



NEWSLETTER

NOVEMBER 1983 No. 29

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EDITORIAL

The new Editorial Board has now met and, before long, hope to produce the Newsletter in a new format which has been under consideration for some time. During the coming year, it is hoped to devote at least one edition to Special Education, and the effects of integration. So many Physiotherapists are working in Special Schools that their views on this subject are very relevant and reports of action or progress which would be of interest will be welcomed - preferably before the end of February.

Maintenance of a high standard of professional expertise is not always easy for those of us who work away from centres of excellence, or single-handed. Pressures of work and financial cuts make it difficult to attend those courses which would be of interest. Therefore, we hope the Newsletter provides a continuous update of recent developments within Paediatrics, together with your ideas and adaptations of equipment. Wider understanding and exchange of knowledge about current theories and philosophies not only brings a maturity to our chosen specialty but leads to the confidence marking a good paediatric Physiotherapist.

Bound by a common interest and linked by the Newsletter, strong bonds of support can be forged to maintain contact and banish isolation.

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Original articles, abstracts from other journals, notes on new products etc., and any other material for publication, should be sent to the Editor:

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HANDLING OF THE PREMATURE, LIGHT-FOR-DATES
AND "AT RISK" BABIES IN THE
SPECIAL CARE BABY UNIT, DORSET COUNTY HOSPITAL

During the follow ups of babies from the Special Care Baby Unit in Dorchester, it was observed that some developmental delay was related to postural problems and not neurological ones, in particular, too early extension with the shoulders retracted. If parents were shown how to handle and position the baby correctly, this helped them to allow extension to come through at the appropriate time.

It was therefore decided to look more closely at the factors which influenced the normal babies' sequence of development and how these compared with the babies in the Special Care Baby Unit.

A normal baby should spend approximately the last month in utero curling up into a flexed position. This occurs with the increase in size of the baby, combined with the marked decrease in the amount of liquor giving less room to move. Also at this stage the development of the motor system relating to the myelination of the cortex and long spinal tracts is moving from extension postures to a greater increase in flexor tone. This then becomes the posture from which the sequence of development begins. A baby born before 36 weeks or light-for-dates has not experienced this period of increased flexion and therefore does not have the expected degree of flexion recoil.

A term baby has predominantly total patterns of posture and shows the characteristic attitude of lying passively with the limbs drawn up. After birth the baby is tucked up in a cot in a naturally curled position on its side and this facilitates the sequence of normal development. Unfortunately some babies do not have this beginning and instead of being tucked up in a cot are transferred to the Special Care Baby Unit spending their first hours or maybe weeks in an incubator. Reasons for admission to a S.C.B.U. include:

- (a) Pre-term babies (less than 2.5 kgs.);
- (b) Light-for-dates babies;
- (c) Birth trauma;
- (d) "At risk" babies.

When possible, these babies were nursed in prone lying.

At the follow up clinics it was noted that these babies had externally rotated hips and everted feet. Asymmetry was observed if they persistently turned their head to one side with retraction of the shoulder and hip on the face side. For these reasons, when the medical conditions permit, the babies are now nursed from side to side. Prone lying is only used following a particularly windy feed.

A programme of handling and positioning for the preterm and light-for-dates babies is taught to all staff and parents in S.C.B.U. as we become aware of how posture could influence the developmental sequence during the first year.

The aim of the handling is to pick up the baby in a smooth co-ordinated manner causing as little disturbance as possible and maintaining the curled position. The baby is picked up from side lying with the mother placing one

hand under the sternum and rolling him onto his tummy. He is then lifted up in this position of ventral suspension which allows the head and shoulders to fall forward into flexion quite naturally. The mother's other hand comes under the bottom keeping the hips flexed and the baby gently rolled over into the crook of the arm. Care must be taken to keep both the shoulders forward and not to put pressure on the occiput or the soles of his feet as this stimulates extension.

The flexed baby settles more readily and appears to be more secure when handled. This enables him to relax in the mother's arms and allows her to nurse him. The baby who is constantly pushing into extension is difficult to cuddle and the mother feels that this could be rejection or her inexperience.

With the flexed baby feeding is facilitated both at the breast where the baby stays on more readily and with the bottle because with extended head and shoulders the baby swallows more air. The Paediatricians are associating this with being a contributory factor to colic. Winding should be done with the baby being brought forward to the flexed position with gentle pressure over the abdomen. Patting the back only stimulates more extension of the back muscles. If winding over the shoulder, it is essential to keep the baby fully flexed. Excessive crying is sometimes reduced by gently rocking a baby in ventral suspension.

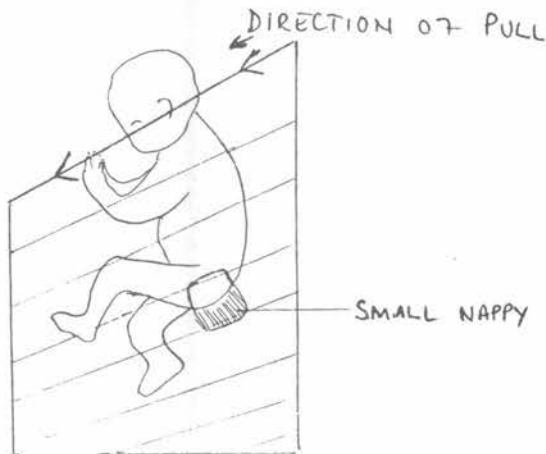
The baby is nursed on its side in flexion, this position being achieved by the mother and nurses reversing the picking up procedures, keeping the baby curled up as it is put onto the mattress. The position is assisted by placing a small nappy or wedge under the supporting hip to rotate the pelvis slightly towards the mattress.

The weight of the top leg, which is flexed at the hip and knee, then keeps the rotation with the leg resting lightly on the mattress. The head is forward with the two shoulders protracted, the top arm resting on the mattress in front of face (as in the mother's ante-natal relaxing position). Care should be taken not to over flex the elbow of the supporting arm because this restricts the circulation.



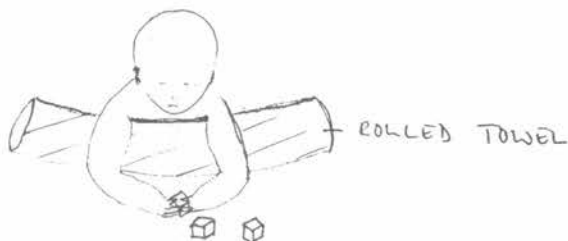
SMALL NAPPY UNDER HIP

In the incubator, the baby will only remain in this position after a feed when it first goes to sleep, but we have found that providing the baby "feels" the curled up position during handling, this seems to be sufficient. Once the baby is in a cot, the side lying position is maintained for longer periods, using the cot blankets to reinforce the flexed side lying position. The baby is curled in the cot as described with the first blanket being tucked in very firmly above and behind the back of the head, then taken very firmly downwards diagonally across the shoulder and tucked in securely. The next blanket is used in the usual way.



On the Special Care Baby Unit, it has been observed that when the prone lying position has been used after a particularly windy feed, if the shoulders are retracted during sleep, the baby becomes restless and appears to be uncomfortable because the head and face are pushed into the mattress. At this stage, the baby is unable to overcome the retraction to extend the cervical spine, in order to turn the face out of the position. Easing the shoulders forward enables him to turn his head.

During the follow up clinics, frequently mothers say they have not been putting the baby on the tummy because it cries. This is once again observed to be the strong retraction of the shoulders, which does not allow the natural extension of the cervical spine with turning of the head. This normally takes place after the first month. To overcome this once the baby is at home, we suggest during wakeful "play time", the mother should roll up a towel and place this under the upper chest with the baby in prone lying. This lifts the thorax, enabling the arms to come forward, the pelvis to lower, facilitating the head raising. The baby appears to accept this we think because of the toys in front to keep the interest.



It is important to distinguish between too early extension and the normal extension that should be encouraged at the appropriate time. If the prone position is omitted then the normal extension which develops from the cervical spine downwards may be delayed or not develop in sequence. The baby should develop his extension but not at the expense of his flexion and should be able to maintain the interplay between the

two patterns. Excessive extension can delay the acquisition of milestones as in prone when retraction at the shoulders prevents the baby from getting his arms forward for weight bearing and reaching forwards. This in turn delays weight transference and circling. Rolling is also hindered by too much retraction at the shoulders as the baby gets stuck because he is unable to roll over the lower arm. Sitting can be delayed because the baby will have a tendency to fall backwards and is unable to bring his shoulders forwards to facilitate his saving reactions.

Through this handling of the babies in S.C.B.U. we are aware of any cerebral babies and their developmental progress is closely supervised so that any problems can be identified as soon as they occur and the appropriate advice given to the parents. We like to check all the babies until they are walking independently. It is important that parents understand that we are monitoring development and only giving intervention when a developmental interruption occurs.

The parents of babies in S.C.B.U. are given a pamphlet which explains the importance of the early handling to encourage the arms and hands forward to promote hand/eye regard and also the development of midline orientation. This provides the basis for knowledge of body image and body awareness. We think that any extra stimulation of preterm babies during the immediate neonatal period is unnecessary because they are experiencing light, sound and handling, which would not occur in utero, and term new born babies at first spend a considerable part of each day asleep.

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CHILD DEVELOPMENT CENTRES -
PROBLEMS AND POSSIBILITIES

In the Court Report ("Fit for the Future" - H.M.S.O. 1976) it says that "Parents understandably want a single door leading to assessment, explanation and treatment. They need a co-ordinated service of care, therapy and education with regular reviews of the child's progress leading to advice and support". Since then Child Development Centres have been springing up throughout the country with the intention of meeting these needs. The personnel involved are usually doctors, health visitors, nursery officers, occupational therapists, physiotherapists, psychologists, social workers and teachers. I am sure there are many models of operation; I am equally sure that we all feel that the families we serve are benefitting from better co-ordinated services. However, here in our particular part of the North West - where staff from all the local Child Development Centres meet together regularly for support and exchange of ideas - we are finding that we (not just Physiotherapists) are all facing similar problems which can, at times, frustrate our aim of giving handicapped children and their families the best possible service. These can be categorised as follows:

- (1) Communication
- (2) Staffing
- (3) Transport
- (4) Stress
- (5) Finance

(1) Communication

- (a) Inter-staff
- (b) Staff-Parent

One of the reasons for having C.D.C's was to bring all the agencies involved with handicapped children together under one roof, thus making communication between them relatively easy. But there are several reasons why it can still be difficult. Some of the staff have work commitments in other places as well as at the Centre, others only work part-time and everyone has holidays, sick-leave and time off for in-service training. So it happens quite frequently that the person one may need to talk to is not actually available. Written notes to each other become vital if things are not to be forgotten.

Most staff at the Centres are happy for colleagues of other disciplines to have free access to their notes but Social Work reports are often a particularly sensitive area. Some social workers worry about their notes being read by other team members while others regard it as vital that details of social conditions should be available because they will affect attitudes towards assessment and/or treatment.

Staff-Parent communication also needs to be good and can be frustrated for some of the reasons mentioned above, but parental involvement is something we are all trying to promote. Some Centres have parents attending multi-disciplinary case conferences and succeed in having very frank discussions about diagnosis, prognosis, and the ways in which family circumstances may have a bearing on the child's progress. Other Centres are more cautious, not necessarily wanting to hide facts from parents but feeling that facing a large team may be somewhat daunting for them. There may also be practical difficulties of getting all the team and the parents together at a mutually acceptable time.

Under discussion as well is the question of giving out written reports of assessments. Only a small percentage of what is said at an interview is actually taken in by the parents but we are still often reluctant to commit ourselves to paper. When school placement is being considered, parents of children with special needs are now - in accordance with the 1981 Education Act - given a written statement of their child's particular needs and details of how the Local Education Authority intends to meet them. However, parents are often denied access to the multi-professional reports on which the assessment will be based. The Government White Paper^{1/} refers to the "widely held view" that such reports should be confidential. An interesting comment on this was recently given by A.C.E. " . . . it may be widely held in Government and some professional circles but it is certainly not widely held by parents"^{2/}.

Certainly inter-staff and parent-staff communication and the availability of records are subjects about which we can learn a great deal by exchanging views with colleagues of other disciplines and in other Centres.

(2) Staffing

This is probably more of a problem in the North-West (Manchester and Liverpool excluded) than it would be in the relatively prosperous and more densely populated South-East. It is not always easy attracting good experienced staff to our Centres which are widely scattered and often cover huge rural areas. Many staff working in the paediatric field are married with families. They often have to wait for husband/wife to change jobs or for children to be at a suitable stage in their school careers before they can move. This means that vacant posts cannot always be quickly filled and, if one member of a team is missing, a greater workload falls on the rest.

Sometimes it is necessary to rotate recently-qualified staff through the Centres. This can bring an injection of new ideas but, if it happens too often, can also lead to a lack of continuity of care. Frequent change of staff can be very unsettling in a small unit, especially if there is only one person of each discipline. As to the suitability of potential staff, some consider that the work in C.D.C's requires people who already have considerable paediatric experience. Others feel that the basic essential in field workers is a strong wish to work with children and a willingness to participate in in-service training.

(3) Transport

The alternatives are usually:

- (a) The family's own transport;
- (b) Ambulance;
- (c) Centre mini-bus;
- (d) Voluntary services;
- (e) Taxis.

1/ Special Needs in Education (August 1980) London : H.M.S.O.

2/ "An Insult to the Handicapped" - Comments on the Government White Paper by the Advisory Centre for Education (A.C.E.).

Most of the Centres in this area seemed to have quite severe difficulties with the organisation of transport when they first opened but these are gradually being resolved.

Families are always encouraged to bring in their children themselves if this is at all possible. Ambulances, on the whole, are disliked partly because they perpetuate the hospital sick role image and partly because families with a handicapped child are already under considerable stress and should not be subjected to lengthy waits for an already over-stretched ambulance service.

Mini-buses, especially when combined with handyman/driver, would seem to be the ideal solution but tax, insurance, service, petrol, garaging and salary all have to be considered. Also, with a minibus, groups of children may have to be organised according to the area in which they live rather than being selected according to their needs. This is especially true if the Centre caters for a large, partly rural area.

Voluntary services are a tremendous asset and they have the advantage of involving the local community with the work of the Centre. However, they can rarely cope with all the requests for help. Taxis are usually only used in emergency because of the cost involved but are often the quickest means of transport.

Most Centres have a slightly uneasy dependence on two or three of these alternatives and there always seems to be worry that the system may break down. We do not like to feel that treatment is planned round transport. Some might suggest that we are over-sensitive to the needs of our parents, but the long-term nature of the work means that we get to know them well and their worries are our worries. "It is no exaggeration to say that in the background of every individual handicapped child is always a handicapped family"^{1/}. They are under stress so we want to minimise their worries about getting to and from the Centre.

(4) Stress

I have just mentioned stress in the families but there is also the problem of stress among staff. C.D.C.'s are very often beautiful buildings, newly furnished and well equipped. It often seems that we are expected - by colleagues elsewhere - to enjoy working there simply because of the surroundings, whereas in fact we have many strains and pressures.

We are dealing all day with anxious parents who may need reassurance, information or a shoulder to cry on. We are often working with very young multiply handicapped children who respond little and learn extremely slowly. There is no acute work with rapid results to relieve the strain.

Often there is only one member of each discipline in the Centre. We work in professional isolation, it is difficult keeping abreast of recent developments and there is not the satisfaction of discussing problems with like-minded colleagues. In fact we often find ourselves having to justify what we are doing to others who may not agree with the particular approach.

If we work only in the C.D.C. and not at all in general paediatrics we can lose sight of the normal child development on which we base our

^{1/} Mary Sheridan - "The Handicapped Child and his Home".
N.C.H. London 1965.

assessments. It becomes all too easy to overestimate our young patients' abilities because we are comparing them with other handicapped children rather than with normal ones.

The overlap of roles, though sometimes stimulating, may cause difficulties especially if there is any clash of personalities. When working with such young children it is difficult sometimes to know who should do what. This is particularly problematic for new staff joining an established team. It is usually necessary for them to spend a considerable amount of time in observation and discussion with others during their first few weeks so that they can work out where their own individual skills and strengths can be brought to bear on the situation.

During the child's limited time at the Centre many staff (usually teacher, therapists and nursery officers) want to see him/her and do their bit to 'get the best out of him/her'. We all have different training and may see the priorities for the child differently. It is therefore necessary to work out co-ordinated programmes or we will all be pulling in different directions. Lack of communication could lead to excessive intervention and attention from adults which may cause a child to lose self-motivation. This could make his/her integration into school (especially if it is to be a normal one) difficult.

(5) Finance

As stated earlier, financial considerations can affect the efficiency of our transport systems. N.H.S., Social Services and Education budgeting can also affect the level of staffing. Vacant posts are sometimes not advertised immediately, some posts are frozen and some staff work on a part-time basis when a full-time commitment is really needed. Alternatively the C.D.C. may only open on certain days of the week.

In-service training is expensive but essential for staff working in such a specialised field. It is so important to study recent developments in treatment and teaching techniques and to find out about new aids and equipment. But money is not always available for reimbursement of course and conference expenses.

Many C.D.C.'s have to rely on fund-raising events to supplement the money available to them. These efforts (e.g. summer fetes, cheese and wine parties) can help to bring about co-operation and a sense of working together between staff and parents but they can also cause stress because we are already over-stretched and there is little time for the level of organisation required to make them a success.

In this article by focussing mainly on problems I may have given a somewhat pessimistic view of the functioning of C.D.C.'s. This was not intended. There are very many positive benefits from working in a multi-disciplinary team and few of us would choose to work elsewhere. I believe however that most people are by now well aware of the advantages so I thought it would be more useful to highlight some of the difficulties. Sharing of problems, as well as successes, can lead to an increase of confidence and efficiency. By pooling our experiences we can improve 'the teamwork between parents and professionals with the common aim of meeting the needs of the child' which is what we are all trying to achieve.

Sheila Bliss, Senior Physiotherapist, Lancaster.

1/ Elizabeth Newson in T.E. Oppe & F. P. Woodford (eds) (1977)
Early Management Disorders. Amsterdam : Associated Scientific Publishers

THE WHEELCHAIR TODDLER

In April 1981 my husband, Dan, and I were told our daughter, Ruth, would never walk. She was a normal-looking 17-month old, bright and contented, but severely weak, suffering from an incurable neuro-muscular disorder. The Consultant Paediatrician who broke the news to us threw into the conversation a vague reference to "needing wheels". Dan, an electronics engineer, set out to provide them and within ten weeks he and Cambridge Consultants, a local firm for whom Dan used to work, and in whose employ we found we had many friends, had produced an electric wheelchair.

Power chairs are not commercially available for children under three, and even then the sort of machine Dan envisaged does not otherwise exist. Ruth's chair turned out to be an exciting, highly-maneuvrable, bright yellow machine, which Dan has described as a forward-control fork-lift truck with the acceleration of a Lotus (up to 4 miles an hour!). It can spin the driver about her centre of gravity, and raise her seat from ground-level to table-height at the touch of a button. The power of the machine enables Ruth to keep up with, or even outstrip her contemporaries in dashing about, as children that age love to do. It is designed to look fun, on the basis that if other kids can do things that Ruth cannot, why shouldn't she have something exciting that they haven't?

Most of all, we felt that Ruth should have an alternative to walking at about the same age as other children learn to walk. Twenty months is late for a child to begin walking, but by no means outside the "normal" age for mobility, and we feel this was important in many ways. Firstly, there is such an urge to move, learn and explore at that age that the job of teaching is relatively easy. Secondly, we wanted to prevent her immobility damaging other aspects of her development.

Children who have to wait until five for the chance of independent movement have already established "disabled" behaviour patterns and attitudes, both in themselves and in others, which are difficult to unlearn.

In those ten weeks of frantic creativity, Dan was reacting much as other parents do, when first confronted by a handicapped child. There is a furious need to do something - anything - to make things better. Most of us find we cannot fulfil that need, and simply have to rely on the "experts" to do what little they can and teach us to cope. Dan, luckily, was an "expert" in his own field and had the skills and the contacts to make a real difference to Ruth's life never envisaged even by the Paediatrician who sparked off the idea. It was a purely instinctive reaction, done with very little consultation with the professionals, and the wheelchair was designed with only Ruth in mind. But we now find so much interest and admiration expressed that we are convinced it should be the fore-runner of many more wheelchairs for children of nine months and up. I should like to pass on what experience and knowledge we have gained to those professionally concerned with such children, about what it is like to bring up a toddler on wheels.

The story starts with a placid, amenable 20-month-old who could always be relied upon to be where she was last put down and didn't, unlike her peers, suffer temper-tantrums over things she couldn't do or have, because her access to those things was so easily preventable in the first place. She was quiet, an observer of life, and not in the least frustrated by her immobility, having never known what it felt like to be able to move. She could sit up, had good fine control of her hands,

though no strength, and, for her age, could concentrate on one toy for quite long periods of time. A charming child! I was the envy of many a harassed mum!

But with the wheelchair, the picture changed. After six weeks of tentatively pushing buttons and joystick with much demonstration and encouragement from us, Ruth discovered that movement was not frightening but fun. This period of learning to "drive" was similar in many ways to the time it takes for a normal child to really find his feet, from first discovering that independent upright motion is possible, to actually preferring it as a method of getting from A to B. Having also put 9 - 10 month old children in the driving seat we know that Ruth actually started "driving" too late as, the younger the child, the less fear has to be overcome first, and the controls are simple enough that a 10-month old baby quickly masters them. Clearly the optimum age will vary according to the abilities and disabilities of each child.

Since becoming a confident driver, at 22 months old, Ruth has developed in many ways I would not have expected of the "passive" child I knew. She began, for the first time, to shriek at the top of her voice, while chasing her father about the room. The speed of movement, and the games she could play, like spinning round and round, chasing, hiding, all gave her that basic attribute - a sense of fun. From being generally contented, she began to really enjoy herself. There is a vast difference, believe me! From being a passive observer, she became actively involved. She learned, as she learned to control the machine, to control her environment more. She could make a decision for herself and act upon it, all at once. She could test things out, and words like "no" and "don't touch" began to creep into my vocabulary, as her access to things expanded at a stroke. Best of all, she could run away! She could defy authority, and discipline became a problem for the first time. We were forced to teach, as all parents have to, what can and cannot be done, and how to respect other people's rights, from not running over their toes, to not touching their property. There has also been the need to learn about dangers and how to avoid them - again another ordinary lesson of childhood, from hot water and not touching the cooker, to road-safety. The wheelchair made a difference in that, in moments of stress or danger, when a normal child could easily be picked up and physically restrained, the emotional hold Ruth could exert against us immobilising her was soon discovered, by both us and Ruth. Other mums, hearing me threaten to "turn her off" may have wished they could flick a switch with their naughty 2-year old too, but it took us a long time to balance out what degree of restraint was appropriate to her behaviour and what was undue punishment by virtue of the complete immobility we could enforce if we wished. But at least she has been able to test out the bounds of "normal" behaviour for herself, at more or less the appropriate age.

Socially, both with children and adults, the wheelchair has had an enormous impact. It is still noticeable how differently Ruth is treated by others when she is being pushed by me in a pushchair, rather than in control of her own wheels. When she is immobile, other children tend to be more stand-offish, or else to "mother" her, treating her like a baby, or doll. Adults speak over her head, rather than to her, in a classic "Does he take sugar?" way. When she is in her wheelchair, other children are at first just fascinated, or envious of her bright yellow car, and quickly learn how active, even dominant, it can make her. They find it fun, and she easily makes friends amongst her peers. Adults' first reaction is often sheer amazement at her apparent skill in "driving". They give her a lot of praise and attention, and talk directly to her much more. The emphasis changes from "What a shame" to "isn't she clever", at a stroke!

The effect of this on Ruth's self-image is to make her thoroughly positive about her abilities, and able to treat her disability in a pragmatic way. There are still many things she cannot do, like climbing in and out of things, dressing herself, toileting without assistance, etc., but it has been fascinating to watch her invent ways to join in, in her wheelchair, with things like jumping, dancing, playing football, etc. These may look inadequate substitutes from the outside but, for her, it is the joining in which is important, not what it looks like!

Educationally, the wheelchair has made it easy for Ruth to integrate into a normal nursery school at the age of 3½, after attending her local playgroup for two terms before that. This process has also been assisted by joining an Opportunity Group from the age of 18 months. Many of her friends at playgroup will be classmates when she moves on to the local primary school when she is four. There has never been any doubt, despite her severe physical handicap, that she could compete in a normal school setting, and that, intellectually, she needs the stimulation of a mainstream school.

Of course, there are therapeutic conflicts inherent in giving such a young child a powered wheelchair so early. It can never be a case of letting her use it all the time, because physiotherapy is necessary to avoid secondary disabilities, and to increase her muscle power as much as possible. In particular, the sitting position is the worst position for her, physically. She can stand, supported in a frame, and the more she does this, the better. There were worries, early on, that an electric wheelchair would create a disincentive for physiotherapy which would be detrimental to her physical development. In fact, it would appear to have had little effect in this way, although it is impossible to assess precisely. Indeed, my observation has been that having the experience of independent movement has actually increased her desire to walk on her own. The wheelchair is a fantastic machine but walking is what everyone else does and, like most of us, Ruth needs to conform!

On the other hand, now that she is learning what hard work it can be to walk with aids, compared with the flick of a joystick in her wheelchair, the disincentive may begin to operate, but she is mainly limited by her weakness, not her will. Because we have now seen the enormous difficulty she has in using a swivel-walker, Dan is now designing a "standing-box" or "driving-frame" to replace the seat on her wheelchair, in the hope of combining therapy needs with fun, and removing the present conflict of interest.

Ruth has taught us three major lessons. Firstly, it is possible to put such a young child into a power-chair, safely, by applying the latest technology to the problem, and it is encouraging to see the use of many features of Ruth's chair creeping into commercially-produced wheelchairs. Secondly, the assumptions previously made about the disincentive effect of "easy" mobility on the use of self-propelling mobility aids should be questioned, in the light of the enormous social, psychological and educational benefits of the early freedom a wheelchair gives. Thirdly, and most important, she teaches us how vital it is to give the right aids at the right time, so that disabled children don't miss out on the experiences and fun to be had at the pre-school stage, and can participate and compete more easily with their class-mates when they go to school. The importance of this for the rest of their lives is obvious.

C. Louise Everard

Louise Everard was educated at Oxford University and the London School of Economics and worked in Social Services, finally as a Psychiatric Social Worker at Fulbourne Hospital, Cambridge, before leaving to bring up a family. She is now active in a voluntary capacity as Chairman and founder-member of the Friends of the Child Development Centre, Cambridge, and as a co-opted member of Cambridge Community Health Council.

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HALLIWICK SWIMMING

Halliwick is a method of teaching water ability to the disabled and was devised by James McMillan, M.B.E., in 1949. The name "Halliwick" is derived from the Halliwick School for Girls in London where Mr. McMillan developed the method.

The Halliwick method is based on hydrodynamics and the physiological properties of water. Halliwick calls for equal development of mental and physical balance, with swimmers learning first to appreciate, and then to utilise, the supportive nature of water. No artificial aids are used, every swimmer having, instead, his own helper, so that work is done on a one-to-one basis while the swimmer learns to find and control his own balance in water. Support is gradually withdrawn as he achieves this. Using Halliwick involves working through a graduated 10 point programme which can be divided into four main sections. These are Adjustment to Water, both mental and physical; Rotations; Buoyancy, and Turbulence and Propulsion. Vocalisation is vital, while much is achieved through the medium of games.

The Physiotherapy Department (Eastern Region) of the Scottish Council for Spastics began using Halliwick in 1979. We take the whole spectrum of disabilities swimming, ranging from ambulant to quadraplegics; both physically and mentally handicapped. Water is used as an adjunct to treatment in the department and is used to create situations not found on land, and to use these to greatest advantage by adapting them according to our aims of treatment. We take the children in small groups, according to their abilities. A regular assessment is made of each child and a record is kept of their progress so that we may evaluate our treatment.

"Swimming for the Disabled" - Association of Swimming Therapy

JOCELYN NESS
Physical Education Assistant
Physiotherapy Department
(Eastern Region)
Scottish Council for Spastics

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS
ANNUAL CONFERENCE, CYNCOED COLLEGE, CARDIFF - 28th & 29th APRIL 1984
"THE ACUTELY ILL CHILD"

Preliminary Programme

SATURDAY, 28TH APRIL 1984 - (Chairperson: Miss K. M. Jenkins,
District Physiotherapist)

- 9.0 a.m. Registration
- 9.20 a.m. Welcome and Opening - Miss A. Grimley,
Superintendent Physiotherapist
and Chairman of A.P.C.P.
- Cystic Fibrosis - Dr. J. A. Dodge
Reader in Child Health
- 10.15 a.m. Questions
- 10.30 a.m. Coffee & Trade Exhibition
- 11.0 a.m. Physiotherapy in Cystic Fibrosis - Mrs. D. Rogers,
Senior Physiotherapist
- 11.45 a.m. Bronchial Lavage (with film on Bronchial Lavage) - Dr. C. Wise,
Consultant Anaesthetist
- 12.30 p.m. LUNCH

(Afternoon Session) - (Chairperson: Prof. O. P. Gray,
Department of Child Health)

- 2.0 p.m. Paediatric Surgery - ? ?
- 2.45 p.m. Paediatric Intensive Care - Dr. P. L. Jones,
Consultant Anaesthetist
- " " " - Miss J. James,
Superintendent Physiotherapist
- 3.30 p.m. Tea & Trade Exhibition
- 4.0 p.m. Head Injuries and Neurosurgery in Children - Mr. Varma,
Senior Registrar in Neurosurgery
- 4.45 p.m. Questions
- 5.0 p.m. Close
- 6.0 p.m. - 7.0 CIVIC RECEPTION PRIOR TO MEDIEVAL BANQUET IN
CARDIFF CASTLE

SUNDAY, 29TH APRIL 1984 - (Chairperson: Mrs. V. Williams,
Superintendent Physiotherapist)

- 9.0 a.m. Renal Problems in Children - Prof. Ascher
Consultant in Renal Medicine
- 10.0 a.m. Coffee
- 10.30 a.m. Leukaemia - Dr. E. Thompson,
Senior Lecturer & Honorary
Consultant Paediatrician
- 11.15 a.m. ANNUAL GENERAL MEETING
- 1.0 p.m. Lunch and Close.

Accommodation will be available on Friday & Saturday at Cyncoed College.
For further information please contact: Mrs. Wendy Williams,
12 Gelligaer Gardens, Cathays, Cardiff.

COURSE DIARY

<u>1983</u>	<u>SUBJECT</u>	<u>ORGANISER/VENUE</u>
Nov. 11	Handwriting Today	National Children's Bureau, 8 Wakely Street, London, CV 7QE.
Nov. 15	Riding for the Disabled (National Conference)	The Grand Hotel, Bristol.
Nov. 23	Cerebral Palsy (Speaker S. Levitt)	P. Paterson, Child Development Centre, Ormskirk.
Nov. 21-24	Creative Activities Workshop	Castle Priory College, Wallingford, Oxon.
Nov. 24-25	Aspects of Play	Lea Castle Hospital, Kidderminster.
Nov. 25	The Changing Management of Young Children with Orthopaedic Conditions	Mrs. M. Costello, O.T. Department, Royal National Orthopaedic Hospital, Stanmore, Middlesex.
Dec. 1	A Dilemma of Resources & Needs (Spastic Society, Neonatal Intensive Care Conference)	The Spastic Society, 12 Park Crescent, London W1N 4EQ
Dec. 2	Seminar on Creative/ Recreative Therapies	Mrs. Michaelis, The Mencap Centre, 123 Golden Lane, London EC1Y 0RT
Dec. 4-7	Rehabilitation Engineer- ing Aimed at Medical and Para-Medical Staff Involved in Rehabilita- tion of the Disabled	Northern Regional Training Centre, Stannington, Nr. Morpeth.
Dec. 10	Workshop on Drama and Movement with Severely Disabled People	Sue Jennings, 6 Nelson Avenue, St. Albans, Herts.
Dec. 10	The Child with Asthma	Vera Smith, M.C.S.P., Our Lady's Hospital for Sick Children, Crumlin, Dublin 12.
Dec. 9-11	Conductive Education (Advanced Course)	Castle Priory College, Wallingford, Oxon.
<u>1984</u>		
Jan. 4-8	Introduction to Paget-Gorman Sign System	Castle Priory College, Wallingford, Oxon.
Jan. 11	Management of the Severely Handicapped Child with Emphasis on Physical Aspects of Care	Mencap Centre, 123 Golden Gate, London EC1Y 0RT

<u>1984</u>	<u>SUBJECT</u>	<u>ORGANISER/VENUE</u>
Jan. 13-15	Autistic Tendencies in Children with Physical Disabilities	Castle Priory College, Wallingford, Oxon.
Jan. 19-20	Communication Aids	Disabled Living Foundation, 346 Kensington High Street, London W14 8NS
Jan. 23-26	Derbyshire Language Scheme	Castle Priory College, Wallingford, Oxon.
Feb. 11	An Approach to the Management of Severe Mental Handicap	Vera Smith, M.C.S.P. Our Lady's Hospital for Sick Children, Crumlin, Dublin 12.
Mar. 7	Experience of Grief and Loss Working with Children	Department of Extra Mural Studies, University of Manchester.
June 9-14	Ninth International Cystic Fibrosis Congress	Congress Office 5 Blyth Road, Bromley, Kent.

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POST REGISTRATION EDUCATION
INTRODUCTORY COURSE TO PAEDIATRIC PHYSIOTHERAPY

This is a pilot scheme to be run in the North West and shortly to be advertised through the Regional Training Office. Employees of the North West Regional Health Authority will have strict priority for the 20 places available.

The dates for the course are 17th February - 18th May 1984.

The aims of the course will be as follows:

- (1) To provide a basis of information, theoretical and practical in a structured and concise manner on various areas pertaining to the practice of paediatric physiotherapy, and the needs of the paediatric physiotherapist, which will complement the in-service training provided by the senior paediatric physiotherapists in the students work situation;
- (2) To draw on the students own professional general experience and to develop and relate this to paediatric practice;
- (3) To discover, examine and evaluate:
 - (a) general and personal aspects of professional practice in the field of paediatric physiotherapy;
 - (b) some of the fundamental theories and philosophies supporting this practice;
 - (c) some of the recent advances in the various sub-specialisms within paediatrics and to relate these to the treatment and management of the sick, disabled or handicapped child;
 - (d) the facilities and resources available to the Physiotherapist in her own work situation.

The course will consist of a total of 90 hours of which 65 will be direct contact hours and 25 will be project work in the student's own work situation.

The course will comprise of:

- (1) Seminars;
- (2) Group discussion based on project work;
- (3) Practical sessions to enable the student to understand their own particular strengths in areas related to paediatric practice;
- (4) Formal lectures;
- (5) Background information given in written form - i.e. handouts, course reading.

Supervision of project work and liaison in the clinical setting will be carried out by the Physiotherapist Tutor assigned to each student.

Not included within the course plan, but central to it, is the assumption that some clinical supervision will be supplied by the student's Senior Paediatric Physiotherapist for the duration of the course.

If the student is working single-handed in her clinical situation this supervision could be arranged by the student's Course Tutor in consultation with the student's manager.

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ABSTRACT

From the British Journal of Special Education : Forward Trends

Vol. 10. No. 3. September 1983. pp 22-24.

"Educational Attainments of Spina Bifida Children Attending Ordinary or Special Schools". By J. Carr, M. Halliwell and A. M. Pearson.

Summary:

Children with Spina Bifida who attend special schools are usually found to be retarded in their school attainment compared with those who attend ordinary schools. This finding has, however, often been confounded by the fact that the special school children tend to have lower I.Q.'s. In order to investigate this, two groups of children were identified from those in the G.L.C. spina bifida survey, one attending ordinary and the other special schools. There were 11 pairs of boys and 11 of girls, each pair being closely matched for I.Q. Examination of their scores on attainment tests showed that while results of reading tests did not differ significantly between the two types of school, children of both sexes at special schools were behind their ordinary school counterparts in number work. These results are supported by similar findings, using analysis of covariance, on the larger group of children in the survey. The effects of other factors are also discussed.

From the "Health Visitor"

Vol. 56. September 1983. p.343.

"Squeaky Toys and Babies' Reactions". By R. T. Bidder, M.Sc., Principal Clinical Psychologist, South Glamorgan Health Authority.

Summary:

The sound levels emitted by twelve different squeaky toys were measured at a distance of two inches from the microphone. All but two toys emitted sounds of 80 decibels or more but none exceeded 100 decibels. The author suggests that this sound level, though unlikely to damage a baby's hearing, would be uncomfortably loud for the baby and parents should, therefore, avoid the frequent use of these toys close to a baby's ear.

ARTICLES OF INTEREST

Photocopies of the articles mentioned below can be obtained from Mr. Martin Saunders, Assistant Librarian, National Demonstration Centre, Pinderfields General Hospital, Wakefield, West Yorkshire WF1 4DG. Please quote the Bulletin Date, the number of the article and full details of the citation. You will be invoiced at 7p per page. Do not send money with the order.

AUGUST 1983

- (1) Jordan IK
Communication methods used at schools for deaf and partially hearing children and at units for partially hearing children in the United Kingdom.
Am Ann Deaf 1982 Dec; 127(7):811-5
- (8) DeGangi G et al
Toward a methodology of the short-term effects of neurodevelopmental treatment.
Am J Occup Ther 1983 Jul; 37(7):L479-84
- (9) Nelson SE
Counterbalanced swivel fork.
Am J Occup Ther 1983 Jul;37(7):489-90
- (20) Gloag D
Caring for the young disabled (editorial)
Br Med J (Clin Res) 1983 Apr 30;286(6375):1376
- (29) Balarajan R et al
A survey of handicap registers for pre-school children in England and Wales.
Community Med 1982 Nov;4(4):315-24
- (52) Hall CD Porter P
School intervention for the neuromuscularly handicapped child.
J Pediatr 1983 Feb;102(2):210-4
- (53) Wedge J Alms M
A method of treating clubfeet with malleable splints
J Pediatr Orthop 1983 Feb;3(1):108-12
- (89) Ruttenberg HD et al
Effects of exercise training on aerobic fitness in children after open heart surgery
Pediatr Cardiol 1983 Jan-Mar;4(1):19-24
- (90) Eickelberg W et al
Effects of passive physical exercise on peripheral vision in muscular dystrophic children
Percept Mot Skills 1983 Feb;56(1):296-8
- Other Articles of Interest
(Ross, Krauss and Auld
(Growth Achievement in Premature Infants and
(Neurobehavioural Outcome
(Journal of Paediatrics July 1983
(
(Miller, Hedmatt, Dubowitz et al
(Use of nerve conduction velocity to determine
(gestational age
(Journal of Paediatrics July 1983

BOOKS

1. Dinosaurs Beware
By Marc Brown & Stephen Kransky. Published by Collins.
A fun safety guide for parents and children, underlining hazards in all sorts of situations.
2. Problems Afoot - Need and Efficiency in Footcare
By Judith Kemp & J. T. Winkler. Published by D.L.A.
Available from - Disabled Living Foundation (Sales) Ltd.,
Book House,
45 East Hill,
Wandsworth,
London SW18 2QZ
3. The 1984 Good Toy Guide
Including over 200 new toys. Published jointly by Play Matters/
The Toy Libraries Association and Inter-action Inprint. Price £3.95
4. Text Book of Cystic Fibrosis
By John D. Lloyd Still. Published by John Wright PSG Inc.
Price £49.50
5. Notes for Teachers of Visually Handicapped Children
By Agnes Cameron A.L.C.M. Cert. Ed.
Available from - Disabled Living Foundation,
346 Kensington High Street,
London W14 8NS
6. Helping Young Children with Behaviour Difficulties
Available from - The Department of Education,
University College of Swansea.
Price £14.95
7. Caring for the Mentally Handicapped Child
By David Wilkins, Department of Community Medicine, University of
Manchester. Price £12.95
8. Encouraging Language Development
By Phyllis Hastings (Leicester Area Health Authority) and
Bessie Hayes (Leicester Education Authority). A volume in the
Croom Helm Special Education Series. Price £6.50 pbk.
9. Let's Talk About Stammering
By R. Byrne. Published London : Allen & Unwin. Price £4.95
10. Easy to Make Toys for your Handicapped Child
By D. Caston. Published London : Souvenir Press. Price £5.95

AUDIO-VISUAL AIDS

1. You Don't Outgrow Downs Syndrome (Tape/Slide : 35 mm./17 mins.)

By J. Finfer. Filmedia Ltd. Distributed by : National Association for Downs Syndrome, P.O. Box 63, Oak Park, IL60303, U.S.A.

* * * * *

DID YOU KNOW

- THAT The Downs Children's Association has appointed a Senior Speech Therapist with Barnet Health Authority as its first salaried director. She will be based at their new Head Office - 4 Oxford Street, London.
- THAT There is a Regional Centre for Disabled Living in Greater Manchester displaying over 700 different kinds of aids. Open Monday-Friday 10.0 a.m. - 4.0 p.m. Based at 26 Blackfriards Street, Manchester.
- THAT Neonatal Thermal Wraps will soon be available providing efficient insulation for the newborn of less than 36 weeks gestation. Not suitable for use in an incubator. For further information contact: 3M Health Care, 3M House, P.O. Box 1, Bracknell, Berks.
- THAT The Physiotherapy Research Centre has transferred from the Health Services Research Unit at Canterbury to King's College, London. A programme of research into the evaluation of physiotherapy practice funded by the D.H.S.S. is being undertaken at King's College within the Department of Physiology. The first project will be started this autumn.
- The Physiotherapy Research Advisory Service is continuing and those needing help are asked to contact Cecily Partridge, King's College, London, Physiotherapy Research, Room 8SEB, Strand WC2R 2LS. Tel: 01-836-0354.

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APOLOGIES

Apologies are offered to Mr. John Fixen, Consultant Orthopaedic Surgeon, who wrote the very interesting article on ARTHROGRYPHOSIS in the August newsletter and whose name was inadvertently omitted.

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS
REPORT OF THE COMMITTEE MEETING HELD ON SATURDAY, 1ST OCTOBER 1983

Conferences:

The final accounts of the Lancaster conference are now available and copies of these were given to all committee members. Although the conference was organised with as small a profit margin as possible built in, it did make a profit and the sum of £1,000 has been paid into the A.P.C.P. national account.

The organising committee was again congratulated on the success of the conference and the committee members thanked for the hard work that they had obviously put into it on our behalf.

A provisional programme for next year's conference in Wales has now been drawn up. Most of the lectures are confirmed and the theme of the weekend is to be "The Acutely Ill Child". The conference will take place at the Cyncoed College, Cardiff, on the 28th and 29th April 1984.

Correspondence:

Letters from the Association of District and Superintendent Chartered Physiotherapists and the B.P.A. promoted further discussion on the reorganisation of the Health Service and the effect this is having on paediatric physiotherapy because of both the fragmentation of paediatric physiotherapy services and the downgrading of senior posts and the subsequent lack of career prospects for specialising therapists. The A.D.S.C.P. are also discussing this problem at present. Ann Grimley is liaising with the C.S.P. and with the D.H.S.S. on our behalf over this topic and would like to know of any problems members are facing.

A.P.C.P. has been asked by "Therapy" newspaper to comment on a circular on H.M.I.'s visits to special schools. These may now be accompanied by a doctor and sometimes a nurse to comment on all the aspects of medical and paramedical provision within the school. The view of the committee generally was that although we would welcome inspection and the publication of reports, which can only serve to improve the service provided, we would not consider any inspection report comments valid unless they had been made by a suitably qualified member of our own profession.

P.R.O.'s Report:

Our P.R.O., Noreen Hare, has been quite busy on our behalf recently - representing us at the C.S.P. congress in Liverpool and working on the preparation of a leaflet explaining the work of Physiotherapists in Paediatrics. This is intended as a basic introduction to who we are for interested Physiotherapists and for fellow professionals - Teachers, etc.

Treasurer's Report:

Sandra Holt reports that our finances are in a much healthier state than usual for this time of year, due largely to the profit from the Lancaster conference and to a refund from the tax office!

Good news - A.P.C.P. subscriptions are now tax deductible.

Post Registration Education:

A pilot introductory course has now been set up in the North West and will take place early next year.

Discussions are still taking place about the possibilities for a more advanced course.

The setting up of this first course is the result of a lot of hard work by Pam Eckersley and Marion Whyte over many years and the committee is very grateful to them for this.

Editorial Board:

An Editorial Board has now been established to produce the newsletter which has been steadily growing in importance over the years that A.P.C.P. has been in existence. This takes the onus of producing a quarterly newsletter away from the P.R.O. leaving her free to concentrate on the other aspects of her job.

The editorial board spent a working weekend together recently and have worked out plans for the newsletter over the next year.

Integration:

A.P.C.P.'s comments have recently been sought by the D.H.S.S. on the architecture of schools and the provisions that need to be made for handicapped children in normal schools. Local comments may be sought in the future about specific projects.

M. R. Soper
7th October 1983

SUBSCRIPTIONS

Members are reminded that the Annual Subscription of £5 will be due on 1st January 1984. If a renewal form has not been received with this Newsletter, please write direct to the Treasurer, enclosing your name, address, place of work and A.P.C.P. number. The Treasurer's address is as follows:

Mrs. Sandra Holt,
43 Westwood Park,
London SE23 3QG.

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GOOD NEWS!

A.P.C.P. SUBSCRIPTIONS ARE NOW TAX DEDUCTIBLE - The position, as set out by the Inland Revenue, is as follows:

"With effect from the year commencing 6th April 1982, a member who is assessable for Income Tax under Schedule 'E' in respect of the emoluments of an office or employment is entitled to a deduction from those emoluments of the whole of the annual subscription which is due and payable by him to the body in the Income Tax year, provided that:

- (a) the subscription is defrayed out of the emoluments of the office or employment;
- (b) and the activities of the Society, so far as they are directed to qualifying objects, are relevant to the office or employment; that is to say the performance of the duties of the office or employment, or the exercise of the profession concerned, is directly affected by the pursuance of the qualifying objects.

A member of the body who is entitled to relief should apply to his Tax Office as soon as possible giving details of his subscription and making a claim for the relief due to him".

Sandra Holt (Honorary Treasurer)

* * * * *

It has come to the notice of several members that, for insurance purposes, it is inadvisable to wear other than C.S.P. recommended footwear, e.g. lace-up shoes. The fact that so many Paediatric Physiotherapists wear no shoes during their work activities has been brought to the attention of the C.S.P. with a request for clarification under the Health & Safety at Work Act.

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REGIONAL REPORTS

Scotland

Reg. Rep. Miss Elma Bell, Scottish Council for Spastics
5 Rillbank Terrace, Edinburgh.

The 1985 A.P.C.P. Conference will be held at the Heriot-Watt University, Edinburgh. The dates are not yet confirmed but it will probably be at the end of March.

The new Committee will be: Elma Bell; Mo Grant; Liz Breckenbridge (Treasurer); and Morag Booth.

North West

Reg. Rep. Mrs. M. Down, 62 Swann Lane, Cheadle Hulme,
Cheshire.

A new Rumpus Room has opened at the Royal Manchester Children's Hospital on its Swinton site. This is a room which has padded walls and is full of foam shapes to give children and/or adults a complete soft experience. There are shapes to represent grass, trees, mountains and a swamp. All the shapes are made in foam rubber and covered in brightly coloured plastic. The room will accommodate up to eight people at a time. In this room there is also a special trampoline designed to give children an experience of movement in space - which is called 'Rebound Therapy'.

A Study Day is to be held at Whiston Hospital, St. Helens, on 11th February 1984 on "Physiotherapy in the Community". The day will include a lecture about Asthma given by a Physiotherapist, with a video of her work, plus talks by a Paediatric Health Visitor and Paediatric Social Worker on their role in the community. It is also hoped to have a talk on the legal aspect of Physiotherapy in the Community. For further information please contact the Reg. Rep.

North East

Reg. Rep. Mrs. M. R. Soper, 13 The Garlands,
Clifton Without, York YO3 6NZ

For the winter and spring we have meetings planned on toys and play with handicapped children; an introductory course on Halliwick Swimming Teaching; and a possible visit to ASBAH's 'Five Oaks' to talk about their work with Independence Training Programmes. Details of dates and venues will be sent to members nearer the time. Members from other regions can obtain them from our Reg. Rep.

At the June meeting there was some discussion about the wording of part of the constitution which allows regional representatives to take on Executive Office within the Association. There has been some concern voiced in the region about this problem but, as the Constitution cannot be altered until the next Annual General Meeting, it was decided that the Regional Committee would discuss this further and submit a suitable amendment to the paragraph concerned, and this would then be discussed by the members.

Please note the Reg. Rep's new address.

East Anglia

Reg. Rep. Mrs. P. A. White, 24 Maltings Drive,
Wheathampstead, Herts.

There is to be a meeting in October when David Scrutton will speak, and we have had an evening meeting about Infantile Ideopathic Scoliosis - the speaker being Miss Menta, Consultant at the Royal National Orthopaedic Hospital, Stanmore.

South East

Reg. Rep. Mrs. Shirley Raymond, 58 Gates Green Road,
West Wickham, Kent.

The first meeting in 1984 will be held on Saturday, 3rd March, from 10.0 a.m. - 4.0 p.m. at Chailey Heritage. The day is entitled 'Assessment and Stimulation of the Child with a Sensory Handicap'. The cost will be £7.50 for members and £9 for non-members. The morning session will cover assessment on hearing with Dr. E. Kerr; Mrs. Smith on Orthoptics; and an Educational Psychologist. There will also be time for questions. In the afternoon, Miss Roma Lear will give many ideas on stimulation. Again, there will be time for questions. Further details and applications to Miss C. Foster, Physiotherapy Department, Chailey Heritage, Chailey, Sussex, enclosing a stamped addressed envelope, not later than 20th February 1984.

Midlands
and Trent

Reg. Rep. Mrs. M. Tarry, The Mullions, Peatling Parva,
Lutterworth, Leics. LE17 5PU

NOTTINGHAM - Miss Rose Dawson retired on 14th October. Miss Dawson came to Nottingham in 1966 as the Children's Physiotherapist then later became Superintendent Physiotherapist at The Children's Hospital. In recent years she has been Superintendent Paediatric Physiotherapist at the University Hospital. Hopefully she will retain some ties with paediatric physiotherapy in her retirement.

At the beginning of September Miss Noreen Hare took up her post as Superintendent Paediatric Physiotherapist for Nottingham.

The Paediatric Interest Group have planned a programme of four lectures for 1983/84. Enquiries to:

Mrs. Pickford,
Rutland House School,
Elm Bank,
Mapperley Road,
Nottingham.

BIRMINGHAM - A counselling course of six lectures in September and October has been arranged. Enquiries to:

Mrs. P. Sole,
Victoria School,
Bell Hill,
Northfield,
Birmingham.

DERBY - Child Development Seminars are held on the first Wednesday of each month from 12.30 p.m. - 2.0 p.m. Enquiries to:

Mrs. J. Harkinson,
Ronnie MacKieth Centre,
Royal Infirmary,
Derby.

LEICESTER - The Ashfield Seminars are on the first Tuesday in the month from 4.0 p.m. - 5.15 p.m. This session, the theme is "Helping the Family with a Severely Handicapped Child". Enquiries to:

Mrs. M. Tarry,
Paediatric Assessment Centre,
Leicester Royal Infirmary.

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The Editor wishes to apologise for any Regional Reports not printed. This is due to them arriving too late for publication.

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ACKNOWLEDGEMENT
CYCLES FOR CHILDREN WITH HANDICAPS - AUGUST NEWSLETTER

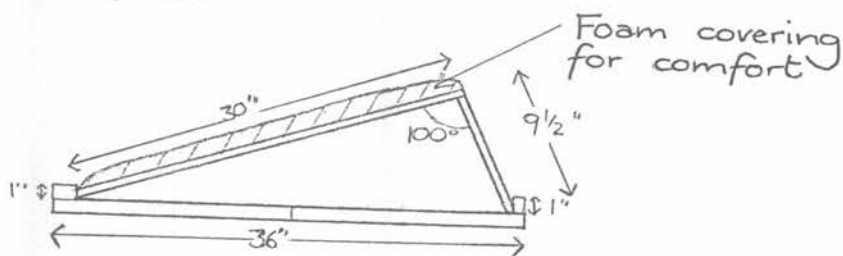
The article "Cycles for Children with Handicaps" published in the August newsletter was first published in "ARK" and was reproduced by kind permission of Playmatters - The Toy Library Association.

Since publication, it has been drawn to our attention that the existing frame for the 'J' bike is totally original in design - quite different from the original modified buggy frame - and having outriders rather than stabilizers, plus multi-adjustable handlebars.

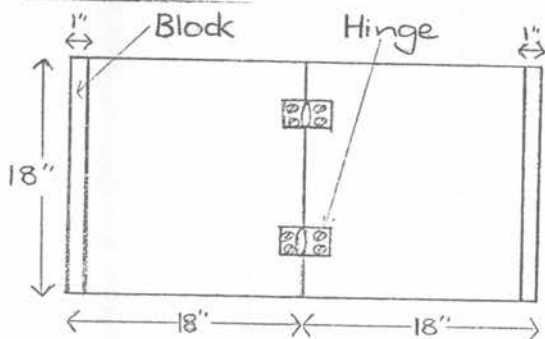
There is also a 'Big T' trike manufactured by Hayes which is most useful for very handicapped children having multi-adjustable handlebars and a tow bar which can be used passively as well as actively for therapy.

Fold-up Tipping Frame.

Lateral aspect.



Base



Top

This is designed to open to a maximum of 100°

