Murphy, 2014). Samhall's model includes three phases: 1) assessment, 2) temporary work-orientated rehabilitation services, and 3) long term employment in the mainstream employment market. Working as a sub-contractor, Samhall offers employment in cleaning and laundry, warehousing, workplace and property services, elderly services, and manufacturing ("Operations," n.d.). Samhall is a particularly effective support system because it offers actual employment opportunities for individuals with LD. The agency has a number of defined targets (Murphy, 2014). These include a requirement to employ a minimum number of employees with functional impairments (expressed in hours worked: in 2012, the target was 24.4 million hours of work, and Samhall achieved 24.6 million hours of work) and a minimum proportion of new recruits from prioritized groups (as identified by the Public Employment Service and Samhall; in 2012, the target was 40% of recruits, and Samhall achieved 43%). (Murphy, 2014) Further, Samhall aims to transition 6% of its permanent employees into other employment positions, with a 12-month possibility of re-employment. This ensures a small turnover rate to allow for opportunities for new jobseekers, while also supporting current employees looking for employment outside the agency.

Employment initiatives in the US, Canada and the UK are less based upon creating actual jobs for individuals with autism and LD and more upon equipping them with employment resources and funding. In the US, the major initiative by the US Department of Labor is Employment First, a movement based on the premise that "all citizens, including individuals with significant disabilities, are capable of full participation in integrated employment and community life." ("What is Employment First?," n.d.) Based upon this premise, Employment First aims to encourage publicly-financed organizations to align policy, service delivery, and reimbursement structures towards integrated employment ("Employment First," n.d.). Under the Employment First approach, employment is designated a first priority for employment services serving individuals with learning disabilities and autism ("What is Employment First?," n.d.). In the US, such services are provided by Community Employment Agencies, which aims to support customized integrated employment designed to fit both the jobseeker's and employer's needs. Similarly, UK's Access to Work is a publicly funded employment support program that provides practical and financial support for LD/autistic individuals to find and stay in work. In addition, the UK's Employment and Support Allowance (ESA) provides money for people with limited capability for work due to disability or sickness. However, an inquiry carried out by the

Public Accounts Committee in 2014 found that almost 90% of Employment and Support Allowance claimants on the Work Programme had not moved into jobs (Public Accounts Committee, 2014).

This disappointing statistic emphasizes that simple monetary funding is insufficient to address employment difficulties for disabled individuals. Rather, more concrete forms of support through resources or provided jobs are necessary. In the UK, Mencap, a charity that is perhaps the best-known provider of learning disability services in the country, offers support, advice, and resources for individuals with autism or LD seeking employment. In Ontario, the *Ontario Disability Support Program: Employment Supports* program funds employment services for people with LD on an outcome-based system (Government of Ontario, n.d.-a). These employment services are mostly provided by non-profit agencies whose government funding is based on their success in finding jobs for clients. *Fulfilling Potential — Making it Happen* is a 2014 UK governmental disability strategy that is promoting new models of support and employment for individuals with LD and autism. In particular, it is developing a Supported Internship Programme (SIP) model in further education colleges, introducing a birth to 25 single assessment process for LD and autism, which represents one of the most promising government policies in improving health, education, and justice for people with disabilities.

Conclusion

Policies that facilitate early assessment, screening, and intervention procedures within school systems, fund specific categories of educational support, and provide concrete job opportunities and resources need to shape the future of government support for individuals with LD/autism.

Currently, the US and Canada have effective models of early school-based LD identification and intervention (e.g., RTIs and “Program Planning”). Further, Ontario provides the most specific categories of federal and provincial educational funding, and Sweden has the most concrete, evidence-based de-institutionalization and employment practices.

However, over the course of this research, it was difficult finding organized, composite federal- or state-issued compendiums of rights and legislation for LD/autism support in all four of these countries. This difficulty is a disturbing weakness; increased efforts should be made to provide streamlined, concise information for individuals with these disabilities (and their families) on the rights, legislation, and resources affecting their care. Additionally, policy changes are constantly being executed, and governments should provide updates to individuals affected by changing legislation. These updates would promote engagement with individuals and their families, whose perspectives are the most important to consider in shaping future policy. The UK has started such an initiative. The UK Department of Education has begun a “Local Offer” initiative

within the Children and Families Act of 2014. Under the Act, local authorities are mandated to publish a local offer, which must include information on the education and training provisions available in their local post-secondary schools, along with services for finding employment, accommodation and participation within society (Department for Education, 2015). Initiatives like Local Offer should be encouraged internationally to generate accurate, organized, and up-to-date information on policies affecting individuals with LD.

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