
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

“PICKFORDS — MOVING ON IN MENTAL HANDICAP”

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The Editorial Board does not necessary agree with opinions expressed in articles and correspondence, and reserves the right to edit material submitted.

EDITORIAL

Twenty years ago coming into the Mental Handicap field as a physiotherapist was a daunting prospect, there was not much easily accessible information, few courses, even fewer colleagues with similar interests and in addition it was rather frowned upon by others in the profession as a "waste of expertise" and perhaps an easy option! How different today, we have truly "moved on", with a wealth of information and research easily available and many highly respected colleagues, and happily it is now being recognised at all levels, how important physiotherapy is in this very complex work. Indeed, this year the CSP National Congress has courses devoted to Mental Handicap in the very busy programme.

Reading through the varied articles from our contributors, with their diverse approach to the work, it is easy to understand why the paediatric physiotherapist with her specialist knowledge and approach to clients can be such an important member of a mental handicap team, and one who in the coming years will become a vital link in the process of successful resettlement into community placements, of those children and adults still in Institutions. The physiotherapist in the Institution must be allowed to carry her expertise into the community, but she must also continue to keep abreast of current thinking, methods of treatment in all their variety, evaluating constantly and discarding those which are superficial. Equally the physiotherapists working in special schools, as reminded by Mrs. Eckersley in her Post Registration article, must be aware of their duties as professionals on the side of children and their families. Finally, it is highly important that we do not hesitate to support our clients when they are unable to speak for themselves - but - imagine ourselves in their situation before we do, - and maybe we will speak more cogently. It is only by being well informed, innovative, persistent, percipient and above all patient that we will continue to improve the quality of life of our clients.



PLEASE NOTE

The LAST DATE for submission of material for the November Newsletter will be SEPTEMBER 25th, this is slightly earlier than usual so please make a note in your diaries! Material submitted after this date will not be included.

TO MY HOME — MY CASTLE?

*Otto Wangermann. Principal Psychologist,
Mental Handicap Unit, Lancaster Health District.*

Who are the mentally handicapped?

Who are the mentally handicapped? - those people in that big hospital beyond Marshfield? - And there are some in that hostel place down Long Lane past that disused warehouse aren't there?

Where do they come from? - Dunno - All over, I think.

We do tend to apply labels to people so that we can slot them into particularly ready-made ways of thinking about them. Actually 'the mentally handicapped' do not exist as an identifiable group with particular characteristics any more than 'the mentally gifted' exist as such a group. There are only people, some with particular gifts, others sadly with particular handicaps, some severe. Where do they come from? They come from where we come from. You and I give birth to people - occasionally one with a particular handicap. So they are us, born full members of our families, our community and our society. So why do we treat them differently?

From Asylum to Community Care

The social history of institutional care for people with a mental handicap is complex. Suffice it to say here that 'asylum' was a caring concept but has become tarnished by accompanying overcrowding, degradation and deprecation in our mental handicap hospitals to the extent that a number of national scandals erupted in the late 60's which gave rise to public concern. Was the Nation's conscience - er - pricked perhaps?

The Government's response was to issue a White Paper¹ which, in its day, was quite radical. The principles underlying its redirection of policy may be summarised as follows:

Needs:	People with a mental handicap and their families have needs in common with others and may have additional needs. These needs should be assessed and met within their local community.
Services:	Services should be developed to meet these needs. They should be local, comprehensive and coordinated.
Residential facilities:	Residential facilities should be available to relieve families temporarily or permanently. They should be homelike and provide sympathetic and constant human relationships.
Support from the local community:	Voluntary services and understanding and help from friends and neighbours and from the community at large are needed to give the handicapped person as normal a life as his handicaps permit.

That was in 1971. Clearly asylum was out and community care was in; but was the Nation's conscience sufficiently pricked to make these principles a reality? A substantial number of people have in fact been discharged from our mental handicap hospitals. They tend to be the more able and those who were admitted because their morals rather than their abilities were deemed to be defective. Now, fifteen years later, we are struggling to make community care a real-

ity for not only the people with more genuine mental handicaps who today remain in our mental handicap hospitals but also for an equal if not greater number of people being cared for within overburdened families or in other systems of care which are more asylum in nature rather than giving support and providing the scope to promote more nearly normal patterns of life.

We are struggling on two fronts. First and foremost, the Government - which acts in your name and in mine - has not backed its policy with sufficient funding to provide for all the needs of people with a mental handicap and of their families. Secondly, there is an essential dilemma in caring for dependent people and at the same time recognising their autonomy as citizens with the same rights to self-determination as the service providers. Such dilemmas are not easily resolved.

Community Units.

Early advice regarding community care² suggested that services should be developed around two main elements: the Community Unit and the Community Mental Handicap Team. Community Units were envisaged as locally based units having about 24 beds, the exact number varying according to local needs. One third of the beds would be for long term residential care, one third for residential care with training programmes for up to two years and one third to meet short term on-demand needs. These units would also serve as a base for the Community Mental Handicap Team. They might also provide some day-care services and they would be a resource centre providing, say, workshops for staff and relatives, toy libraries and venues for professional meetings.

This concept of community unit soon came in for severe criticism. Certainly all or most of the services they sought to provide are required - but all under one roof? Could such a unit be homelike for the people whose home it would be? Would we tolerate our homes being used daily for such purposes? Should we expect people who happen to have a mental handicap to accept as 'home' settings which we would find unacceptable for ourselves? This really boils down to a question of the extent to which we value other people as people like ourselves. 3,4.

The logic of this kind of thinking is that we must provide residential placements in ordinary domestic scale housing within ordinary residential areas in local communities. We must also provide the services which clients require. These two requirements have led to the development of the 'core and cluster' model of provision.

Core and Cluster⁵

This rather unprepossessing nomenclature is actually fairly accurate. It envisages that people requiring supported living arrangements live in a number of ordinary houses, this group or 'cluster' of houses being served from a 'core house'. The core house serves as a base for a peripatetic staff. It is also sometimes suggested that the core house should have residential accommodation and that clients should enter a core and cluster scheme via the core house where a thorough assessment would be carried out. However, this would render the core house open to all the criticisms levelled at the community unit and, in the light of this, it is probably preferable to limit the role of the core house to that of staff base and other administrative uses.

The advantages of core and cluster schemes are their very flexibility. Staff can be introduced or withdrawn as the residents' needs change. In this way residents may remain in the home which is theirs and which they share with others. They may thus enjoy the normal experience of continuity of friendships and of a stable and familiar environment. Also, staff can provide training and support for people in other settings in the vicinity - in their own family home for example, or in an establishment run by some other agency where additional help may be required for a period.

Required Features of Community Services

If we value people with a mental handicap we will promote their access to services which are used and valued by the community at large. As many people with a mental handicap also have physical handicaps they are likely to have considerable need of the various physiotherapy services as well as other services which are available to the rest of the community. Thus all these services must be as available to people with a mental handicap as they are to the rest of us.

If their problem is so severe as to require a specialist service then it would be helpful to contact the local Community Mental Handicap Team as it would be likely that the services of other professions would also be required. Hence it is important that specialist physiotherapists should be members of local Community Mental Handicap Teams in order that their specialist services can be co-ordinated with those of the other professions involved. In this way the person may receive a planned, well structured, multidisciplinary service rather than a number of services delivered independently which may cut across each other.

With the peripatetic support service must come a re-orientation of service provision, from doing things for people to doing things with them, from control of clients' lives to supporting and making viable people's choices, from asylum to supporting and enabling people to engage meaningfully in the life of their local community. This involves all aspects of life, summed up perhaps in the main areas of home-making, day occupation and leisure pursuits. The task is one for the community as a whole rather than for the statutory services alone. The latter can provide training, supporting and specialist services; but how can we achieve integration of our citizens who have a mental handicap with the local community? How can they develop their informal networks of social support such as we take for granted to the extent that we may not be fully aware of our dependence on them? And how can we help local communities to enable them to take advantage of the new opportunities available in the community so that they may experience not anxiety, failure and rejection but acceptance, harmony and satisfaction? We have not yet accumulated the working experience to answer many of these questions.

Can Dependent People Be Independent?

A major challenge for community care is how to offer a service which meets people's dependency needs in a manner which preserves and promotes their autonomy. This at the very least requires that we seek realistic (valid) consent

for every service offered. There are sources of difficulty here. What should we do if, for example, a person declines consent for a service which he or she obviously needs, or if he or she makes choices neighbours would find unacceptable, thus jeopardising their would-be integration with the neighbourhood? There are no simple blue-prints to meet such dilemmas. We need constantly to seek approaches which protect people's interests without violating their rights.

Because of their dependency many people with a mental handicap trying to live as near-normal a pattern of life as possible will require the assistance of an 'advocate'⁶. An advocate in this sense is a person who will pursue, on behalf of the person with a mental handicap, their rights, choices and wishes as if they were the advocate's own. This can only be done on an entirely voluntary basis, otherwise conflicts between loyalty to the person being advocated for and to the agency paying the advocate may arise. The recruitment and training of such advocates is a subject in its own right.

Community care for people with a mental handicap clearly poses many difficulties and some dilemmas. It is based on the simple but compelling philosophy that all citizens of our community are of equal worth and have equal rights. There seems little room for compromise in this philosophy (and the price of any compromise would be paid in terms of some people being offered less than equality and having no redress).

The Greatest Challenge

We must therefore consider the greatest challenge to community care: that posed by people who are twisted, bent, deformed and sensorily impaired - people to whom we refer as profoundly and multiply handicapped. A significant section of professional opinion asserts that they are impaired to such an extreme degree that they are not appropriate for care in the community and should be cared for in hospital for the duration of their lives.

It is difficult to see why the principles of community care should not apply to everybody whatever their particular degree of handicap. Sensory impairments and gross deformities do not detract from their worth nor reduce their rights. And when one considers that *organisationally* the difference between community care and hospital care is that of taking the service to where the client is instead of taking the client to where the service is, the provision of community-based services should not present insuperable difficulties however severe the degree of handicap.

However, much may depend upon the view that physiotherapists take because their services are essential for people with such handicaps. For people without sight or hearing touch is probably the most significant exploratory sense, and where there are gross motor impairments as well, it is physiotherapists who have the skills to promote their experiencing the world.

And if we value them, to what range of experience should we offer them access? Should they not have their castle too?

References:

1. 'Better Services for the Mentally Handicapped'. Cmnd. 4683. H.M.S.O. 1971.
2. See e.g. 'Local services for mentally handicapped people'. Ed. G.B. Simon British Institute of Mental Handicap. 1981.
3. This is not as simple as it might seem. See 'Normalisation: The principle of normalisation in human services'. Wolf Wolfensberger. National Institute on Mental Retardation. 1972.
4. For a simpler treatment of the subject see 'The Principle of Normalisation: A foundation for effective services'. CMH The Campaign for Mentally Handicapped People. 12a Maddox Street, London. W1R 9PL. 1981.
5. See 'An Ordinary Life': Comprehensive locally-based residential services for mentally handicapped people. King's Fund Centre. 1980.
6. 'A Balanced Multi-Component Advocacy/Protection Scheme' W. Wolfensberger. NIMR/CAMR Publications, Toronto, 1977.

MAKING PROGRESS

Phoebe Caldwell, Adult Education Lecturer and Designer

People who are severely or profoundly mentally handicapped are separated from their environment and other people by their inability to accept or organise or respond to incoming information. They have sensory deprivation on a sliding scale which at worst results in total failure to be able to communicate with, or structure the world in any way at all. Life can be a meaningless kaleidoscope of unrelated events; it doesn't make sense.

This barrier between them and the external world may result from failure of the senses, or from the loss of motor skills, or co-ordination, or psychological factors such as fear, which can lead to withdrawal or disturbed behaviour. All these factors interplay, and one may mask another. It is often quite difficult to determine whether there is an actual failure in sensory function, or whether it is "switched off", so to speak, because of some psychological factor. What we have to work with is the "effective use" of a sense. For example, a person may not see because his eye is malfunctioning, or because his brain cannot interpret incoming information, or because he is afraid to look. Sorting all this out can be very difficult, and in particular, assessment by a strange person in a strange environment can be misleading.

We know that play is the normal way in which we all learn to structure our world, and most of us participate in it naturally. However, children with severe and profound mental handicap need teaching to play. We have to show them what they can do, how to do it, and how to enjoy it. Because of this, play is a very structured activity which takes place on a one-to-one basis.

We start with a period of non-intervening observation, preferably in an environment with which they are familiar. We are looking at their needs, and asking ourselves a number of questions:—

- (a) Do they show certain patterns of behaviour? Are there certain places where they appear to feel safe? How do they react to being approached - do they try and defend their safe place, or is this the place where they are secure enough to play? Do they prefer to sit on the floor?
- Do they show obsessional behaviour which acts as a barrier between them and positive participation in an activity e.g. constant flicking fingers?
- (b) Do they show any particular preferences? Is there anything that would act as a positive reinforcement towards activity e.g. flashing light, sound, vibration? In this context we shall be looking at the positive use of obsessional behaviour.

It is helpful to talk to relatives, very often useful information comes in the form of a parent saying:— "Well, he always likes to sit with his hands on the gramophone" (i.e. he likes picking up vibration).

- (c) Are they comfortable? Seating can be crucial for the multiply handicapped. No one can be expected to play if distracted by pain. If using a table or tray to play, is it the right height and are their hands free to move?

At the end of the observation period we should have some idea of behaviour patterns likes and dislikes, both of people and of their environment, and should understand what are the barriers to communication and activity. Now we have to try and engage their attention, so that we can use this knowledge to build reinforcement into the stimulatory equipment that we use, or into the techniques that we use with it.

We have five different approaches, which may well overlap. These are visual, auditory or tactile stimulus, the positive use of obsessional behaviour and rewards, and we look for a response which may be watching the source of the stimulation, showing signs of pleasure, or physical manipulation.

Helen was diagnosed as autistic, with aggressive and anti-social behaviour, her only positive response to her environment, was to a flashing light. We wanted her to look at herself in a mirror, for it is important to recognise ones own body image, that oneself is a person. A mirror box was designed that rotated around a horizontal axis when flanges were depressed. Spinning fast it gave flashing light, and as it slowed down moving images appeared which drew the watchers attention into the mirror. Her teacher used the box with Helen for short periods daily. At first she just spun the box, for it gave her in a dramatic way the only stimulus to which she responded. Gradually her attention was drawn in and she started looking at herself intently, and this new interest in herself was accompanied by a marked improvement in her behaviour. So what we have done here is make a positive use of an obsessional behaviour pattern and visual stimulus, in order to initiate participation in an activity which led Helen into recognition of herself, and so on to the first stage of interaction with others. There are a number of ways in which one can intervene where obsessive behaviour is linked with visual stimulation. For example one can use a brilliant yellow, loose plastic coil (compressed air line). Moving this gently up and down stimulates the compulsive finger flicking, which is so often used to stimulate the

peripheral vision. This is particularly useful in order to gradually centre the vision by moving the desired object i.e. the yellow coil to the mid-line.

Some people are not interested in visual stimulus but respond well to sound. In addition to a specially designed slide rattle, which requires some pressure to operate it, it is sometimes useful to use a Walkman radio. Most severely/profoundly mentally handicapped people I have used this with, will not tolerate the headphones, so it is better to remove the ear pieces, hold one against the ear whilst listening to the other oneself, so you can hear to what they are reacting. I use a tape such as tubular bells, and if it is tolerated, sit with my arms round them for close physical contact which is important. At this stage it is important to use the stimulus in short bursts to attract attention, and then remove it. As with all stimulating equipment, it is important not to regard it as 'occupational', and it should never be used for long periods, otherwise the user will become either obsessed with it, or bored.

With tactile stimulus, the most important aspect is physical contact, such as holding hands, cuddling and bodily contact, particularly as developed by Veronica Sherborne. I was told recently of the successful use of physical contact in conjunction with olfactory stimulus, by using eucalyptus oil to massage a child, which it much enjoyed. Vibration is another form of tactile stimulus, which can reach some people who do not respond to any other approach. As with the Walkman radio, it is important to use it for short bursts and not prolonged contact. We found a portable fan helpful with someone who was blind and deaf, and afraid of being touched. He seemed to equate touch with 'hit' and pushed everyone away. Using the fan gave him surface stimulus before he was touched, and gradually built up his confidence enough to take the fan and play with it. Hard feely toys are often more successful than soft ones - lengths of different types of chain, from the light slippery bath type, to the hard and heavy to handle bigger chain. (A lot of manipulation is needed to feed a heavy chain through a hole). When using soft feely materials, it is important to have large enough areas so that a limb may be wrapped in it, and the finger tips are not necessarily the most sensitive feeling areas. In the cases discussed so far, reward is built into the equipment, but sometimes other rewards such as food, crisps, drinks etc are needed. Whatever method we choose, we always talk to them, using our voice as reward and using the play situation to build up a relationship.

Once they have started reaching out and we know to which stimulus they respond, we use this approach to develop the capacity, to explore the physical properties of their environment and learn the necessary skills to cope with it. To do this they must always be successful, and to achieve that, equipment has to be designed to make the task as easy as possible. Total prompt is used initially, and as ability grows it is gradually faded out. There are two ways of moving them from a stimulating piece of equipment to another.

- (a) Use the particular equipment to which they respond, as a reward, accompanied by verbal - and where appropriate-physical contact reward until it can be faded, by which time they may find their positive relationship with you, strong enough to counterbalance the withdrawal of the object which fascinates them.

- (b) Sequencing:— where development is extended by moving from the initial stimulus to a piece of equipment which has either similar characteristics or different.

Valerie used to sit on the floor, endlessly patting a small pink bag. This was substituted by a shiny wine box bag, which felt much the same, but had reflective surfaces which interested her. From there it was possible to move her on to the mirror box to start looking at herself.

Developmental work starts with very simple games of placing a ball in a bucket, peg in a hole, ring over peg, and must be easy, with the hole through which the balls are posted big enough to admit the hand. Billiard balls, which are brightly coloured and heavy enough for the weight to be easily felt were useful. Similarly, holes in which to place a peg should be wider than the peg, the ends of which should be rounded, to allow it to slip easily into the hole. The diameter of the central hole in the ring over the peg, should be larger than that of the peg, to allow it to slip over easily. All simple points which make the difference between success and failure. From putting large rings over pegs, to smaller and then fitting ones, and using the same movement it is useful to progress to Turnadisc. This toy has a disc with large notches in either side, which is fitted over a central peg and then has to be rotated until the notches slip over two projecting side pegs. This piece of equipment moves from simple placing, to placing and rotating, and begins to introduce the idea of sequencing movements.

When working with the profoundly handicapped its useful to use a very structured form of play, and look at each person as an individual, whilst assessing what they are capable of, and what movements they need to learn. We now have a whole range of equipment to meet these needs, but when in doubt I always consult my psychology or physiotherapy colleagues.

WORKING IN THE COMMUNITY WITH THE MENTALLY HANDICAPPED

A Personal View

S. Baker, Senior Physiotherapist working in the Community

As a member of the Community Mental Handicap Team, eighteen hours a week are divided between two special schools and five Social Education Centres. Home visits, assessments and case conferences together with occasional lectures, report and letter writing all combine to make life full and varied.

In school I see eleven children each week all of whom are suffering cerebral palsy apart from one six year old with spina-bifida. One child is ambulant, the remainder being severely handicapped.

The Social Education Centre

Working across the age range means that it is possible to follow school leavers into the S.E.C. and be positively involved in their integration into the diffe-

rent environment. The physiotherapist with her knowledge of the young persons physical problems and special needs is invaluable in helping care staff to feel informed and confident in the management of their new client. This in turn helps the client to more easily accept such an important change in his life and contact already established with parents can also help to allay their anxiety.

Regular contact with colleagues working in other schools in the district should mean that every school leaver with special needs has his problems anticipated and the necessary preparation made to meet those needs in the new environment. The severely handicapped are cared for in "Special Care" units within the S.E.C. Some units are well equipped with mats, wedges, Kirton chairs, Flowtron machines and soft play equipment, however others are without any such equipment. Special care units also have to cater for people with severe behavioural problems, this puts great strain upon staff and is very demanding of their time. Individual programmes with other clients are often constantly disrupted.

A regular input of treatment sessions is not possible and therefore my role is mainly an advisory one. It is extremely important to ensure that care staff are fully involved in functional and preventive positioning programmes which are written out and kept in the patient's file and with easy access. Suitable activities to encourage movement and perhaps some passive stretchings may also be included, depending on the ability and willingness of staff to carry them out correctly. Staff must, of course, be given as much support as possible, particularly in the early days of transfer from school. However even well informed and enthusiastic care staff do not adequately replace the regular presence of the therapist.

One Special Care Unit has taken part in a research program concerning the use of the Flowtron intermittent compression system to help the severely physically handicapped. Although no definite conclusions could be drawn from the trial, staff have become firmly convinced of its value.

Other requests for physiotherapy input may involve the more able clients who present with such problems as painful joints, unsteady gait or perhaps footwear problems. The correct choice of walking aid or referral to the orthotist maybe all that is needed to reassure anxious parents or care staff.

At the present time there are fifty mentally handicapped adults within the catchment area of one training centre waiting for places, many of whom are ex-residents of the institutions.

Out of the Institution

During the last two years, it has been the policy of most Health Authorities to expedite the movement of all children from the Institutions out into the community. Whilst it is undeniable that areas of deprivation exist in the institution, this movement of the severely multiply handicapped has deprived them of the one thing they need most to maintain their physical well being and quality of life - Physiotherapy.

In the hospital setting frequent treatment sessions and easy access to other carers, such as nursing and teaching staff, meant a high input of expertise by physiotherapists. This expertise was on hand to advise on and supervise seating, positioning and handling. An active involvement was also possible in feeding programmes, lifting problems could be tackled on site and aids and equipment were readily available.

It has always been a difficult task for therapists to convince others of the importance of carrying out regular and frequent treatment programmes. At least in the institutional setting the physiotherapist was a constant figure, able to supervise these programmes and exert an influence both on the ward and at school.

Now that the severely handicapped are living in small groups of three or four in the community, it is impossible to provide a comparable service. The homes are staffed by one or two trained leaders together with untrained, inexperienced care assistants. In one home there has been an 82% turnover of staff in ten months, the average annual turnover being 52%.

There has been a reluctance on the part of some home leaders to accept suitably supportive furniture, and special aids, in an effort to preserve "normality". This lack of understanding of the nature of the handicap leads to a low priority being put on physical needs and to misinterpretation of actions and behaviour. It has been necessary to hold many meetings with staff to instruct them in lifting and positioning techniques. Programs are put in writing and kept in the clients file. The shift system means that often untrained care staff are on duty for many hours unsupervised. It is difficult for them to fully understand their client's physical needs.

In all, a once weekly "hands on" treatment session has to be supplemented by a physiotherapy aide and teaching staff in school, together with the care assistants at the home. Such a diverse involvement of carers is unlikely to achieve satisfactory levels or standards of treatment programmes and regrettably contractures and deformities are deteriorating.

Despite the difficulties, the former residents of the institution seem to settle well in their new environment, responding to the increased personal attention they undoubtedly receive. If there is a somewhat unrealistic optimism about their potential abilities, perhaps this is necessary to maintain staff input and enthusiasm.

Whilst not wishing to advocate a return to the institution, I do not believe that it can be in the long term interests of the severely multiply handicapped to be in the charge of untrained unsupervised staff, caring though they may be. Such a vulnerable group of people cannot speak for themselves. This major upheaval in their lives was undertaken without paying heed to those professionals who, by dint of close working knowledge, spoke for them. If more credence had been given to these professional judgements it may have been possible to more adequately meet the special needs of the profoundly handicapped now living in our community.

A SPECIFIC APPROACH TO PREVENTING DETERIORATION OF MOTOR FUNCTION IN CHILDREN AND ADOLESCENTS WITH SEVERE PHYSICAL HANDICAP

MOVEMENT THROUGH MUSIC

A. L. Wigram and Lyn Weekes

Foreward

The authors have worked for several years in a large hospital for the severely mentally handicapped of approximately nine hundred beds. There are a large variety of handicaps in the hospital and a number of different techniques are used by the music and physiotherapy departments.

Tony Wigram is head of a music therapy department of three music therapists and Lyn Weekes is a Senior Physiotherapist in a department of six therapists.

Introduction

The particular treatment technique this paper describes is simple in its concept but complex in its range and application. It is a specific approach using and developing a range of movements to music, and the patient group for which it is designed have severe physical and mental handicaps. The original design was developed in a music therapy session, and in its early form was basic and unstructured. Over the last six years we have looked at the aims of the physiotherapists, teachers and nurses involved in the treatment of these patients and devised the session in its present form. This session is neither specifically a music therapy session nor specifically a physiotherapy session, but a session run by music therapists and physiotherapists who have incorporated their aims in a joint treatment approach, demanding the expertise unique to each profession. There are now a range of twelve movements which are general in so far as they encompass the needs of the whole group, but specific in that with each different patient - whose array of problems differs - each movement will be moulded with a special emphasis to suit the individual. The movements have been designed in a specific order which remains the same each session. Each weekly session lasts for one hour, including recording the results. When the full complement of music therapists, physiotherapists, aides, teachers, student therapists and student nurses are present, the ratio aimed at is one-to-one. If possible, the same therapist works with the same patient each week. The relevance and appropriateness of the music used is very important to the effectiveness and success of this particular treatment. Style of music, tempo and timbre in particular have to be carefully chosen for each movement, and even then much depends on how the therapist plays as to whether it is effective. For these movements the music must envelop and support the patient. The relationship formed in the work must be primarily between the patient and the music, the therapists' role being to help the patient respond to and use particular elements in the music.

Firstly and most fundamentally, the rhythm and tempo is a motivating and moving stimulus: secondly, the melodic and harmonic content must sustain interest and awareness in the sound, helped by varying the volume and frequency; and lastly, the style and timbre must support and encourage relaxation or stimulation as appropriate. Badly presented or inappropriately presented, any one of these elements might have exactly the opposite effect to what one might hope or expect. For example, the tempo has often to be slow, with emphasis on strong beats. If played too fast, with a loosely defined rhythm, the majority of the group will not only find the movement concerned ineffective (as will the therapist attempting to do it) but it will become difficult to do, and achieve the opposite effect.

A most important point is the element of anticipation. Anticipation of the movement and of the rhythmic structure of the music is very important for the patients and for the therapists working with them. Even with no knowledge of the music being played (i.e. if it is improvised), both patient and therapist can anticipate the rhythmic emphasis and time the movement with it. Frequently a familiar piece will develop even greater anticipation. Perhaps the most important progress that can result from this anticipation is the patient's ability to develop spontaneous or active movement.

Nature of Handicap

All of the group are in wheelchairs and a large proportion of them have cerebral palsy in one of its various forms: hypertonic, hypotonic or athetoid. No two are ever exactly alike, because in each case the motor dysfunction will depend upon the degree of damage and the site of the lesion. This is an important factor to take into consideration when using music at differing speeds and rhythmic emphasis.

The ages range from 16 to 30 and several have dislocated hips, subluxed hips, windswept hips and scoliosis. Because of their long-term institutionalisation and physical problems, they are resistant to movement. There are problems of increasing stiffness as adolescents become adults and consequently heavier and larger. This means it is not so easy for staff to move them. If they are unable to move themselves very much, it is likely they will develop deformities - mobile deformities at first, which eventually can become fixed deformities. They need to keep mobile, and this scheme of movements fulfils this need.

Aims and Expectations

1. To maintain the physical status of the patient.
2. To maintain and improve general mobility.
3. To develop active and spontaneous movement.
4. To develop greater body awareness.
5. To develop rhythmic anticipation.

- | | | |
|----|--|---|
| 6. | To increase: respiration
circulation
stimulation
relaxation | To achieve: better general alertness
increased appetite
improved bodily functions |
| 7. | To improve motor control | |
| 8. | To reduce: flexor and extensor muscle spasm or delay the onset of possible deformity.
the eventual severity of the deformity. | |
| 9. | Toleration at being handled increases, particularly through the pleasurable experience of the session. | |

Music Input and Specific Content

The music can be repertoire or improvised. If improvised music is used it is important to construct it on an 8 or 16-bar format which will provide both a rhythmic case and a structure in phrases. The rhythm and phrasing are fundamental to developing the anticipatory reponse within the whole movement. Repertoire is quite appropriate, particularly if in some movements it is valuable to vocalise using appropriate key words. Counteracting or working against the regressing physical disability outlined requires an encouraging and persuasive element in the musical stimulus. Therefore the quality of the sounds and the structure and order of the music have to be extremely conducive as a catalyst for the physiological progress we are trying to make.

Format of Session

We take for granted our ability to accommodate to the surface we are on, whether it is the floor, a chair, or whatever. But many of our handicapped people cannot do this and at the start of the session, when patients are put on the floor, they may be feeling uncomfortable, apprehensive or vulnerable to a greater or lesser extent. Some become agitated or disturbed, so starting with a Good Morning Song calms and reassures all of them. It indicates the beginning of the session and establishes the relationship between patient and therapist. The therapist sings very close to the patient and tries to establish eye contact.

Having started at the head the first movements consisting of spinal rotation and shoulder girdle movements are designed to loosen and relax the patient. These are followed by arm movements and it has been found beneficial to start with the more severely affected arm where there is a disparity. The last trunk movement is rolling, by which time the patient has relaxed sufficiently to co-operate and perhaps participate in this total body movement.

Specific leg movements follow including:—

- flexion and extension
 - abduction and adduction
 - foot work
 - hip extension in prone lying
- pelvic tilt and side flexion and rotation in sitting have been used with younger patients but have proved impractical with the older group.

Relevance of Live Music

What is the relevance of live music, appropriately played and carefully chosen? The way to examine this is to assess the alternatives.

(a) Recorded tapes.

It was often difficult to find a style that was effective. The emphasis rhythmically and the orchestration were frequently unsatisfactory. It was impossible to monitor and control the speed. Mentally handicapped people do not respond to music coming out of a speaker nearly as well - they do not understand it.

(b) Recorded piano or other instrument of appropriate music for the session.

Again, it is difficult to monitor and control the speed. It is also impersonal because it is not live. One also finds that it is unalterable to cope with the problems of the day. It is difficult to vary the length of time and it is not easy to stop and start.

(c) No music at all.

These movements are more difficult in a silent or unresponsive environment. In physiotherapy sessions, the staff sometimes sing in order to reassure, relax and encourage the patient, but probably the main encouragement is verbal.

Summary

Physiotherapists undoubtedly appreciate the rhythmic influences in movement (which can change the approach to this problem), and will become aware of the musical responsiveness within the patient. Where music therapists can learn and understand the physical and anatomical problems of the patients, they will design the music input more appropriately. A lot of thought is given to the design of the movements so that one can develop the patients' contribution to making the movement well, e.g. movements like rolling. We have tried it working from the side, working from the shoulders, and finally decided working with the legs is most likely to develop their active participation.

This paper was first given in 1983 at a World Conference of Music Therapy in Paris, and has been followed by several workshops in this country. It is in the workshop situation that this approach can be best understood, as in a paper of this length it is impossible to go into the necessary detail. Particularly the intimate relationship between the movements and the music must be experienced and the need for the most appropriate music both in style and tempo can only be felt when working with a patient.

MENTAL HANDICAP IN THE COMMUNITY ESHTON TERRACE

In view of the final date of December, 1982, for the discharge of the under '16s' age group into the community from the mental handicap institutions, a

committee was convened at Brockhall Hospital to set up a hostel for the housing of young people. The number of children living in the hospital had already been depleted at this stage by an indictment against new admissions and the early discharge of some either to their original districts to their homes. One child was admitted to a Dr. Barnardos Home, so exchanging one institution for another.

The children are encouraged to join local groups as applicable, Scouts, Guides, Youth Clubs, Discos, handicapped swimming and weekly Sunday School attendance. These regular commitments and visits to shops, libraries and cinemas bring the children into contact with the towns' residents, and with neighbours. The population in general are becoming accustomed to seeing the children in the streets and stop sometimes for a chat, but neighbourly good relations have been more difficult to establish inspite of efforts by the staff to welcome neighbours, to be friendly and entertain them when possible in the hostel when parties are given and birthdays celebrated. Neighbours are afraid that handicapped children next door reduce the value of their property and it is very likely that prejudices start with financial fears. The staff are aware of the difficulties of noise and work to reduce the irritation that this might cause.

Staff meet once weekly to review the children's care, behaviour, progress and problems. These weekly meetings are also attended by the social worker involved with the hostel, the psychologist, the physiotherapist, speech and occupational therapists who all attend on a once monthly basis. The 'key workers' report on the daily happenings of their children, and a general discussion follows. Problems of management, differences in staff attitudes to behaviour, worries on equipment, seating, physical development or feeding may all be voiced and action decided upon. The meetings give staff an opportunity to discuss problems between themselves and with the other professionals involved with the children.

It is apparent that the children at Eshton Terrace have blossomed both physically and mentally in the three years of their residency. The close working relationships of adults and children in a home-like setting where children help in the kitchen with the meals, collect up dirty laundry, set tables and turn out their cupboards and clean up their rooms have all helped to stimulate understanding, responsibility and vocal skills. Each child's relationship with the rest of the 'family' and the necessity to cope with other peoples strengths and frailties have been an education in themselves for institutionalised children.

Transport is provided for the children in staff cars which are suitably insured for the purpose. Taking this last point into consideration with the other terms of reference for the hostel it can be seen how the individual 'houses' within a mental handicap hospital could be run in a similar way to the community hostel. Members of staff could become integrated with the residents through the combined commitment to a home provided by the everyday jobs that are required in any family setting. Visits to shops, libraries, cinemas and clubs could all be accomplished by staff cars and the only real losses would be those of the local community passing the doorstep and 'normal' ratepaying neighbours. For these new 'family' houses to be successful they would have to be allowed the same degree of autonomy that is now enjoyed by the hostel in the community.

FROM A PARENTS VIEWPOINT

Mrs. Ann Quigley

My daughter Samantha, now seven years old, was born in Derby, - an easy birth and short compared to my two previous deliveries. How proud I felt to have my little girl, — a sister for her brothers. Friends and relatives came to see us when we went home, and she was much admired. For the first fortnight she was a good baby and I remember looking at her tiny fingers and thinking how perfect they were! Then, she started crying, and didn't seem to stop for five years.

Twice in that first six months I took her to see the local G.P. about the constant crying and was reassured that it was colic and she would grow out of it. Then I was referred by the local Baby Clinic to the Derby Childrens Hospital, where we saw the Paediatrician, who with great experience and understanding, told us he thought Samantha was severely handicapped. A shattering piece of news. I remember that after telling the immediate family I left the telephone off the hook one night, as I didn't want to speak to anyone about it. Life was very unreal at this time, and I found eating and coping with mundane everyday affairs very difficult.

When we moved to Kinross, Samantha was admitted to the Sick Childrens Hospital, as she had weight problems following chicken pox. After two months of exhaustive tests, she returned home and life seemed to stretch before me. How to look after her? What about the future? How can I help her? Now, seven years later Samantha has the time and ability to see the world. This came with the help of the physiotherapist who came weekly, giving me the confidence, knowledge and support to adjust to bringing up a handicapped child, at the same time the Doctors gave Sam the medication, which enabled her to be free of the irritation that had caused her early distress.

I had help in the form of a lady who came two afternoons a week, and either took Samantha out for a walk or to her house. This lady has since become a second Grandmother to Samantha. At the age of five, Samantha was offered a place at a nursery in Perth, for one morning a week, and these combined to give me a short and much needed break. When school started it was not only a hurdle for her, but an exciting release for me. Now I find the freedom that I have during the day, is a very precious part of my life. Samantha is also being guided towards communication and various other skills by trained staff at school. Dr. Barnardo's have also helped with respite care schemes for holidays and week-end breaks. My thanks to all who have given me their knowledge and support, especially pre-school, when Samantha was my full-time, twenty-four hour job.

OPENING GATES

By Liz Hare, for 'OPEN GATES', Lancaster.

When David saw the picture of his favourite cartoon hero, Captain Pugwash, on the wall, he knew that here would be a clue as to the whereabouts of the lost pirate treasure. He stepped forward and 'took' the cutlass from Pugwash's hand. He turned to face the rest of us and raised the imaginary cutlass threateningly. "Find the treasure" he said.

David is a resident at the Riverview Hostel for mentally handicapped adults in Lancaster. I have just described what happened during one of our drama sessions with a group from there when we first started work in November 1984. Please do not think that David was behaving or being treated like a child. He was taking part in a drama experience just as you or I might participate in a play.

'We' are 'Open Gate', a small non-profit making organisation consisting at present of 3 permanent members, myself, Klaas Overzee another Drama teacher, originally from Holland, and an administrator/volunteer actor, Ninka Koc. We spend a lot of our so-called spare time devising and carrying out projects in drama for groups of mentally handicapped people.

Each of us has a different reason for becoming engaged in this work, and I think I can only tell you about mine.

I am a Drama teacher and I think that from working with mentally handicapped people I gain tremendous insights into the way in which I may approach my work. Secondly, I think that drama helps us all to improve our communication skills and our confidence in ourselves. Thirdly, drama is an art form and like any other creative activity needs no justification other than doing it for its own sake. Last and not least, it is a whole lot of fun.

Our work to date, that is since early 1984, has been very varied. We have worked a lot with Gateway Clubs, and also with long stay hospital residents. One most recent project has been at a school in Silverdale (Lancashire) for profoundly and multiply handicapped children. We took them and their house parents through a series of sensory experiences in the context of a story about a garden.

So far we have made two videos of our work. The first was about work with adults from the Riverview Hostel. The second which is not quite ready yet, is about our work in Silverdale. They are called "Please leave this gate open" and "Sounds like a Rainbow to me".

We sell them in the hope of spreading the word about our work and in order to encourage other people to try it.

These videos are also going to be part of a thesis about drama with mentally handicapped people, that I am working on part-time at Lancaster University.

We all find the work very exciting and important, and therefore would welcome enquiries from anyone reading this article.

For Miss Hare's address please contact the Editor.

POST REGISTRATION EDUCATION REPORT

Mrs. Pamela Eckersley, Supt. Physiotherapist, Advisor Post Reg. Education.

In future editions the A.P.C.P. Newsletter will have a regular Post Reg. Education page, aimed towards the subject of the Newsletter, as well as containing up to date paediatrician education information. All comments will be gratefully received and should be sent to myself — Mrs. Pam Eckersley — for address see front page. The Education Committee consists of four members:—

Mrs. P. Eckersley — Advisor and Spokesman (Manchester).

Mrs. M. Clegg — Assistant Spokesman (West Midlands).

Mrs. L. Weekes — East Anglia.

Mrs. Trish Hartley — Trent.

We hope that a revised and expanded edition of the 1981 Education Act Guidelines will be published shortly by the C.S.P. Implementation of the Act, and assessment and advice for the Statement seem to be causing increasing problems, particularly in those authorities where many children are being moved into mainstream schools. I would like to monitor any difficulties and would be pleased to receive any relevant information.

The two most common queries I receive are:—

- (1) Do physiotherapists write their own advice for the statement?

Yes.

READ STATUTORY INSTRUMENTS 1983 No. 29 para. 4 "For the purpose of making an assessment an education authority shall seek —

- education advice
- medical advice
- psychological advice
- any other advice which the authority consider desirable".

This means that 'other advice', i.e. physiotherapy, speech therapy, is separate from medical advice. It is not subsumed into the medical report (Appendix D of the statement) but remains intact in Appendix G. DES CIRCULAR 1/83 ASSESSMENTS AND NEEDS para 22 states —

"Advice submitted will be the responsibility of each professional advisor." Para 24 "It will be open to individual professionals to select the points which are relevant to their own specialisms."

This means that physiotherapy advice is sought through the medical officer but is not written into the medical advice.

- (2) What do we write under "physiotherapy provision"? —

THE TRUTH!

We are professionals with clinical skills and abilities to assess children's needs.

DES CIRCULAR 1/83 (as above) para 39 states "ultimate responsibility ... rests with the LEA ... to decide on the weight to be given to different kinds of advice." This means that if the child receives physiotherapy three times weekly in a special school that is because he needs it. If this could not be provided in a mainstream setting this must also be stated.

Suggested wording could be:—

“At present receives physiotherapy three times weekly in a special school environment. Will continue to need this frequency of treatment but this can only be provided in his present placement”.

It is up to the LEA to “weight” this comment with all the other factors on special or mainstream placement.

Information which gives a false picture of the needs of the child is unprofessional and certainly against the spirit of the Act. Parents — and colleagues in education — have a right to know what support and advice they may expect. Children have a right to a truthful assessment of their needs.

It may not make us popular but it makes us professionals on the side of the child and his family.

Comments please.

SNIPPETS

Trade-in Deal on New Pressure Pad System

Huntleigh Technology Health Care Division is reducing the price of a new alternative pressure pad system by up to £20 if an old system of any make is traded in.

Details of the “trade in” deal may be obtained from Huntleigh Technology PLC, Health Care Division, Bilton Way, Dallow Road, Luton, Bedfordshire, LU1 1UU.

Wrap Around Range of Heat Pads

Dreamland has recently launched a new range of four individually shaped heating pads — Physiopads — designed to wrap around the neck, back, shoulder and knee.

The pads are compact and flexible with removable, washable velour covers and are secured by a combination of velcro fastenings, straps and buckles.

Physiopads retail at £24.95 and may be purchased direct from the manufacturer or from branches of Boots.

Contest Discovers Poet

*They did not leave deep treatises
on the meaning of the universe.*

*No, theirs was a greater legacy —
a waltz among the stars with death's armament
freely spinning in a sunless shrieking sky!*

This assured, very adult poetry comes — amazingly — from an 11 year old. What's more, Davoren Hanna from Dublin has cerebral palsy, cannot speak

and can barely move. He communicates with his eyes, or by a typewriter he controls by shifting his weight.

His remarkable talent was discovered in the Spastics Society's 16th annual literary contest.

Safe Paints

Valspar now market a range of paints called 'Child Safe' which conform to strict safety standards, for use indoors or out, in black, white, clear varnish or six other colours. Primer & undercoat available. About £3 for ½ litre.

Save Child Benefit

A coalition of 68 organisations campaigning for improvements in child benefits. A special pack is available outlining the present position, giving useful facts and figures and ideas for action.

£1.15 inc. p. & p. from CPAG, 1 Macklin Street, London, WC2B 5NH.

Play Helps Children in Hospital

This NAHPS poster sponsored by Galt International, is available for the cost of postage to anyone wishing to promote play for children in Hospital.

Published by the Spastics Society, 12 Park Crescent, London, W1N 4EQ.
Tel: 01 636 5020. (Disability Now — May Edition).

No Miracle Cure in Bridgwater

As an Association representing parents and professionals living and working with those with Down's Syndrome, we are somewhat concerned at recent reports in the Today newspaper about the treatment of Downs Syndrome.

Articles appearing in Today on 17th and 18th March claimed that the Bridgwater Jacket produced by the British Institute of Brain Injured Children provided a 'miracle cure' for Down's Syndrome. The articles explained that the waistcoat 'forces the child to breathe properly. By increasing the blood supply to the brain it causes a remarkable transformation in physical looks and mental ability!

Our Association has, for a number of years, offered help for children with Down's Syndrome in the form of a wide range of early stimulation programmes. Achievements are not unique to those children who take part in the Bridgwater programme; a number of children with Down's Syndrome attend normal nurseries and primary schools and are happily placed at secondary level. The majority of these children have led relatively normal lives with extra stimulation in the form of physical activities, sensory training games, special subject and language activities.

The favourable results of such early stimulation have been carefully assessed and documented over a number of years and by a number of renowned experts.

It seems that there is not reliable proof that children wearing jackets would not have made similar progress without them or that the acceleration of development may be directly attributed to the jacket rather than traditional

stimulation, which the children doubtlessly also received from their highly motivated and involved families.

We are naturally interested in any new development which helps children with Down's Syndrome but we felt that it was irresponsible and premature to talk of 'Miracle Cures' and to presume, as this article had, that hitherto there has been little hope for these children.

Maggie Emslie, LCST Dip. IPA, Director, Down's Children's Association, 4 Oxford Street, London, W1N 9FL.

EQUIPMENT

Playing Card Holder

An effective, low cost way of holding playing cards so that up to 14 can be seen at a glance. The Classwood Playing Card Holder has two rows of angled slots in a lightweight polished wood block. Available from:— Classwood Ltd., Carlton Street, Liverpool, L3 7ED. Tel: 051 236 5311.

Book Stand

A simple, low cost, portable book stand made from two pieces of woodgrained board which slot together to provide a firm angled support for most books. (Size: 9½" wide × 6" high). Available from:— Classwood Ltd., Carlton Street, Liverpool, L3 7ED. Tel: 051 236 5311.

Computer Table

Attractively designed piece of furniture for use at home or school, fitted with castors for mobility. Height: 74 cms. Top: 74 cms. × 59 cms. Available from:— R. Taylor & Son (Orthopaedics) Ltd., Compton Works, Woodward's Road, Pleck, Walsall, Staffs.

Typing Tables for Disabled Students

The June edition of 'Educare' the journal of the National Bureau of Handicapped students, features an interesting article on tables for handicapped students, most conventional typing tables being almost impossible to use when in a wheelchair. Staff in the Engineering Dept. of Romney College, Cardiff, were asked to find a solution, encompassing light, strong construction, portable, quickly and easily adjustable, collapsible and cheap. The result is what appears to be a very successful improved design desk. Further information from:— Lloyd Richardson, Special Needs Lecturer, Romney College, Cardiff.

Duvet, Pillow & Blanket Protection

Lightweight covers in water repellent but breathable fabric. Long lasting and washable. S.A.E. for enquiries and further information to:— Feeder Products, 18 Broadway, Wheathampstead, St. Albans, Herts., AL4 8LN.

TOYS

Linkits. 4+ Matchbox Toys — £4 and £15.

A very versatile construction toy with which children can make virtually anything.

Nibbler Set. 3-12 months — £13.50 Design Games.

A group of four brightly coloured rattles fitted on to a central base, which can be clamped on to a cot or playpen. All rattles have different noises and visual attraction.

Walk 'n' Ride — 12-30 months. Fisher Price — £20.

Two toys in one, sit and ride or a baby walker. Makes an interesting clicking noise when pushed.

BOOKS

- * **Dyslexia: What Parents Ought to Know.**
Vera Quin & Dr. Alan Macauslan. £4.95. Pelican Original.
- * **Mental Deficiency. The Changing Outlook. 4th edition.**
Edited by Ann M. Clarke, Alan D. B. Clarke & Joseph M. Berg. £40.
Methuen & Co. Ltd.
- * **Schools, Pupils & Special Education Needs.**
David Galloway, £6.95. Croom Helm.
- * **She'll Never do Anything Dear.**
Joan Hebden. Souvenir Press, Human Horizon Series. £5.95 Paperback.
- * **The Hearing Impaired Child in the Ordinary School.**
Alec Webster and John Ellwood. Croom Helm. £8.95.
- * **Handicapping Conditions in Children. (Special Education)**
B. Gilham. Beckenham: Croom Helm 1986. £7.95.
- * **Working with Parents.**
R. McConkey. Beckenham: Croom Helm 1985. £9.95.
- * **From Toys to Computers: access for the physically disabled child.**
C. Wright, M. Nomura. San Jose: Christine Wright. (P.O. Box 700242,
San Jose, CA95170, U.S.A.). 1985 \$17.00.

AUDIO-VISUAL

- * **A Lending Hand.**
20 min. Video showing a day in the life of Ravensbourne Toy Library.
Copies from: Positive Video, 84 Downhill Road, London, SE6 1SY.
Purchase price £30.

* **I Can Go Where I want.**

19 min. film/video showing how modern engineering and microchip technology can help the most severely handicapped child. Concord Film Council Ltd., 201 Felixstowe Road, Ipswich, Suffolk, IP3 9BJ.

* **Electric Wheelchairs.**

N. McAleer (13 min. tape/slide). Graves Medical Audio-Visual Library, Holly House, 220 New London Road, Chelmsford, Essex, CM2 9BJ.

* **Making Progress**

A fascinating video of a two year project filmed at Hortham Hospital with severely disturbed men, and using specially designed equipment to engage their attention. The participants making the film were Phoebe Caldwell, Adult Education lecturer and designer, Sue Staite, a psychologist and Julie Wilkinson, a Ph.D. student Dept. of Mental Handicap, University of Bristol. Available from:— Concorde Films Council Ltd., 201 Felixstowe Road, Ipswich, Suffolk. Price on request.

* **Can I Help You Sarah?**

17 minute video on independent living for the severely disabled. John Grooms Association, 10 Gloucester Drive, Finsbury Park, London, N4 2LP.

LETTERS TO THE EDITOR

A boy with spastic quadriplegia was recently supplied with a new Corby wheelchair, but surprisingly the footrests were too far out in front for his feet to even reach them, making it impossible for the child to sit with his knees at right angles. Consultation with our local ALAC Technical Officer produced the response that physiotherapists and occupational therapists in another part of the country, had insisted on 5" castors to make the chair easier to push. This had placed the footrest so far in front that some other areas were using a wooden attachment.

It seems curious that a new design, attractive children's wheelchair, has to have a makeshift wooden footrest. Have other people had this problem?

Ann Caverett MCSP. — Replies to the Editor please.

DRESSING FOR PEOPLE WITH MENTAL HANDICAP — REQUEST FOR INFORMATION

The Disabled Living Foundation (DLF) is undertaking a 15 months project, funded by DHSS, to produce a textbook and training package dealing with the clothing and dressing needs of children and adults who have a mental

handicap. DLF's researches have shown that there is no other such resource on this subject which is of vital importance to the social integration and well being of mentally handicapped people and their families. The text will be based on the many examples of local good practice, on the experiences of those professionally or personally concerned, on existing literature and on the advice of experts in this area of rehabilitation and care.

To this end DLF seeks the help of readers in letting me know of clothing problems encountered or overcome, including design or adaptations of garments, fabrics, techniques for independent or assisted dressing, examples of good or bad practice, laundering, literature or other training material found useful and any other training material and other relevant information. Such information could relate to mentally handicapped people of all ages, whether they are living in their own homes or in residential care, and whatever the degree of their disability.

At this stage in the project I am seeking information and regret that I will be unable to answer requests for information or advice because of the limited time I have to produce the text.

I look forward to hearing from readers and would be grateful if you could let me know on your reply whether you would be happy for me to contact you for further information if this proves necessary. Please reply to me at the DLF, 380-384 Harrow Road, London, W9 2HU.

Philippa Moore, Dip. COT., Researcher for the Project on Clothing for People with Mental Handicap.

FORTHCOMING COURSES

September 5 - 7

ASBAH Conference at Sorby Hall, University of Sheffield. To include papers on: Problems of the Newborn, treatment of Hydrocephalus, education potential and problems, difficulties of independence, social needs of physically handicapped young adults.

Details: Mrs. Susie Dobson, ASBAH, 22 Upper Woburn Place, London WC1H OEP.

September 19

Visual Handicap in Childhood.

Details:— The Conference Organiser, Room 137, A Floor, Clarendon Wing, Leeds General Infirmary, Belmont Grove, Leeds LS2 9NS. Price £12.

September 25

Problems of the Spine and Foot in Paediatric Physiotherapy.

Details:— Mrs. B. Hindley, Higher Clerical Officer, Rehabilitation Unit, Witherington Hospital, Nell Lane, Manchester 20. Tel: 051 447 3409. Price on application.

September 25

Study Day on Muscular Dystrophy, for Therapists, at the Post Graduate Centre, Derby Royal Infirmary, London Road, Derby.

Programme includes:— Diagnosis and Development by Dr. J. Axton, Consultant Paediatrician. Aids & Adaptions for Children with Muscular Dystrophy. Miss P. Harpin, National O.T. Advisor to M.D.A. Recent Developments in Genetics and Family Counselling. Dr. J. Fitzsimmons, Director of Genetic Studies. Physiotherapy Treatment. Miss P. Bennett, Hebden Green School.

A.P.C.P. members £12. Others £15.

Details:— Mrs. M. Meagher, Westbrook School, Thoresby Road, Long Eaton, Derby. Tel: Long Eaton 729769.

October 4th

Paediatric Respiratory Care.

West Kent Post Graduate Centre, Farnborough Hospital, Orpington, Kent.

Programme includes:— Interpreting X-Rays, Dr. I. Kenny, Consultant Radiologist. Management of long-term ventilated children, Dr. P. Williams, Consultant Anaesthetist. Physiotherapy for the pre-term baby, Mrs. Annette Parket MCSP. The Use and Abuse of Suction, Miss Christine Young, B.Sc., MCSP.

Course fee: APCP Members £7 — Non-Members £10.

Applications to:— Mrs. J. M. McKinley, 3 Stanley Gardens, Sanderstead, South Croydon.

October 18th

A Practical Introduction to the Use of Portable Video Equipment.

St. Martin's College, Lancaster, Lancs.

Fee: £15. Details:— Mrs. S. Bliss, Portland House, 51 Portland Street, Lancaster, LA1 1SX.

October 15th - 17th

Transition to Adulthood, for those with severe physical impairment.

November 3rd - 7th

Micro-technology and Special Educational Needs.

November 21st - 31st

Young Children with Severe Learning Problems.

December 1st - 3rd

Personal and Social Development, Young People with Special Needs.

December 5th - 7th

The Child with Cerebral Palsy in School.

All the above courses are to be held at Castle Priory College, Thames Street, Wallingford, Oxfordshire OX10 0HE. For details apply to the Principal Mrs. J. W. Knowles, B.A. Dip. Ed.



POST VACANT

CENTRAL BIRMINGHAM HEALTH AUTHORITY

Community Paediatric Services

An additional post involving all aspects of community paediatrics has just been created. This service has close links with the Birmingham Children's Hospital. Some general paediatric experience is desirable, but up-date or in-service training are available. Part time or full time applications are invited from State Registered Physiotherapist. A car and current driving licence is an advantage, but not essential.

Further information or arrangements for an informal visit can be organised by contacting:

Mrs. C. Foster, MCSP Superintendent Child Health Services Sparkhill Clinic, 858 Stratford Road, Birmingham 11. Telephone: 021 777 1754.



BRIGHTON HEALTH AUTHORITY

From September 1986 a Senior Physiotherapist with paediatric experience will be required for 15 hours/week, term time, to be based at the Royal Alexandra Children's Hospital and with a commitment to work in Special Schools and the community. An interest in the multiply handicapped child is essential.

For further details contact Miss Christine Young, Superintendent Physiotherapist. Tel.: 0273 28145. Ext. 15.

REGIONAL REPORTS

South West Reg. Rep. Miss G. Riley, Meadows, Bower Chalke, Nr. Salisbury Wilts.

Unfortunately the Study Day on 'Neonates' to be held in Plymouth in May had to be postponed for various reasons. It is hoped to hold the study day at a later date. Details for the study day to be held in Bristol on 'Recent Trends in Paediatric Orthopaedics' are well in hand. In this wide spread region, it would appear that smaller localised, discussion sessions are more practical and effective - as an increasing number of these are being reported.

London Reg. Rep. Miss V. Read, Flat 2, 62, Madeley Rd., Ealing, London W5.

The first of our two evening lectures was held on Thursday May 8th at Great Ormond Street and entitled "Cystic Fibrosis - the

Current Practise in Physiotherapy". It was very well attended and proved to be a most successful event. On Tuesday June 17th the second lecture, also at Great Ormond Street was on "Muscular Dystrophy - the management of the older child". The speaker was Clare Walker, a family case worker for the Muscular Dystrophy Society. Coffee was served prior to the meeting. The Autumn Study Day will take place on Saturday, September 27th at the Wolfson School of Nursing, Westminster Childrens Hospital. The subject will be "Orthopaedic Surgery and the Cerebral Palsied Child - What and When? A workshop on management".

West Midlands

Reg. Rep. Mrs. Jackie Reynolds, 35, Bodmin, Rise, Walsall, West Midlands.

A meeting was held on May 15th at Victoria School, Northfield, when a fascinating lecture on "Genetic Counselling" was given by Dr. Farndon, Consultant in Genetics at Birmingham Maternity Hospital. The lecture was well attended.

Following the lecture a committee was held and the 1986/87 programme was arranged:— July - Treatment of Head Injuries on the Therapy Ball by Mr. Thackeray from the Birmingham Accident Hospital.

September - Making and use of Videos - to be held at Ridge Hill.
November - a Saturday Day Course on Perceptual Problems of the Multihandicapped Child.

January '87 Informal Discussion Panel. Questions to be sent in by Branch members.

March '87 Assessment of the Older C. P. Child.

The next committee meeting is to be held on June 19th at Birmingham Childrens Hospital.

North East

Reg. Rep. Mrs. E. Barron, 5, Sandy Lane, Ripon, North Yorks.

An evening meeting was held on June 23rd, when Mr. T. Gausson gave a short talk and led a discussion on the "Psychological Approach to the Problems of the Handicapped Child".

In October we hope to hold a Study Day in Hull on Paediatric Hydrotherapy.

East Anglia

Reg. Rep. Mrs. Lyn Weeks, 37, The Cedars, Milton Road, Harpenden, Herts.

Mrs. M. Moon, MCSP from Watford Spastics Centre, will hold a Workshop on 'Peto for the Young Adult with Severe Mental and Physical Handicap' at Cell Barnes Hospital on Thursday October 2nd 1986. 1.30 - 4.30. Numbers limited to 40. Fee Members £2.50 - non-members £3.00. Closing date for applications - September 19th 1986.

Applications to:— Mrs. P. A. White, Supt. Physiotherapist, Cell Barnes, Hospital, Highfield Lane, St. Albans, Herts.

Scotland

Reg. Rep. Mrs. Liz Breckenridge, 19 Langside Drive, Newslands Glasgow.

The Constitution of the Scottish Branch is now finalised and submitted to the National Committee.

The first AGM of this Committee to be held on Saturday 25th October at Royal Hospital for Sick Children, Edinburgh. This is planned to tie in with a Study Day on the Management of Respiratory Problems at Royal Hospital for Sick Children, Edinburgh on 24th/25th October. The Committee to be enlarged to represent more areas in Scotland and nominations have been sought for vacancies in Fife, RHSC (Yorkhill), Tayside and Dumfriesshire/Borders.

Study Day on The Clumsy Child in April was very well attended and successful.

Study Day on Temple Fay and Vibration is almost fully booked.

North West

Reg. Rep. Mrs. K. Jones, 66 Mellor Brow, Mellor, Blackburn.

The region has organised a workshop day on video-filming to be held on October 18th in Lancaster, when it is hoped that all course members will have a chance to actually use the cameras and practise filming. There is a note in this issue of the Newsletter giving details.

Early next year at the Annual General Meeting we hope to organise a study day on the visually handicapped child.

The region is sponsoring 10 physiotherapists to attend the C.S.P. Congress for one day at a maximum cost of £25.00 each.

Wales

Reg. Rep. Mrs. Vivienne S. Williams, 5 Larch Grove, Lisvane, Cardiff CF45TH.

A one day bereavement course was held at the Children's Centre University Hospital of Wales, Cardiff on January 12th. Due to its success a second day was held on June 26th and requests have been made for a further repeat, with a follow up in the autumn.

The Bobath Course which was an introduction to the concept was oversubscribed and very successful.

A meeting was held at the Children's Assessment Unit at Carmarthen with physiotherapists from Dyfed. It was decided at that meeting to form a sub-group of the Welsh branch and a further meeting has been arranged at Withybush Hospital, Haverfordwest on July 17th 1986. It is hoped that perhaps further sub-groups may be formed for example in North Wales to overcome geographical problems.

Future meetings are being planned next autumn on the following subjects:

- i Movement for the Mentally Handicapped.
- ii Move to Grow (movement for the under 5's.)

Both of these are being held with Mrs. Dilys Price, Senior lecturer, Cyncoed College of Further Education.

STOP PRESS

1987 APCP Conference will be held in York from April 23rd - 25th.

The theme will be "The Management of the Neurologically Handicapped Child" and the aim is to offer comparisons of the different methods used with such children.

The Conference will consist of both lectures and smaller group sessions. Subjects covered will include Conductive Education, Bobath Techniques, Serial plastering and Dolman/Delacato methods. There will also be a general discussion meeting for APCP members. Topics for discussion should be sent to regional representatives.

The venue is the very attractive and comfortable College of Ripon and York, St. John which stands facing the ancient city walls, within sight of the Minster and within very short walking distance of the city centre.

The full conference programme and booking form will be included in the next Newsletter.



FURTHER EMPLOYMENT OPPORTUNITIES

Private physiotherapist required to treat a three year old with a mild left hemiplegia in own home. Should live within 10 miles radius of Fleet in Hampshire. For further information and enquiries ring Mr. or Mrs. Jobe 0252 623110.

Senior II Physiotherapist for 4 - 10 sessions per week in a day school for cerebral palsied children, run by Croydon Sutton and District Spastics Society. In service training and participation in courses encouraged. For further information or an informal visit please apply to:— Mrs. M. MacNeill, Croydon Sutton & District Spastics Society, Rutherford 1a, Melville Avenue, South Croydon, Surrey. CR2 7HZ.

Does anyone wish to spend a year or two in New Zealand? There are two posts for Paediatric Physiotherapists in two beautiful areas of New Zealand. In addition, the child development centres with the vacancies are attractive with excellent facilities. One is in Rotorua and one in Wellington. The people are friendly and enthusiastic. For further information contact:— Sophie Levitt, Patron, Visiting Therapists Association of New Zealand, 21D Randolph Crescent, London W9 1DP. Other contacts are:—

Dorothy Gordon, 14/51 Bombay Street, Wellington, New Zealand or
Nancy Barnett, Child Potential Unit, PO Box 1342 Whakaue St. Rotorua.

DO YOU KNOW?

★Anyone who has used the RDA CHAIR or who has one that could be lent for trial with a child in a Special School? Has anyone any comments on how they like it? If so please contact: The Editor.

★About Sparky the Dragonbus, a double decker playbus converted to provide play facilities, and working throughout Glasgow, also the Toy Horse, the horse drawn Toy Library working in Bristol?

★Bandwagon Clothing, individually made to measure leisure clothing with disability in mind. 100% cotton, fully washable. For details contact: Bandwagon Clothing, 47, Scotts Road, Leyton, London E10. Tel. 01 556 3924.

The address of the Association of Professional Music Therapists is:— Music Therapy Dept., St. Lawrences Hospital, Caterham, Surrey CR3 5YA. Useful if you need advice for your music group.

★Pillow Paws - disposable slippers, made from porous polyurethane, machine washable, stretchable, non-allergic and silent! Size 3-4 £0.83 per pair 4-5 £0.96 per pair 5-7 £1 per pair 7+ £1.06 obtainable from Home Nursing Supplies, Headquarters Road, West Wilts. Trading Estate, Westbury Wilts. Cash with orders, Cheques/postal orders should be made to Home Nursing Supplies and crossed.

★P. R. Cooper (Footline) Ltd., Sycamore Works, Tilton-on-the-Hill Leicestershire LE7 9LG have a new boot that is fleecy lined, water resistant, and has a full length back opening with a large loop which makes it easy to get into to. They will make anything to specification and also make singles. Further enquiries to the firm.

★If you are going to the Garden Festival at Stoke-on-Trent contact DIAL Tel. 0782 269744 for a list of Accessible accommodation catering for the disabled.

