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Educating the Mentally Retarded Deaf Child

by G. Bunch, B.A., M.Ed., Principal, Teacher Education Centre
Ontario School for the Deaf, Belleville.

Few provinces have made any effort to survey the numbers of mentally retarded deaf individuals in Canada or to provide educational or residential programs to meet their needs. It is therefore necessary to refer to studies conducted in the United States. Ten to fifteen per cent of the population of a school for the deaf who may be classified as retarded fall into the mildly retarded rather than the educable or trainable categories. In state hospital settings, of the 40 to 60 per cent of residents with some degree of hearing loss, some 7 per cent in the educable and trainable categories are functionally deaf. If these survey figures can be applied to the Canadian situation, a minimum of 10 per cent of school-age deaf children and 7 per cent of deaf provincial hospital residents would fall into the educable and trainable categories. Many other residents would suffer a detectable hearing loss.

In preparation for this paper[1], a simple questionnaire was mailed to medical or educational directors of selected provincial hospital schools in Canada. Routine identification of and provision for an appropriate program for hearing impaired residents varies widely from hospital to hospital. A second questionnaire mailed to major residential schools for the deaf in Canada, while designed to elicit information on multiply handicapped deaf children in general, provided useful information regarding mentally retarded deaf children. Many retarded deaf individuals who would benefit from an appropriate educational and residential program are excluded from Canadian schools for, as yet, undetermined reasons. Indeed few areas in the world attempt to make provision for retarded deaf individuals. Only two comprehensive programs existed in the United States in 1971; it was reported that the mean I.Q. of students classified as retarded by U.S. Schools for the Deaf was 80.1.

SERVICES IN ONTARIO

Provincial Hospitals Services: The province making greatest provision for deaf people is Ontario. Academic programs are available in three Ontario hospitals schools (Rideau, Midwestern and Cedar Springs) for approximately 99 eight to twenty-five-year-old hearing impaired residents. All teaching staff are certified in education of the retarded and have taken courses of up to one year's duration in education of the hearing impaired.

In the fall of 1972 a comprehensive educational and social program for young and senior deaf adults was initiated at new Prince Edward Heights OHS. The program provides written and oral language training, sign language training, independent living skills, vocational and socialization training for a maximum of 38 residents. Specially qualified deaf and hearing staff members were selected some months in advance to prepare for the arrival of the residents. The facility was sited purposefully in the Prince Edward Heights Hospital near the Ontario School for the Deaf, Belleville, to take maximum advantage of past experience and expertise with the deaf. It will be some time before the program can be evaluated but it would appear to be a desirable development.

These four programs and a very few others offering special training to deaf mentally retarded residents barely begin to meet the need. Research indicates that of the 36,000 Canadian in residences for the mentally retarded (*Mental Retardation, 1972*) 7 per cent or 2,500 are profoundly deaf, while 40 to 60 per cent or 4,500 to 6,800 are hearing impaired. Of the 11,400 residents in the provincial hospitals surveyed, only 309 residents or less than 3 per cent had been identified as hearing impaired. Nine of the 12 hospitals reported that routine audiological tests were not administered on admission.

Provincial Schools for the Deaf:

In 1966 specific programs designed to meet the needs of mentally retarded deaf children were initiated at the Ontario School for the Deaf, Milton, and shortly thereafter at the Belleville school. Prior to the initiation of these programmes, children with tested intelligence to the 50 I.Q. level were eligible for admission, but many had to be referred to their homes, schools for the mentally retarded, opportunity classes or Ontario hospitals.

School for the Deaf, Milton

Pre-School: Parents are usually the first to suspect that a child has a hearing impairment. Sometime after their suspicions are aroused, they are advised by their physician, otologist, a relative or some other person to make contact with their regional school for the deaf to arrange for whatever assistance is available. Due to the lack of routine hearing examinations during the early years, the difficulty of examining young children and the frequent advice that a child "will grow out of it", it is not until after the age of three that most hearing impaired children become known to a school for the deaf. From the time of referral to age five home visiting teachers regularly work with children of all abilities in their homes or individually in central clinics. A great deal of advice on educational and social management is provided for the parents. A school assessment team comprised of an audiologist, psychologist and social worker performs a complete evaluation of hearing, intelligence and social skills.

Junior School: At age five children are admitted to the Junior School at Milton. Children who appear to have a low I.Q. (45 to 65) and who appear to need a maximum of individual attention are placed in class groups of 3 to 4. It is possible that children with handicaps other than, or in addition to, mental retardation but functioning on a similar level may be included in this small group. Training is focused on language growth and social skills utilizing the communication method most appropriate for the individual child. If the child has a slightly higher I.Q. and the apparent ability, he begins his education in a class of 6 to 8 children following a more general curriculum. If the child begins in a small group, he is integrated into a normal class as soon as his abilities permit. In some cases it is not possible to achieve integration and a child may remain in a "special" class for most of his education.

Senior School: At approximately age 12 the child transfers to Senior School where he may continue in a "special" class or be integrated. If he is integrated the child follows the normal curriculum designed for his age and ability level. If retained in a "special" class, the child enters a total environment education area. This term refers to a number of class areas designed to include academic, vocational, grooming and craft areas in close proximity. Lesson topics begun in one section may be completed, developed, furthered or supported in others.

Younger boys work in an area provided with orthodox academic desks, individual work benches, hand tools and a basic assortment of simple power tools. Older boys work in a large area basically devoted to vocational equipment but with a discrete academic area. Basic carpentry, metal working, welding and small engine repairs form the vocational program. A third general shop area is provided as well. Basic skills in the above areas are furthered and brick laying, masonry, sign painting, and gardening is introduced. The program philosophy emphasizes flexibility, integration where possible and continuing academic and vocational training.

Girls initially enter a compact classroom containing a normal academic area, power sewing, beauty culture and kitchen. The learning area for older girls contains more sophisticated training along these lines plus a laundry and an apartment living centre. The same philosophy underlining flexibility, integration and interplay of various programs is followed.

The girls are offered on-the-job training in the dietary, laundry, maintenance, and cleri-

cal areas. They may take further training in formal beauty culture, home economics, sewing, dressmaking and commercial areas. The boys are offered the possibility of on-the-job training with the dietary, maintenance, laundry and groundskeeping staff as well as the opportunity to train in carpentry, cabinet making, metal trades, welding and auto body. Few of the more limited students are able to enter the major shop areas but all are able to take advantage of the on-the-job training opportunities.

The majority of mentally retarded deaf students who have graduated from this program are fully employed in occupations such as maintenance, food services, groundskeeping, farming and factory trades. One or two work in sheltered workshops. Others are unemployed and living with their parents apparently for family reasons rather than lack of employment opportunities.

Late Referrals: Not all students entering the "special" class system arrive at age five. Many are referred at later ages from schools for the retarded, occupational classes in elementary or secondary schools or Ontario hospitals. Following audiological, psychological and social evaluation the child is admitted on a trail basis to the appropriate program for his age and ability level. At times it is necessary to provide a full-time teacher to work with one or two children or to place a teacher aide in a special class of three or four students. The trial admission system has two definite benefits. Children who do not fully meet the normal admission requirements may enter the school. Others, from hospital situations, who may be able to accept the program for only a short time may transfer back and forth as their needs indicate.

Residential Life: Those children who live in residence rather than at home are integrated with children of their own age and general behavioural level. Stress is laid on independence training and every effort is made to lead the child to care for himself and for his belongings. Every residential child is required to participate in a variety of activities including house league sports, swimming and some social functions. Since the children are with other children who are more capable in some areas of functioning and less capable in others, no one child stands out as being less able in all areas. If a child is encountering difficulties with general adjustment, a case conference is held and residence counsellors, teachers, supervisory staff, psychologist, social worker and appropriate consultant staff plan a course of action designed to reduce the difficulty. In the past the most frequent difficulty has been experienced with children transferred from hospital settings. It takes some time to eradicate inappropriate "ward" behaviour. In most cases sufficient success has been met for the child to remain in residence. In a few cases a child has not been able to meet the minimal social requirements to remain in residence. The child then returns to the hospital situation until the admissions committee feels he or she will benefit by another trial.

Staff Qualifications: In most cases teaching and counselling staff have not been dually trained in working with deaf and retarded children. All, however, have been trained to work with deaf children including the deaf child with limited ability. This training appears to suffice but additional training in educational and residential treatment of the retarded would be of immense benefit. At present the staff rely heavily on the school psychologist, consultant psychiatrist and those among the staff with dual training for advice and assistance.

School authorities have found that teachers and counsellors with vast funds of patience, wide range of skills and large helpings of enthusiasm and imagination are best suited to work with the deaf retarded child. Even those fitting these criteria, however, require the constant positive support of their supervisors and specialist consultants.

Some Data: No attempt has been made to establish a formal evaluation for the program for a number of reasons. Perhaps the

most significant is a lack or research skills among staff at the inception of the program. The most meaningful data concerns the number of mentally retarded deaf graduates employed. Of some 17 graduates of this program only 2 are known to be unemployed. These two are a girl whose third handicap of cerebral palsy is such that she is very limited in her manual skills and one boy whose parents have decided to keep him at home. The majority of the graduates are employed in service trades. One is working in a sheltered workshop and one on a farm. Of the 17, four were transferred in their teens from hospital settings where they had been institutionalized prior to age five.

Data of a different type was obtained in a post hoc fashion. A review of intelligence test scores indicated that test scores for children in the special program tended to rise. In 1970 figures for the 28 children in the program were obtained. For 19 of these children test-retest scores were considered valid and reliable. All 19 children received the WISC two or three years prior to being retested on the WISC or WAIS in the latter months of 1969. For 7 children with a WISC-WISC series, the rise in scores was from an average of 69.57 to 82 or 12.43 points; for 12 children the rise was from an average of 70.25 to 80.08 or 9.73 points. These changes are significant beyond the .05 level. A possible explanation is that the children were not as retarded as had been thought and the provision of an appropriate program by trained teachers guided the children to a fuller realization of their potential.

Some **Actual Cases:**

- Larry was committed to an Ontario hospital at the age of three. At that time he was diagnosed as being in the lower educable to higher trainable range in intelligence. He had no language, would not obey his parents, was hyperactive and subject to fits of temper. At age eight he entered the hospital school where his progress in all areas was slow. He was especially slow in the areas of speech and language. Larry's teacher suspected that Larry had difficulty hearing and by age ten a hearing loss had been confirmed. Larry was transferred to the new class for the hearing impaired at the Midwestern Regional Children's Centre. Audiological and psychological testing by the assessment team at Milton confirmed the hearing loss and revealed a slightly above average intelligence. At age 12 Larry began to attend classes at Milton as a trial placement student. After a year in a special class and a special residential setting, he was integrated into regular classes and the normal residential setting. Shortly thereafter the hospital released him to the care of his parents for the first time in 11 years. At present Larry is near graduation. His academic and vocational training have progressed well and he is expected to obtain employment with little difficulty.

- Jimmy was clearly a retarded deaf child. Staff at the Hospital for Sick Children in Toronto had seen him a number of times and the diagnosis was always the same; low mental ability, profound deafness and visual difficulties probably as a result of the mother contracting German measles early in her pregnancy. The authorities at the hospital advised the parents to contact the Milton school. The family visited the school clinic where further tests confirmed the findings at Sick Childrens'. A home visiting teacher was assigned to work with Jimmy and his parents until he could begin school. Minimal progress was made for the next four years and Jimmy was not ready for school until age seven. At that time he entered the school on a trial basis and was placed in a class group of three. Some progress in language and mathematics has been made. More progress has been made in the area of behaviour. It appears that Jimmy will be in a special class situation at Milton for his school life. Future employment possibilities include a sheltered workshop situation and janitorial duties.

Summary:

Canadian hospitals and residential schools for the deaf have been unable for various reasons to implement programs for the mentally retarded deaf population. Appropriate staff is difficult to find. Accurate surveys of the deaf retarded population have not been carried out. (This applies especially to hospital settings.) Physical space to house new programs is often unavailable. Authorities believe that available budget is better spent elsewhere. In the case of the hospitals some educational programs do exist and one academic-residential program is being initiated. In the case of most schools some mentally retarded deaf children have been admitted but no specific programs have evolved. When programs are provided, many such individuals prove employable. With the present shift in many Canadian provinces from the concept of quantity provision in educational and hospital settings to quality provision, the needs of mentally retarded deaf Canadians should receive appropriate attention.

Identification of the population is a first step. While it may not be feasible for every hospital facility in Canada to provide routine audiometric tests on admission, certainly those hospitals with 500 or more residents should procure the full or part-time services of an audiologist. Psychological testing by an individual versed in the special techniques recommended for the deaf should follow for all those identified as suffering a significant hearing loss. Larger urban centres should provide audiological testing for children entering schools for the retarded. When sufficient numbers of children or adults are identified, their needs should be met in a realistic manner. It is nearly axiomatic that parents, teachers and other concerned individuals will be faced with the duty of motivating educational and medical authorities to provide assessment facilities and programs for mentally retarded deaf individuals.

[1] *Paper presented at AAMD Region I Conference in Vancouver, October, 1971.*

Special Winter Olympics for TMR at UWO

As the Special Olympics flag was raised on campus of University of Western Ontario, February 17, 300 trainable mentally retarded young people and 300 UWO student chaperones sang a steamy "Hi Look Us Over" in the 6° below zero temperature. UWO Faculty of Physical Education proposed to find out whether the Canadian winter environment could be used to stimulate TMR youngsters to enjoy a new learning experience. Boards of Education and institutions for the retarded in counties surrounding London, Ontario, responded favourably. Contestants between the ages of 8 and 21 were matched with volunteer student chaperones so that they would not miss any opportunity to take part in individual and team sports which included skating, skiing, tobogganing, co-ed open (best distance attained on any mode of transportation downhill) and broomball. Members of the Royal Canadian Regiment provided snowshoes and instruction. Contestants were divided into three groups according to age, sex and ability shown on practice trials. Each contestant took part in two events plus broomball and received a Special Winter Olympics crest designed by a UWO art student. A hot noon meal and donuts and hot chocolate at the end of the day were welcome. When UWO President D. Carlton Williams opened the event he said, "This is the first time you have been here, but we hope it won't be the last" . . . 600 winter sports enthusiasts agree.

NIMR financial support included the production of a video tape. Dr. Frank Hayden and Dr. Conrad Milne of UWO Faculty of Physical Education planned and executed a valuable learning experience for TMR young people. Snow is a plus, didn't you know?