

# Joining the mainstream

A father whose son was moving from a somewhat sheltered school to a mainstream school following neurosurgery to remove a tumour, expressed concerns that his son would be liked by neither the adults in the school nor the peer group, and that he would be bullied. His concerns were not about the child's persisting neurological difficulties nor his specific learning difficulties (associated with a profile on standard psychological testing showing that the child had major deficits in certain areas of functioning but quite good performance in other areas). He was determined that his son should enter mainstream education. Concerns about these issues may, however, lead other parents, particularly those of children who present with severe behaviour problems, such as some of the autistic disorders, to have the opposite feeling. Research data<sup>1</sup> are sparse but indicate some benefit of inclusion in mainstream education in areas such as social responsiveness. However, in general, though not always, the results have shown that mainstreaming was more beneficial in terms of the child's academic rather than social progress.

Given the lack of data, one does fall back on one's clinical experience and, having worked both in special and mainstream schools, my experience has been that children with moderate or severe disabilities are more readily accepted by younger children. But in the postpubescent years, children strongly identify with their own peer group and are often more reluctant to accept anyone who departs from their perceived norm (which often varies from generation to generation). This makes intervention difficult.

The notion that one should try and intervene earlier is surely sensible; the idea being that the child is prepared for difficulties. The study reported in our current number by Yude and Goodman<sup>2</sup> on children with hemiplegia and the problems they experience in mainstream schools is to be welcomed in terms of trying to identify which children are more likely to have difficulties. Using a well-defined sample of children with hemiplegia living in Greater London, they identified two factors which were predictive of peer relationships in the 9- to 11-year age group: low IQ and teacher-reported conduct and/or hyperactivity problems. Both were measured shortly after the children had entered school. As the authors state, the negative findings are also of great interest, namely that neither the degree of neurological involvement nor the visibility of the physical disability were predictors of difficult outcomes. Yude and Goodman's predictors do not by any means address all of the possible variants. Clearly, further studies are needed to identify other likely predictors and also to look at qualitative features which are protective against such difficulties. As ever, the research tends to stress problem areas rather than focus upon features of the child and family which are positive and protective.

Yude and Goodman discussed ways in which early intervention may prevent problems. While this is possibly a laudable intention, they do not discuss the alternative strategy of examining the social and physical environment that the child is joining or is part of, to see whether changes there might not be a better way to deal with the problem. In my experience, the staff of mainstream schools first encountering children with disabilities have been ignorant of the nature of certain disabilities but, nevertheless, extremely willing to learn more. In one school where I offered to talk to three or four teachers specifically involved with a child who had spastic diplegia, I was astonished to discover that the entire staff of 70 was waiting to hear my talk; even though staff were not directly involved with the child in question, they were anxious to learn about his potential difficulties.

There is one other service issue which is perhaps worth raising. Many therapists and doctors who see children with neurological disabilities work from the perspective of the child's physical or perhaps learning difficulties and have less experience of the children's psychiatric disorders. They are then confronted with these issues and perhaps lack the training to deal with them. Equally, however, a referral to psychiatric/psychological services might find those working in such areas just as inexperienced with the nature of the problems encountered by children with neurodisabilities. We need, therefore, to close the gap between the disciplines of neuropsychiatry and neurology, which was opened in the early years of the century, as soon as possible.

The children and their families must ultimately decide which school the child should attend. Often they will ask the advice of professionals about the most effective provision for their child. It is impossible (and inappropriate) for the health professional to know about what local provision there is which might suit particular children—that is a task for our educational colleagues. We should, however, be informed about the factors that may affect the child's performance and be able to discuss with the family some of the significant prognostic factors. Yude and Goodman provide us with some more valuable information to help us with this task.

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## References

1. Butler C. (1996) Mainstreaming experience in the United States: is it the appropriate educational placement for every disabled child? *Developmental Medicine and Child Neurology* 38: 861–6. (Annotation.)
2. Yude C, Goodman R. (1998) Peer problems of 9- to 11-year-old children with hemiplegia in mainstream schools. Can these be predicted? *Developmental Medicine and Child Neurology* 41: 4–8.