

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

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FEBRUARY 1982 - NEWSLETTER NO. 22

Three A.P.C.P. 1981 Conference Lectures - Hatfield Polytechnic.

The Different Paths to Walking.

David Scrutton.
Supt. Physiotherapist,
Newcomen Centre, Guy's Hospital.

Rather than summarise the talk I gave under this title I thought it might be of more use to discuss briefly what I said together with the reasons for saying it.

Observation of the gross locomotor development of infants and young children by Dr. Peter Robson and myself at the Newcomen Centre between 1965 and about 1972 led us to the conclusion that, for the population studied, there were two major types of development. The first and predominant group used the "normal" prone developmental sequence; the second group preferred supine and resented (some very strongly) prone. The second group appeared to shuffle on their buttocks as their pre-walking locomotion. Subsequently, as more children were seen, a further two groups were noticed; those with "normal" tone and those who were floppy. All these children seemed to have (and subsequently were seen to have) no neurological or mental abnormality.

If these two sets of factors were put together our children could then be described as prone normal tone, prone floppy, supine normal tone or supine floppy. It appears that if we choose to classify them by their predominant pre-walking means of locomotion, then there are five categories.

1. Crawlers (normal tone prone)
2. Creepers } (floppy prone)
3. Rollers }
4. Shufflers (floppy supine)
5. "Just stand and walk" (normal tone supine.)

"Just stand and walk" implying that there was no pre-walking locomotion, although they can and do crawl freely after they have walked.

The normal tone children undoubtedly achieve getting to standing and walking sooner than their floppy counterparts (see tables) and so it was impossible to use terms like 'early' or 'late' for these (and some other) milestones without having first assigned the child to the appropriate group.

Furthermore, once a child can be grouped correctly, it is possible to predict (from the age of previous achievements) the age of some future achievements with clinically useful accuracy. It is worth noting that not all gross locomotor skills are good predictors and that a skill that is a good predictor for one group may be poor for another.

After the talk I was asked how we used this information and I failed to mention one of its greatest "uses". It highlights how little we know of how children acquire their skills and brings into question the rationale behind some types of "developmental" physiotherapy. The other uses of this sort of information (categorisation and prediction) are manifold and will be obvious to all. It should be appreciated that these tendencies to certain sequences of locomotor development are not confined to the normal child and will be operating (although sometimes overshadowed) in a child with a locomotor disorder. It would seem hard to ignore such factors when planning treatment.

NORMAL CHILDREN

SITS unsupported

	percentiles		
	3	50	97
Crawler	5.5	7.5	12
Creepers	6	10	13
Roller	6	9	13
Shuffler	6.5	10	15
J. St & Wa.	5	6.5	11.5

CRAWLS

	percentiles		
	3	50	97
Crawler	6	10	13
Creepers	12.5	15	20
Roller	10	14.5	20.5
Shuffler)			
J.St & W)	Only after walking		

Gets self to STANDING

	percentiles		
	3	50	97
Crawler	7.5	12	14
Creepers	11	16.5	25.5
Roller	10.5	14	23
Shuffler	12	15.5	24
J.St & W	7	11	14

WALKS at least ten paces

	percentiles		
	3	50	97
Crawler	9	13.5	18.5
Creepers	12.5	20	30.5
Roller	14	17	24.5
Shuffler	12.5	19	27
J.St & W	8.5	11.5	14.5

Tables showing ages in months that each of the five developmental groups achieve sitting, crawling, getting to standing and walking.

References: Robson P (1970) "Shuffling, hitching, scooting or sliding: some observations in thirty otherwise normal children." *Developmental Medicine & Child Neurology*. 12, 608.

References cont: Robson P and MacKeith R.C. (1971) "Shufflers with Spastic Diplegia Cerebral Palsy: A confusing Clinical Picture".
Developmental Medicine & Child Neurology. 13, 651

The Physiotherapist's Role in Helping the Multiply Handicapped Child.

Sophie Levitt,
Supervisor of Therapy Studies,
The Wolfson Centre, Institute of Child Health, London.

Having had a wellknown actor as Guest Speaker at last night's dinner, I mused about the physiotherapist's role in a theatrical way. Who creates a role, the actor or the director? In some clinics it is the actor, or actress, the physiotherapist herself who must educate other disciplines in what she has to offer to help the handicapped child. In other clinics it is more from the director and in others a healthy mixture.

Who are our directors? They can no longer be doctors only. Although we have to have a medical diagnosis we cannot plan therapy to a diagnostic classification alone. It would be quite inadequate in many cases. Although we treat defects we are not only "defectologists". We also train new skills. We cannot only be obsessed with what is wrong with a child, we must look for assets and potential. We need the philosophy of teachers, that is, the educative or learning approach which develops potential, therefore our directors must also be psychologists and teachers. Because of the emotional and social problems that are an integral part of our work with the handicapped, we must obtain advice from social workers, clinical psychologists and psychiatrists.

What then is our role? Well, you know THAT. All I propose to do is to articulate what you know and add a few thoughts of my own. My views are coloured by my experiences just as each one of you has a specific experience in your individual set-up.

Our role is not only in Secondary Health teaching hospitals where we received our education or training. We are increasingly functioning in Primary Health Care. Paediatric physiotherapists contribute much in the community when they home visit and go to nurseries, play groups and schools. We must see our methods in the context of the child's daily life. How do our methods help in the home, the school and the playground? Which methods can be transferred there and which methods are too highly specialised and must be used in the clinic room? As much expertise is needed to modify methods to work outside the clinic as to use them in the physiotherapy department.

Our role is in preventive medicine as much as in curative or rather corrective medicine. Through early assessment and advice to parents as well as with early treatment we prevent deformities and more severe handicap that would otherwise occur. We prevent stress in families by giving early practical help and treatment. Before a firm diagnosis can be made in some neurological conditions, we can still offer much advice on developmental stimulation and child care. A developmental picture of the child's movement and posture can be assessed and methods given before diagnosis is firmly made. Parents can do something while they wait. They need advice and ideas on good posture, good furniture, toys, training feeding and other basic self care development and appropriate motor stimulation relevant to the child's developmental levels. This we also share with other disciplines, especially occupational therapy. Parents will receive much encouragement and support during the difficult time when a diagnosis is still being investigated and at the period when they receive the diagnosis.

In preventive and ameliorative work as part of our motor training of children our roles might fall under the following headings:

1. Assessment
2. Planning therapy and daily care
3. Selection of techniques
4. Selection of equipment
5. Supervision and demonstration of the therapy plans.

1. Assessment

Although we carry out a motor assessment, this overlaps into the motor assessments of others. The Developmental Paediatrician, the Neurologist, the Orthopaedic Surgeon also assess the motor problems. The psychiatrists and psychologists especially when using Behaviour Modification, also do motor assessments. Teachers and physical educators also contribute motor assessments. What is our very special contribution which we call physiotherapy? It seems to me that all the years of work with Facilitation Methods with ideas from various systems of therapy have only been gathered by neurological and paediatric physiotherapists. We have "played" around with these techniques in order to use them with individual patients. They are however ASSESSMENT METHODS. They reveal whether activity is or is not dormant in each patient and thus they assess whether the time is ripe for facilitating and training that activity. Other professionals using a variety of learning techniques including behavioural methods need information from this type of assessment so that they know whether the nervous system or motor apparatus has the capacity to respond to methods of movement motivation. Many teachers and psychologists do not know we have this to offer. Many doctors may be unaware of this contribution by physiotherapists.

Our assessments discover what a child can do and what he cannot do. We can also say what is "beginning" or what is the "flicker" of action that could be trained. These emerging actions could be trained with our own techniques or with techniques from other disciplines.

The assessment made by physiotherapists also reports on how a child functions. Many lay men can tell you whether a child can or cannot walk, but the physiotherapist's observation tells how he walks. This pattern of movement and posture may change and our assessments should thus be contributing to assessment of that change.

We must grade our assessments more carefully. We owe it to our children, their parents and our own profession. If we record large stages, in broad detail, the severely multiply handicapped child seems to be unresponsive to therapy in the short term. If we "break down" the task we will detect whether or not something is happening. This would justify further therapy or not. This would also encourage parents, nurses and even ourselves to carry on working with a child. Naturally, you each have your own way of grading. But whatever is used it must grade smaller stages of achievement and include the pattern of performance as either or both of these aspects of function improve with therapy. The variety of ways of analysing any motor skill is itself a study and we all need to learn from each other and also from other professions.

Once again, I must state that the medical profession has not given us enough data on movement and posture analysis. Psychology of movement and motivation for movement have contributions from many non medicals - including the parents of each child.

Assessments made by paediatric physiotherapists should not only be of the child but also of the people in his environment, especially the parent. We must evaluate what methods we can show them, what methods will be feasible and what

likelihood there is of their carrying out our specially modified methods. Social workers, psychologists and our own sensitivity and experience helps us in these judgements. Community physiotherapists are particularly well informed in this area as they have seen the child in his own environment and not just at the hospital or special centre.

Assessment of child and of parent must be assessing techniques themselves. Is the technique too complex, is it a technique for the therapist's hands only or for the parent, nurse or child care staff member? All this must be considered in good assessment.

2. Planning therapy and daily care.

Once assessments are made, the pointers to therapy plans are emerging. The general aims of therapy plans must include:

1. Prevention of deformities and correction of existing deformities.
2. Stimulation of corrective postures and movements within the context of the child's developmental picture.
3. Application of postures and movements to the child's daily life.

Therapy plans include the specialised physiotherapy methods, methods used by child care staff and selection of equipment.

3. Selection of techniques

As many of you know, I suggest the selection of methods from any system of treatment according to the child's individual assessment and total assessment.

4. Selection of Equipment

The occupational therapists work closely with the physiotherapists in selection, supervision and ordering of equipment, furniture and playthings. Consideration of the child in his home and school must be made before deciding on suitable equipment.

5. Supervision and demonstration of the therapy programme.

Although we may be well trained to carry out methods of therapy on patients, we are not well trained to teach normal people how to carry out a physiotherapy technique. In courses I have given when the practicals consisted of showing how a child should be handled and demonstration of selected physiotherapy methods to child care staff, nurses or parents, some very good physiotherapists have been poor in this role. We are really teaching a motor skill to a mother when demonstrating how to correct her child's posture or how to provoke desirable movements. If we expect child care staff to carry correctly, sit and stand the child correctly we should do more than just let them watch us. Perhaps you know all this, but let me emphasise the principle of "learning by doing". Let mother or father do it in front of you, giving encouragement where you can. Build up their confidence as parents who can do something to help their child.

I shall not talk much on these aspects of our roles as Paediatric Physiotherapists. I expect you learn this in your work each day and in the Courses offered by our Association, and by other organisations.

Comprehensive assessment and Integrated therapy Programmes.

It is obvious that a child with multiple handicaps attracts help from multiple specialists. The role of the physiotherapist is to work in a team taking direction from many different disciplines and also to be a director to other disciplines as well. Although we share our knowledge with others and allow them to overlap into our area of movement and posture problems, we must not hesitate

about overlapping into other fields. Once advised of ideas to help the visual handicap we should try to incorporate these into our motor training, wherever possible. Advice on how to communicate with children should be used whilst working with them. The way we handle a deaf, a hyperkinetic or a mentally low child is influenced by other professions and again we must use this information from others as we work. More should be taught to the physiotherapist about attention and concentration development, about perception and perceptual motor development. The teams of specialists have co-operated in keeping their knowledge in separate compartments and not enough in integrating the therapy programme for each child. It is not possible to know everything about a multiply handicapped child as one works with the child. We can at least strive to know the priorities from each aspect or from each discipline, which relates to his motor function. Motor function should no longer be studied as an isolated problem. Motor development is influenced by all other avenues of child development. The overlap of each avenue of development is the area of integration and leads to treatment of the whole child. Our limitations must also be known and those are the details and concepts of other special areas of function such as speech and language, hearing, vision, concentration, personality, behaviour, social backgrounds, and various other aspects of emotional and intellectual development.

There is much to learn and the physiotherapist will never be bored in the field of multiple handicap. In carrying out her role in a team or advised by a team, the physiotherapist inevitably widens her view of handicapped people. The purely "physical" aspect is put into a deeper perspective. If a child does not move it may not be because he has a physical handicap. There are visual disorders, emotional, perceptual, social reasons why this could occur. Many of our Developmental methods used for physical therapy can be adapted for other handicaps which cause motor problems. This is part of my research study with the visually handicapped which I am currently involved in at the Wolfson Centre.

We must come to understand which motor handicaps are organic and which are due to lack of experience. Our role is to highlight the physical or organic defects in the motor apparatus together with medical consultants. In addition we should understand the learning experiences which are missed or which lead to motor delay, speech delay, perceptual delay and/or other developmental retardation.

Psychologists, teachers and social workers help us there. Our closest friends who have similar but not precisely the same function as us are the occupational therapists. We are all interested finally in motor function and independence. Physiotherapists are no longer mobilisers of joints and strengtheners of muscles only. Passive movements and passive physios are out; the Paediatric physiotherapist is not the general physiotherapist working with adults. Our role is active training of movement and posture in child development, not just the motor development but taking account of the total development. Let people know our role through our Association of Paediatric Chartered Physiotherapists and also individually in our own "theatre" at home. Do not presume all other disciplines know what we do, even if they do, they may be out of date! Remember they are busy keeping up with their own profession and may not know the new trends in ours which could help the multiply handicapped child. Speak up ladies and our few gentlemen, you have something to say and something to give!

The Development of Communication

Carol J. Miller,
Director of Studies, Cardiff School of Speech
Therapy.

In considering communication as the means by which people interact, it is necessary to look at its various components. These are -

- (a) Voice - the sound produced in the larynx, which is specific to an individual and varies in females and males, children and different personality types. The pitch and patterns of intonation will change according to mood and emotional state.
- (b) Language - the symbolic code used, may be considered from the receptive or expressive angle.
- (c) Speech - the sounds used to articulate spoken language.
- (d) Fluency - the rhythm and flow of spoken language.
- (e) The Non-verbal aspects - gesture, facial expression and body posture.

The development of communication implies the development of socialisation and relationships and will involve initially an increase in the skills of vision, hearing and touch. The context is usually the everyday experiences of feeding, dressing, playing etc., with the mother or other caregivers. The innate reflex responses are gradually changing to become more complex and meaningful.

The first changes in a child's vocalisations will be noted in intonation patterns, which gradually begin to resemble those of the language environment. Recognisable words develop from these as the child's repertoire of sounds increases.

Comprehension, first of general situations and then of the specifics of language, increases and the child begins to link words in grammatical sequences. It is probably significant that adults usually exaggerate their speech to children and frequently expand on the young child's telegraphic utterances.

At all levels, communication changes from the general to the specific. Initially, a simple system of sounds and words is produced which increase to give greater clarity of meaning and expression.

There are probably links between the development of speech and feeding patterns as this requires the child to coordinate finer movements and cope with a greater variety of foods and utensils. The reflex responses of suckling and infantile swallowing are modified until mature feeding patterns integrate with skills of head control, sitting, eye - hand coordination and social development. Non-verbal aspects of communication develop and fluency increases as the child's access to greater vocabulary and grammatical complexity increases.

From this brief resume' of the development of communication, it is clear that the child must have certain prerequisites:

- (a) Motivation to communicate must arise from social relationships and the need to interact with other human beings.
- (b) The environment must be conducive to the development of spoken language and must provide adequate models from which the child may learn.
- (c) Sensory mechanisms of hearing, vision, touch etc., are necessary, and if the child is to use the senses to good purpose, -
- (d) perceptual mechanisms must develop so that the child will be able to listen, discriminate, remember and make sense of the stimuli around.
- (e) Intelligence is related to the level of development of communication.
- (f) Physical skills are also necessary for motor coordination in the production of speech.

The child whose communication is not developing adequately may have difficulty in one, or many aspects and it may be possible to identify a special need if one of the prerequisites is lacking. In giving help to these children, a careful analysis of the communication processes is required if an effective programme of

A.P.C.P. NEWS

Conference 1982. April 3rd/4th. Community Paediatrics.
Dorset Institute of Higher Education, Weymouth, Dorset.

S C H E D U L ESaturday April 3rd

- 9.30 a.m. Registration and coffee
- 10.00 a.m. Welcome by Miss R.M. Dawson, MCSP., Chairman APCP
Chairman: Miss C. Mason, MCSP., GRSCM., ARCM.
- 10.15 a.m. Introductory Lecture: Professor D. Court, CBE., MD., FRCP., FCST.,
Emeritus Professor of Child Health,
University of Newcastle-upon-Tyne
- 11.15 a.m. Parents Eye View (1) Dr P. Johnston, MRCP.,
Consultant Paediatrician,
West Dorset Health Care District.
- 12.30 p.m. Parents Eye View (2) Two parents with interest in self-help groups.
- 1.30 p.m. LUNCH
- 2.30 p.m. Chairman: Dr. R.J. Purvis, MRCP., DCH.,
Consultant Paediatrician
West Dorset Health Care District.
- 2.30 p.m. Resources for the Handicapped Child and his Family
Mrs. Philippa Russell, Senior Officer, National Children's Bureau.
- 3.30 - 6 p.m. District Handicap Team and their Roles.
Discussion. (Break for tea 4.30 - 5 p.m.)
- 7.30 p.m. Sherry Reception.
- 8.00 p.m. Conference Dinner.
After dinner entertainment - The Cornell Music Group.

Sunday April 4th

- 9.30 a.m. Discussion for APCP members only.
Chairman: Miss D. Wheatley, Dip. Phys. Ed. M.C.S.P.
- 10.00 a.m. Handicapped Children. Family and Community Support.
Professor F.S.W. Brimblecome, CBE., MD., FRCP., DCH.,
Professor of Child Health, Exeter University.
- 11.00 a.m. Coffee
- 11.30 a.m. Portage: Dr. A. Kushlick, MB., B.Ch., MRCP., DPH., FFCM., CRCPsych.
Director Health Care Evaluation Research Team,
University of Southampton.
- 12.30 p.m. Close by Miss Dawson.
Lunch

APCP Members £44.00., Non-members £48.00. Conference dinner extra.

Applications to Miss T. James, MCSP., Child Development Unit, Damers Road,
Dorchester, Dorset by MARCH 12th. Will members PLEASE apply promptly - it
is a great help to the organisers. The full programme is in the January Journal.

Page 28.

A.G.M. Notice. The Annual General Meeting of the Association of Paediatric
Chartered Physiotherapists will be held on Sunday April 4th at 9.30 a.m.,
Weymouth Institute of Higher Education. Please bring your membership card
with you.

CONFERENCE 1981

As you will see, three of the Speakers at last year's Conference have kindly given permission for publication of their lectures. It is hoped to produce the whole of this year's Conference programme for the benefit of members who are unable to attend personally.

Increased postal charges.

It will be necessary to increase p. & p. charges for the sale of APCP booklets in the near future. Regional representatives will be notified.

BOOKS

PUPPETRY FOR MENTALLY HANDICAPPED PEOPLE. Caroline Astell-Burt. Souvenir Press Human Horizons Series. 1981. £4.95 paperback. £6.95 hardback.

Caroline Astell Burt believes that the mentally handicapped, either as the audience or as puppeteers themselves, can gain a great deal from the art of puppetry. Her book sets out to help other people working with the handicapped to try puppetry, both as an enjoyable activity and as a valuable aid to communication and the acquisition of social skills. She gives simple instructions on how to make several different types of puppet from readily available materials, and also plenty of ideas for introductory activities and examples of scripts for puppet shows that have been successful in different situations. There is a list of suppliers of specialist materials (which does not assume that everybody lives in London) and a short reading list. The book covers a wide range of subjects but is obviously very well researched and is well worth reading for anyone involved in the care or education of the handicapped. Margaret Soper, MCSP.

TAKE TIME. Exercises in coordination, rhythm and timing for children with specific difficulties related to language. Mary Nash-Wortham. 1982. (2nd ed.) £1.95 + 30p postage. Suitable for 5-6 year olds to 10-11 year olds. From: 58, Pashley Road, Eastbourne, Sussex. BN20 8EA or bookshops, quoting - ISBN 09506555 1 1.

HELPING THE HANDICAPPED CHILD WITH EARLY FEEDING. A manual for parents and Professionals. Jennifer Warner. Lecturer in Speech Pathology & Therapy. University of Manchester. £3.00
From: PTM., 23 Horn Street, Winslow, Buckingham. MK18 3AP. Tel. 029 - 671 - 3776.

SWIMMING FOR THE DISABLED. Association of Swimming Therapy. 1981
E.P. Publishing Ltd., Bradford Road, East Ardsley, Wakefield W. Yorks. WF3 2JN
£3.95 paperback + 75p. p. & p. from: A.A.A. International, 16 Calderfields Close Walsall, W. Midlands. WS4 2 HR

CAN'T YOUR CHILD HEAR? Roger Freeman. Robert Boese. Croom Helm Ltd.
A comprehensive guide for parents and professionals on what it is like to be deaf, the causes and ways of overcoming problems.

OUTDOOR PURSUITS FOR DISABLED PEOPLE. Norman Goucher O.B.E. Woodhead-Faulkner Ltd. For the Disabled Living Foundation. £4.75 + 80p. p. & p. paperback; £6.95 + £1. p. & p. hardback. From: DLF Sales Ltd., Book House, 45 East Hill, Wandsworth, London SW18 2 QZ.

EPILEPSY: THE FACTS. Anthony Hopkins. Oxford Medical Publications 1981. £4.95.

PUBLICATIONS

'IN CONTACT'. Information and news for the young arthritic. The magazine is produced by the Under 35's Group of Arthritis Care, 6 Grosvenor Crescent, London. SW1X 7ER. Membership costs £2.00 per year. Contact Hon. Sec. Linda Catling, Oakwood, 78a Selwood Road, Brentwood, Essex.

VISUAL HANDICAP. Information sheets for those working with visually impaired children are available from Ann Woodhead, Education Dept., RNIB, 224 - 6 - 8 Great Portland Street, London, W 1. This is a new venture by the RNIB. The information sheets are very informative and full of ideas on observation and assessment of the multiply handicapped, ways of encouraging the use of vision and where to obtain visually interesting toys and equipment. Free.

"PLAY AND THINGS TO PLAY WITH". The Health Education Council, 78 New Oxford Street, London, WC1A 1AH. Leaflet illustrating the potential of homemade toys from boxes, newspaper etc., for various age levels. Very good.

SPASTICS SOCIETY PUBLICATIONS. "Who's Holding the Baby Now". 75p. Experts discuss reasons for Government action on perinatal and neonatal mortality levels. Spastics Society, 12 Park Crescent, London, W1N 4EQ.

"BENEFITS FOR HANDICAPPED CHILDREN & THEIR FAMILIES". A supplement to the Disability Rights Handbook. 70p. From Disability Alliance, 1 Cambridge Terrace, London. NW1 4SL.

"YOUR CHILD IN HOSPITAL - A PARENT'S HANDBOOK". NAWCH, 7 Exton Street, London SE1 8UE. Price. 40p. + 20p. p. & p.

SCHOOL HEALTH SERVICE. A report produced by the Children's Committee looks at the implications of integration of the handicapped into normal schools, for the school health service. The report recommends that medical and teaching staff should be more prepared to share knowledge with each other and with parents. The paper can be obtained from The Children's Committee, Mary Ward House, 5 - 7 Tavistock Place, London. WC1H 9SS. Please send large S.A.E.

"TEACHING THE MULTIPLY HANDICAPPED". Written by Walsall Working Party on Curriculum Development for the Multiply Handicapped ESN(S) child on a multidisciplinary basis, the booklet has sections on aids and adaptations, play, communication, stimulation programmes and physiotherapy. £1.50. (Cheques to Walsall Metropolitan Borough) From: Education Department, Psychological Services, Child Guidance Centre, Littleton Street West, Walsall. WS2 8EN

MENTAL HANDICAP: THE FIRST TWELVE MONTHS. Report from Association of Professions for the mentally handicapped, of a two day workshop. It includes - working with parents, an in-service training scheme, Down's Syndrome questionnaire. From Publications Department, APMH, 126 Albert Street, London, NW1 7NP. £1. + 25p.p&p.

PRELIMINARY EVALUATION OF CONDUCTIVE EDUCATION: The progress of Twelve Children with Two years attendance of the Conductive Education Unit at Ingfield Manor School. By Lillemor Jernqvist B.A., Department of Educational & Social Studies, The Spastics Society, 16 Fitzroy Square, London. W1P 5HQ. June 1980.

ARTICLES

Psychiatric Sequelae in children treated operatively for hydrocephalus in infancy. Connell H.M., McConnell T.S. Dev. Medicine & Child Neurology. 1981.23: 507-17

Origin of handicap in young children. Jones CEM. Radford M, Archives of Diseases in Childhood. 1981. 56 : 535 - 7 (Most handicap occurs before birth.)

Developmental Assessment. Martin Bax. Health Visitor. Nov. 1980. Vol. 53
461 - 462. Written for the health visitor student.

Foetal Alcohol Syndrome. The Incurable Hangover. Beattie J. Health Visitor,
Nov. 1981. Vol 54. 468 - 469.

Helping Parents of Handicapped Children. - The Health Visitors Role. Russell P.
Health Visitor. Nov. 1981. Vol. 54 p. 472 - 475

The Specialist Health Visitor for Handicapped Children : Luxury or Necessity ?
Twinn S., Health Visitor. Nov. 1981. Vol. 54. 478 - 479

The Lancaster Portage Project: A Home base service for developmentally delayed
young children and their families. Holland J., Health Visitor. Nov. 1981
Vol. 54 486 - 488.

Portage - A Parent's View. Health Visitor. Nov. 1981. Vol. 54, 488 - 489

Muscular Dystrophy. Hosking G. Health Visitor. Jan 1982. Vol. 55 22 - 23.

FILMS AND SLIDES

And Baby Makes Three. A two part 16 mm . film lasting 22 minutes and giving the
baby's view of the world from birth to six months and the parents adaptation to
their new role. From Random Film Library, 21, The Burroughs, Hendon, London.
NW4 4AT.

Spina Bifida. A set of 12 colour slides and teaching notes, on how spina bifida
affects daily living and mobility, is now available from Educational Products Ltd.,
Bradford Road, East Ardsley, Wakefield, W. Yorks. Tel. 0924-823971. £3.15 + VAT

DID YOU KNOW? The Independent Council for Mentally Handicapped People (IDC)
has been launched under the chairmanship of Professor P. Mittler and will continue
the previous work of the National Development Group. The council will offer
strategic advice to the Government and other bodies who are concerned with
relevant policy making e.g. education, social services, housing and employment
so that a real multi-disciplinary approach can be developed at National level.
NDG. Publications can still be obtained from Room C411, DHSS. Alexander Fleming
House, Elephant & Castle, London, SE1 6BY.

Cystic Fibrosis Week. April 17th - 24th 1982. Publicity material is available
from the C.F. Research Trust, Blyth Road, Bromley, Kent, BR1 3RS. Tel. 01-464-7211.
Sunday April 18th will be observed as National Cystic Fibrosis Sunday when
prayers will be offered in churches of all denominations so please approach your
local vicar, parish priest or minister.

DHSS Wheelchair Selection. A training package to help those responsible for
selection of patients' chairs which includes slides, a video film and written
material prepared mainly by physiotherapists and O.T's. On loan from: The
Training Aids Unit, Hydestile Hospital, Godalming, Surrey GU8 4 DQ. Tel:
04868-23703/4.

International Federation for Spina Bifida & Hydrocephalus. The inaugural
meeting took place in Dublin on 24th Sept. '81., and attracted delegates from
18 countries. The theme was "How to lead an Independent Life." The papers
presented will be published later in the year. The next meeting will be in 1983.

Toys for Handicapped People. The Leeds and District ACTIVE group are offering
for sale a variety of toys for handicapped children. The catalogue is 25p + 15p
p. & p. Prices are reasonable and there is no VAT. From: Leeds & District
ACTIVE, 3 Roxholme Terrace, Leeds LS7 4JM . Tel. Leeds 622339

ROSPA Wheelchair Proficiency. If your school has not already been sent the details of this scheme, by ROSPA, it would be worthwhile asking for details. A series of tests present tasks at three levels which lead to a Bronze, Silver or Gold Award. There are limitations in the design of the tests at the moment but ROSPA would be grateful for comments from staff and children using the scheme, as it proposes to revise it in the next few months. Contact: Royal Society for the Prevention of Accidents.

Play Aids for the Handicapped Child. An exhibition is to be mounted in Newcastle in May 1982 and the organisers would like to hear from anyone who has ideas which they would like to submit. Contact: Mrs. Ednie Wilson, Handicapped Persons Research Unit, Newcastle-upon-Tyne Polytechnic, 1 Coach Lane, Coach Lane Campus, Newcastle-upon-Tyne, NE7 7TW. Tel. 0632-664061

Mentally Handicapped Register. ^{MCS,} Mrs. J. Flynn/ is compiling a register of physiotherapists working in the field of mental handicap. A questionnaire has been designed (which is available for any interested members to complete) which will help to delineate the professional role, identify essentials in the task and outline personal strengths, and weaknesses, which could be overcome by attending courses or sharing experiences. A News Sheet, the first of which was prepared in January will also be available on receipt on a large S.A.E. If you would like to contribute please contact Mrs. Flynn at:- Physiotherapy Department, Mary Dendy Hospital, Great Warford, Nr. Alderley Edge, Cheshire.

EQUIPMENT

MALDEN CARE GO-KART. Designed for the severely handicapped child, this programmable Go-Kart will change direction or movement for as long as required, at the touch of a button. It can be used out of doors. It looks rather like a Dalek so should appeal. From Malden Care, Malden House, 579 Kingston Road, Raynes Park, London, SW10 8SD

MEDI-SPOON. For children who have difficulty in swallowing medicine or are just rather uncooperative, the medi-spoon could solve the problem of spills. It consists of a clear plastic hollow calibrated handle with a spoon bowl attached at one end. The plastic is sturdy. £1.65 from Rolanworth Ltd., 1 - 3 Grey's Road, Henley-on-Thames, Oxon.

RAINCOSY. Weather protection for children who are carried in a sling. It is tied around the mother's waist and to the shoulderstraps of the carrier without disturbing the baby. Navy proofed nylon with a fleecy lining. £8.90 or £5.50 unlined. From Jilly Mac Ltd., 587 Lanark Road, Juniper Green, Edinburgh.

JUSSILA FURNITURE. A junior table chair and stool in bright colours. Similar in design to the 'Theramed' chairs and also originating in Scandinavia. From Puzzles by Post, Eskdalemuir, Langholm, Dumfriesshire.

AQUA - AID. A newly designed air inflatable support for the disabled swimmer from Crelling Harnesses for the Disabled, 11 and 12 The Crescent, Cleveleys, Lancs., FY5 3LJ. 0253 - 852 298. The child is supported in an upright position so enabling him to float and see. Toddlers to 8 years. £15.00; 9 years to teens £16.50., adults £17.50.

AIRPLAY INFLATABLES. Inflatable play structures for children made from durable nylon reinforced P.V.C. Inflated with ordinary domestic vacuum cleaner and can be used in the hydrotherapy pool. Cost is calculated per yard of tube, e.g. £60. for 4 yards. £150 for 10 yards. Some shapes resemble animals, large enough for many children to sit on. From Airplay, 26 Ebenezer Terrace, Newport Gwent. 0633 54318.

COURSES DIARYCastle Priory College

- 1st - 3rd Feb. '82 Perceptual Problems in Cerebral Palsied and Spina Bifida Children. A programme for parents and professionals working with handicapped children. Tuition £32. Residence £30.
- 24th - 28th Feb '82 Blissymbolics Communication. An introductory course concerned with communication for the severely handicapped. Tuition £75. incl. Bliss materials. Residence £60.
- 8th - 12th Mar. '82 Cued Speech - A Language Tool. An introductory programme for staff and parents who wish to appraise, practice and use this support of lip reading. Tuition £47. (including course materials). Residence 60.
- 19th - 21st Mar. '82 Margaret Morris Movement. A practical programme introducing this unique system with application for all handicapped groups. Tuition £32. Residence £30.
- 26th - 28th Mar. '82 Revised Makaton Vocabulary (BSSL) for the Severely Retarded. Practical workshop for all categories of staff;
1) beginners 2) intermediate and 3) advanced programmes.
Tuition £32. Residence £30.
- Mrs. J.W.Knowles, Principal, Castle Priory College, Thames Street, Wallingford, Oxon, OX10 OHE. Tel. 0491 - 37551

International Society for Prosthetics and OrthoticsEvening Seminars 1982

- 11th Jan. '82 Foot Pressure Problems and Benefits of Gait Analysis.
7 - 9 p.m. Anatomy Lecture Theatre, The London Hospital, Whitechapel E.1.
- 1st Feb. '82 Prevention of Hand Deformities and Maintenance of Function.
7 - 9 p.m. Lecture Theatre B, New Alexander Wing, The London Hospital.
Whitechapel. E.1.
- 1st Mar. '82 Amputations and Alternatives to Amputation.
7 - 9 p.m. Lecture Theatre B, New Alexander Wing, The London Hospital.
Whitechapel. E.1.
- U.K.National Member Society. Annual Scientific Meeting.
1st - 2nd April '82. University of Leeds, Bodington Hall, Leeds.

International Cystic Fibrosis Association

- 31st May - 3rd June 1982. Brussels, Belgium.

European Working Group for Cystic Fibrosis. (EWGCF)

- 2nd - 4th June 1982. Further details available from Mr. Ron Tucker, Executive Director, Cystic Fibrosis Research Trust, 5 Blyth Road, Bromley, Kent. BR1 3RS. 01-464-7211

Disabled Living Foundation

- 13th - 14th May 1982. Children's Equipment. Further details from Miss Margaret Dowden, Conference Secretary, The Aids Centre, Disabled Living Foundation, 346, Kensington High Street, London, W14 8NS. 01-602-2991

Association of Professions for the Mentally Handicapped

6th - 9th July 1982. Care in the Community.
Congress 1982.

Speakers include Professor Mittler, Maureen Oswin, Phillipa Russell.
Information - APMH, Miss A. Whittaker, Secretary, King's Fund Centre,
126 Albert Street, London, NW1 7NF. 01-267-6111

APCP REGIONAL REPORTS.

Scotland Regional Rep. Miss M. Booth, MCSP, 210, Union Grove, Aberdeen, AB1 6SS

15th May 1982. Psychological Implications of Handicap and Illness
for Children and their families. Study Day at Stirling Royal
Infirmary. £4.00 Members. £5. Non-members. Contact Reg.rep.
for details.

North East. Regional Rep. Mrs. M. Soper, MCSP, 29 Garth Terrace, Clifton, York.

An evening meeting was held on December 1st 1981 with a talk by Mr. T. Gausson,
Educational Psychologist. Members were also able to enjoy wine and mince pies.

13th March 1982. Study Day. St. James' Hospital, Leeds.

a.m. "Asphyxia, haemorrhage and the new born brain". Dr. Dear,
Consultant Paediatrician, St. James' Hospital.

"The work of the Special Care Baby Unit". Sister Taylor.
Special Care Baby Unit, St. James' Hospital.

p.m. "Non Accidental Injury". Speakers to be confirmed.

Details from Mrs. B. Pickard, 73 Moseley Wood Gardens, Leeds, LS16 7HX

North West. Regional Rep. Mrs. M. Down, 6 Swann Lane, Cheadle, Cheshire.

Wales. Regional Rep. Mrs. W. Williams, MCSP, 12 Gelligaer Gardens, Cathays,
Cardiff.

South West. Regional Rep. Miss T. James, MCSP, 23a High West Street, Dorchester,
Dorset, DT1 1UW

A well attended meeting in conjunction with the National Association
for Special Education on the 'Special Care Unit' held in Exeter on
21st November. The emphasis was on the multidisciplinary approach.
The speakers included the teacher, physiotherapist, occupational therapist,
and speech therapist. Further study days are to be announced later.

Midlands and Trent. Regional Rep. Miss R. Dawson, MCSP, 19 Main Street,
East Bridgford, Nottingham, N13 8PA

South East. Regional Rep. Miss P. Charon, MCSP, Physiotherapy Department,
Royal Alexandra Children's Hospital, Brighton, Sussex.

East Anglia. Regional Rep. Mrs. P.A. White, MCSP., 24 Maltings Drive,
Wheathampstead, Herts.

London. Regional Rep. Miss G. Riley, MCSP, Physiotherapy Department
Belgrave Hospital, 1 Clapham Road, London. S.W.9.

Absence of Regional Reports due to severe weather conditions.