

Moving Together Collaboration towards Orientation and Mobility with children who have MDVI

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I work for Guide Dogs Victoria as an Orientation and Mobility Instructor in the Children's Mobility Service. My agency is run as a charity, funded by public donation, and is independent of the school system. Nevertheless, our O&M Instructors work quite closely with schools to meet the needs of our vision impaired clients.

We have been receiving O&M referrals for over 15 years from a special school in the southern suburbs of Melbourne. This school accepts children between the ages of 5-18 who have physical disabilities and health issues. Walking through the corridors of the school, I meet many kids in wheelchairs, some with walking frames, some free-walking. Many children recognise me and stop to chat. Sometimes I wonder what they are doing in a special school, their disability is hardly apparent. Other children in the school live with an astonishing array of disabilities – they cannot move, speak, eat, drink or toilet independently and seem to recognise no-one. They need assistance with every area of their lives. Inevitably, vision impairment is part of the mix of disabilities in the school.

The school is well resourced to meet the needs of these very disabled children. Their staffing profile includes special education teachers, therapists, a registered nurse and support staff. Each class consists of a collaborative team comprising a teacher and an assistant, who are supported by speech pathologists, occupational therapists, physiotherapists, a music therapist and therapy assistants.

The first time I walked into this school 12 years ago, I was daunted. Nothing I had learned in my O&M training equipped me to serve the needs of these children. Long cane training was not appropriate. Most of these children would always need supported accommodation and assistance with daily living skills. Familiarity has made going to the school gradually easier. But working with these children prompted me to rethink traditional orientation and mobility and come up with a model which is more helpful to me in assessing a child's O&M status and determining appropriate goals. The tool I developed is called the Orientation and Mobility Framework.¹ I can make the fuller version available to any who are interested.

Several years ago, when I received an O&M referral at this school, I found it difficult as an itinerant worker to develop any rapport with a child who had multiple disabilities, particularly when they couldn't speak. I couldn't remember the names of all the adults involved in the child's program. Often the child had a bad day. If they were at home, sick, no-one would remember to phone me and cancel my session, so I'd travel 100km round trip to no purpose. If the child was at school having a bad day, I couldn't work with them anyway. Just because I happened to have a session scheduled with them did not mean they were always in the mood to learn. When I took the child out of their classroom to work one to one – to explore the corridors, or investigate the gym, or free-walk outside, or attempt trailing, or do some concept assessment through play, no-one was available to come with us. I often felt I needed help to interpret the child's communication. It would have been great to have someone along to see what we were doing together and to provide reinforcement of the child's skills after I left. I had no idea how to do safe wheelchair transfers, how to entice a child from the floor to the swing, how to motivate them to action from inaction.

And worst of all, I felt that the vision-impaired children I worked with were rather lost in their own classrooms. They seemed to spend a lot of time waiting around while others in the class, who could see, were taught using vision-based strategies.

Towards the end of 2004, there was talk about the possibility of putting several vision-impaired children together into the one class. I was ecstatic – this could solve many of my O&M difficulties, but it would also mean that their class teacher would need to develop multi-sensory teaching strategies right from the start of the year, instead of as an after-thought. I promoted the idea with the assistant principal and the new class was formed for 2005.

The new class had five children, aged between 11-16. Of these five children, four were my O&M clients. One was born very premature, one was shaken as a baby and had resulting brain damage. All were reliant on a wheelchair for everyday mobility. All were non-verbal communicators. They could hear and understand some of what was said to them, but 'spoke' in a combination of grunts, groans, facial expressions, body postures

and natural gestures. One child used a few modified makaton signs. The oldest child was blind and the rest had un-specified low vision, including slow reaction times, functional tunnel vision, and cortical vision impairment requiring eccentric viewing.

Their timetable included two physiotherapy sessions per week. The physiotherapist determined that one session would be spent outside on the bikes. The other session we would run together as a joint physio / orientation and mobility session.

As an itinerant worker, I had the freedom to do home visits, and I went to see each of the children's families in the earlier part of the year to determine whether the children were functioning at the same level at home as there were at school. I also wanted to find out something about the parents' goals for their children and the amount of mobility the child experienced at home – whether they went to the supermarket, whether they had been on trains or planes, whether they went to the park, whether they moved around their own home independently.

Our physio / O&M sessions together were well staffed. In addition to the physiotherapist and myself, we had the class teacher and two or three aides depending on how many children were present that day. We decided to use the gym for our sessions and offer a flexible range of activities, encouraging the children to make some choices about what they would like to do. We committed ourselves to accept their likes, dislikes and preferences in response to activities we tried together, rather than over-ride their preferences for the sake of 'the program'. With this went a flexible approach to time – while the sessions were meant to go for an hour, sometimes it took half an hour just to get to the gym. This time was considered to be well spent if the children got to explore or travel part, or all of the route to the gym more independently.

While the session was scheduled as a group session, in reality we worked one to one with the children, but in a shared space. Their individual needs and communication styles required this. Sharing the gym space enabled the staff and myself to watch the children carefully and share our observations of them during the sessions. I learned wheelchair transfer strategies from the aides. I learned from the class teacher to value my relationship with the children and make communication with them my first priority – more important than orientation and mobility. I learned to interpret the children's communication cues more quickly – the aides were good at interpreting for me. I reminded the school staff to keep stimulating the children's vision, to offer the child items to look at, move towards and explore in their near range of vision. We tried to reward the children when they used their vision intentionally, especially making eye contact.

In the gym, we had access to the trampoline, the wheelchair swing, a range of mats and foam blocks, rollers, discs and wedges, a recumbent bike, a treadmill. We also had plenty of room to trial other mobility aids – a Rifton walker, a walking wheelchair, a

Kilparrin harness. This harness held the child suspended from the ceiling and enabled her to move her feet across the floor without having to support her own weight. Later in the year we moved outside for a few sessions, taking picnic rugs with us. We explored the grass and the playground environment, and enjoyed the sun.

Our goal was firstly to give the children time out of the wheelchair for independent movement. We aimed to observe what the children were interested in now, and find ways of extending that interest and their range of independent movement. A secondary goal was to use the language of WESST² (weight, ends and edges, size, shape, sound, texture and temperature) while exploring the environment or objects in it. Several of the children also had a range of physiotherapy exercises they needed to do during each session to maintain their range of movement and prevent muscle contractures. We took turns working with each child and often worked together for several weeks on one activity before swapping partners or activities.

On a more formal level, I was involved in collaborative meetings with the multidisciplinary team for this class once a term (Class Teacher, Physiotherapist, Speech Pathologist, Music Therapist, Occupational Therapist and Visiting Teacher). During these meetings, we shared our observations of the children's progress and reviewed the goals for each area of their program.

By end of the year, I found that the pace of progress in independent mobility was still extraordinarily slow with this group. The children continued to have a lot of days off school with illness. One girl had renal failure during the year and was off school for weeks, returning only two days a week. The class teacher took long service leave in the middle of the year and was replaced by several other teachers for four months. Surprisingly, this changeover of staff was less disruptive than expected because the pattern of the class had already been established. We did a lot of guessing about what was working with the children, and what wasn't, but the freedom to guess was good – I didn't feel that I had to know what would work before I tried it.

Overall, I felt the experiment of combining these children for the year was a resounding success: The staff and I were able to encourage each other with this difficult work. The children were more settled as priority was put on developing relationships with them rather than on their program. Each child had the opportunity to explore movement in new ways. A joint approach enabled staff to gain a greater understanding of orientation and mobility as well as low vision.

My own commitment to being a regular part of the school program increased the profile of orientation and mobility in the school. I had the opportunity to liaise with the physiotherapy team regarding the purchase of mobility aids. We were able to be spontaneous in trying new aids and equipment with the children – there were enough

staff on hand to source them from around the school. My time was never wasted if children were absent through illness, or just having a bad day. I was able to work with another child in the group. By the end of the year, the speech pathologist had developed an individual communication dictionary for each child in the class to facilitate our work together. These dictionaries included photos and descriptions of each communication gesture the child used, as well as its meaning – very helpful for me as I was only seeing the children for an hour a week.

But how do we determine whether the process was a success for the children, not just for the staff? In the course of the year, I came across the Leuvin Involvement Scale, developed by Ferre Laevers amidst his work on experiential education theory. His theory suggests that learning only occurs when children become really involved in what they are doing, and that can only take place if “students feel at home and are free from emotional constraints.”

“Involvement is not the state of arousal easily obtained by the entertainer. The crucial point is that the satisfaction stems from one source: the exploratory drive, the need to get a better grip on reality, the intrinsic interest in how things and people are, the urge to experience and figure out...Involvement only occurs in the small area in which the activity matches the capabilities of the person, that is the ‘zone of proximal development’...Involvement means that there is intense mental activity, that a person is functioning at the very limits of his or her capabilities, with an energy flow that comes from intrinsic sources.”³

Laevers describes five levels of involvement. While I didn’t use this scale of involvement formally in evaluating the children, I found that the scale did help me to understand what I was seeing when observing the children during their O&M sessions. In short, the Leuvin Involvement Scale recognises the following levels:

- Level 1 : No activity. Child is mentally absent. May show purely stereotypic repetition of very elementary movements.
- Level 2 : Actions with many interruptions.
- Level 3 : Activity Child is doing, without concentration, motivation and pleasure in activity. Routine functioning.
- Level 4 : Moments of intense mental activity occur.
- Level 5 : Total involvement expressed by concentration and absolute implication. Any disturbance or interruption is experienced as frustrating.

Prior to last year, I saw no more than Level 3 involvement.⁴ That is, the children went through the motions of doing what they were asked in class, or by me, but without really being engaged by their activity. But during 2005, the discipline of putting relationships and communication first, and allowing the program to develop according to the child's likes and dislikes, meant that during our joint physio / O&M sessions we often saw involvement at Level 4 and sometimes at Level 5, where real learning takes place. The difference in job satisfaction for me, and for the team, was extraordinary. We actually felt that we were making progress.

References

¹ *Orientation and Mobility Framework*, Lil Deverell, 2006 lil.d@guidedogsvictoria.com.au
Outlines the breadth of orientation and mobility content, including concepts, skills and experiences which are foundational to the development of independent mobility skills.

² *Six Step Method* Leo Golding & Grant Brannock

WESST is an attention directing device devised by Leo Golding to facilitate multi-sensory exploration of objects in the environment.

³ *The Project Experiential Education: Concepts and Experiences at the level of context, process and outcome* Ferre Laevers

<http://www.ecd.govt.nz/publications/convention/Laevers.pdf>

⁴ *Effective Early Learning Program: Child Involvement Scale*, Tony Bertram & Christine Pascal <http://www.eddept.wa.edu.au/lc/pdfs/involvementworkshop.pdf>
Identifies signals of involvement.