

## A RESIDENTIAL SCHOOL FOR CHILDREN WITH MULTIPLE HANDICAPS

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That many educationally subnormal children are additionally retarded due to communication difficulties is something emphasized by recent research. Traditionally, the remedial education of markedly subnormal children has concentrated to a considerable extent upon special methods of teaching reading and improving practical and manual skills. This article describes a school specializing in the care of subnormal children with speech difficulties and communication difficulties. It is unique in this way, and takes advantage of that part of the 1944 Education Act that authorises E.S.N. children to receive 'some special form of education **wholly** or in part in **substitution** for the education normally given in ordinary schools'.

Eryri Hospital School, Caernarvon (24 children), is a joint venture between Caernarvon Local Education Authority and the local Hospital Authority. The former supply 3 teaching staff, classroom furniture, material and education service; the latter 12 nurses and a residential side for a joint venture into the field of children whose various handicaps summate into a particular difficulty in communicating with others. The present Head was appointed in 1965, to a school housed in two Victorian buildings used for adult welfare and hospital cases until Summer 1965. It is located in a general hospital by a beautiful park on the edge of Caernarvon town. Part-time experts include two doctors and one speech therapist in addition to help from an audiometrician, psychologist and physiotherapist. Children are drawn primarily from North and Mid-Wales, although a few come from more distant Welsh Education Authorities.

By 1970 it is expected that the school will have enough candidates from the 250,000 population of North West Wales to confine its attention solely to this area.

Educationally, the school ranks as a Hospital School catering for educationally subnormal children with communication difficulties. It is not yet recognized as a Special School under the Act. Children are admitted from the age of four up to the age of eleven, when it is expected they will be sufficiently improved to pass into ordinary residential E.S.N. schools. In rare cases a child over the age of eleven is accepted, but by this time it is usually found that the patterns of faulty communication and of speech are too deeply set to be easily remediable. It is hoped with increasingly effective assessment by local residential diagnostic clinics, both in being and being proposed by the Ministries, that children will be forwarded at a suitable early age for effective treatment.

Educational methods used concentrate on establishing a good relationship between teaching staff and children, and upon supplying plentiful and adequate stimuli. Efforts are made to get priorities correct, consequently the three R's do not here hold their traditional place. Situations are contrived and experiences provided which induce a strong desire and need to communicate, as well as to militate against lethargy, fear and behaviour disorders. For instance, James is a very active, normal looking little boy. Unfortunately his speech is little more than a very noisy jabber—(especially if he is excited). To help James to be more articulate and to increase his vocabulary, his teacher makes use of his love of playing house and copying mother.

She gives James a colourful P.V.C. apron, and mop and dishcloth, and a large bowl of warm soapy water on a well protected table. James then meticulously re-

moves all the toys from a particular shelf and proceeds to wash and rub the shelf until it shines. His teacher talks to him while he is busy, and names the various objects—wall, shelf, basin, cloth, apron. She also uses the words 'dry', 'squeeze', 'mop', 'rub' accompanied by actions until comprehension dawns on James. As the toys are replaced the teacher names them all, and asks James to repeat first a few of the names. When all is spick and span James waits for the magic words, "Will you take the basin to the cloakroom and wash it out". As the days go by he makes a good attempt at saying the words 'wash', 'water', and a few others without any prompting.

Neurologically, the children are fully assessed at paediatric and diagnostic clinics prior to admission. The majority of admissions are ambulant (although some are poorly so) and have severe speech defects. Children with substantial physical handicaps, substantial deafness, or who are substantially blind, or whose impairment is substantial educational retardation or social maladjustment are expected to be sent to schools catering for their special need, but it is a feature of the school that it accepts children with several moderate handicaps, a combination of which produces a substantial impairment in communication. Almost one third of the children have minor degrees of deafness not sufficient for a hearing-aid, rather less than a quarter have minor ophthalmic defects, others apparently lack the adequate appreciation of sensory intake. Over one third of the children have a history suggesting past brain injury which is probably responsible for their difficulties in putting together information from various sources, and making good use of what they have.

About a third appear to have specific difficulty in formulating words and constructing sentences, and could be said to be partly aphasic. Others have difficulty in the adequate production of writing or the visual identification of words, due to central causes. A further group of a quarter lack adequate motivation and could be described as on the autistic continuum.

One boy who for months never uttered a word while out walking threw stones into the river day after day. At last he turned to the teacher and said quite naturally "Wasn't that a big splash". For days afterwards he would ask spontaneously "Shall we throw stones in the water—". Another boy who for weeks did nothing but speak loudly and incoherently to his toy animal, on one occasion after listening to music on the record player, suddenly looked up and said "That was a nice tune—wasn't it, Sir?" Another incident which indicated that the methods followed were bearing fruit concerned two boys who previously had no interest whatever in trees, but after being allowed to climb a few were one day heard to be arguing as to the name of a certain tree in the park. It was a delight to the teacher to hear children of this type at last venturing opinions and reasons, in spite of the crude manner in which they were put forward.

Speech therapy is provided by one of us, based upon diagnostic tests and assessment of individual resources of child and staff. The aim of the treatment is to help the children speak in individual or group situations, and by case conference to ensure all staff help in the same way. Short periods of direct work with the therapist are supplemented by each teacher having the three most needful children from his class for one hour speech therapy each day; whilst other children play ball games with the nurses. All group work uses stories, rhymes and games involving speech, to try to improve understanding of language as necessary. After school hours nurses continue integrating speech with the normal, daily routine of the children, e.g. naming articles of clothing as the child is dressing and undressing.

Nursing care extends over more than half the total number of hours in the week. Emphasis continues to be placed upon the development of a good relationship between staff and children, so that they can be taught and motivated towards interest, self-care, satisfactory play with other children, social behaviour with adults

appreciated by both, finally, adequate integration with either the next residential school, or better, the village community from which the child came. Parents visit frequently, take their children out, and keep in contact by regular correspondence and telephone calls to the child. These are potent stimuli to speech.

Psychologically, the children pose particular difficulties in assessment of their ability. It would be possible to give a psychotic child a score of zero on the Terman Merrill/Wechsler Scales, although this would not mean much. Similarly, for a child of imperfect speech, the rank on a standard test of intelligence means extremely little. One can, therefore, only report that we do not expect to admit a child with an initial I.Q. over 55; that the upper third of children give scores which rank them in the lower group of children usually regarded as E.S.N., although, like most E.S.N. schools, an occasional child rises to a score higher than the I.Q. 70 normally regarded as the upper level of children in special schools. Tests of personality would reveal that nearly a third give results varying from withdrawn to very withdrawn, similar to those children usually diagnosed as having Childhood Psychosis. These children appear to lack motivation for learning and communicating, although their physical agility in putting together jig-saws, in climbing the inside and outside of buildings and of outwitting the staff in apparently mischievous behaviour leaves no doubt as to their true ability.

Early results show that whilst the children continue to need considerable educational help after leaving Eryri, like most E.S.N. children, most are able to be settled in the community following departure. Of the 28 children admitted prior to the headmaster's appointment in 1965, all have been replaced in the community, although two are now back in a subnormality hospital system. Since 1965, 16 children have been discharged from the school. 2 have returned home and to state primary schools, 8 home to training centres, 2 to a hostel, 3 to residential special schools, 1 is a maidservant. 2 had to be admitted to subnormality beds at a later stage of their community career.

In conclusion, we would feel that this school meets a very real need. Best described still as an experimental school, it has been reported on television, discussed at many local meetings, has an active League of Friends from an interested local township, and because of the enthusiasm aroused, has attracted as many specialist staff and services as are needed for such children. Most important, it has given stimulus and encouragement to teachers and parents working in the field which was often previously lacking. Many parents arrive with children for assessment who have been told previously that their children are a waste of time and should be despatched to residential custody. Such advice may still be necessary in many parts of the country, but is very destructive for parent and child. It is of interest to note that during the two-year period the school has been fully operational only 3 ambulant children, I.Q. 0-70, had to be admitted to the local subnormality hospital system for short term care, and none for long term. We feel that it will be generally agreed that the admission of subnormal children to large institutions with scanty resources is to be avoided.

The school is at least three times more expensive than large local institutions, and we have to thank our local authorities for allowing us to advance our children. There is much we would still like to do, but it is clear that most of what we would like now lies well within the realms of possibility.

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