ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS

NEWSLETTER

Association of Paediatric Chartered Physiotherapists

Newsletter No. 41 **November 1986**

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

EDITORIAL

It is a common misconception to consider paediatrics as concerned only with babies and young children, although it does in fact cover a much wider age range, usually tailing off at around 16. However, with a school leaving age which can be 19 and a voting age of 18 there is a grey area of adolescence which tends to overlap into adulthood. Youngsters in this category with disabilities can face many problems, not the least of which may be legislation in all its forms. However, in recent years more efforts are being made to deal with some of these difficulties. Adolescent clinics are opening, new opportunities for training are being created and funding is becoming available whilst through the media the public at large are becoming increasingly aware, as we need to be, of these resources which may benefit our older clients, many of whom may be bewildered at the complexities facing them in adult life after the relatively sheltered existence of childhood.

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Would YOU like to be an Author??????

The Editorial Board has decided to devote the FEBRUARY 1988 edition of the Newsletter as a FORUM for you — the members! We are therefore inviting you to contribute articles of any length between 50 and 2000 words on any aspect of paediatrics you care to choose, or you may like to describe a piece of equipment you have adapted or even invented! Maybe you would just like to air your views on paediatrics in general. We are sure that you all have lots of talent, so come on readers let us hear from you! Any contributions should be typed double spaced and sent to: 'The Editor', 22 Whernside Road, Cross Hill, Lancaster LA1 2TA before September 30th 1987.

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PLEASE NOTE ......

The last day for submission of material for the February 1987 Newsletter will be December 20th - slightly earlier than usual because of Christmas.

SERVICES FOR YOUNG PEOPLE WITH SPECIAL NEEDS IN THE 18-25 AGE GROUP

Sylvia Simmons, Information Officer, National Bureau of Handicapped Students.

"Services for young people with special needs in the 18-25 age group" is an optimistic - not to say misleading - title and a daunting prospect to anyone asked to describe them. How much more so for the young people with disabilities - be they mildly handicapped or severely disabled resulting in the need for extensive personal care help - who are faced with many choices as they come up to school-leaving age. Attempting to present a comprehensive description of the range and nature of the available services would cover many pages. These comments highlight the fact that in the creation of a comprehensive Welfare State we demand many skills of young people with disabilities who are making the transition from childhood to adolescence and adulthood, from school to further education, training and employment, and from living at home or in a specialist residential setting to independent living. The key word is 'transition' but unfortunately there is no one standard transition process which serves as a stepping stone from one world to another.

Whilst it is tempting from my own standpoint, working with people over the age of 16, to view services for children as co-ordinated and comprehensive, I know that this is far from the truth. However, community child health teams are often multi-disciplinary and inevitably special schools are focal points in the provision of services both formal, e.g. speech therapy, physiotherapy, and informal - parents' self-help groups, advice from teachers, etc. Since the majority of children disabled in childhood have been diagnosed in the first few years, by the age of 16 patterns of care and daily living and a 'modus vivendi' - however inadequate and in need of further support - will have been established. Adaptions to a parents' home will have been carried out and contacts established with local hospitals and Social Service Departments, as well as the Local Education Authority, which must now provide "statements" under the 1981 Education Act. Approaching school-leaving age brings for the young person the glimmer of independence and many unanswered questions, and for parents fears of change and the need for more planning, upheaval and stress. The gap between the two, and the need for encouragement, pragmatism and co-ordination by and between the professional staff with whom they come into contact, cry out for a comprehensive multi-disciplinary adolescence team of medical, para-medical, counselling, careers guidance, education and social services staff. Until such utopian teams are established and young people with disabilities are able to seek guidance from a "named person" as envisaged in the Warnock Report, most of them will be faced with the need to consult many different professionals working in different statutory and voluntary authorities - see Fig. 1.

The Family Fund, which provides financial assistance for children with severe multiple handicaps, recognised these difficulties several years ago when their social workers were receiving an ever-growing deluge of enquiries on post-school opportunities. They commissioned a booklet entitled "After 16 - What Next?" which describes options for further education, training and employment, financial benefits, mobility, housing leisure, etc. It is available to any professionals working with young people with special needs - price £2.25 inc. p. & p. from the National Bureau for Handicapped Students.

The National Bureau for Handicapped Students (NBHS) is a voluntary organisation which was set up in 1975 at a time of growing concern at the small number of young people with special education needs in further, higher, continuing and adult education and training.

The development of NBHS services over the last decade has parallelled the growth in opportunities and the increasing attention being paid to this group of young people. NBHS aims to co-ordinate information on opportunities and facilities in colleges and training establishments, and to encourage more comprehensive opportunities with appropriate specialist support in all centres of education and training.

Its Information Service deals with enquiries from and on behalf of students and intending students and their families and professional advisers, in education, guidance, health and social services, on a range of issues including study support, access and financial assistance. The advisory service for colleges provides help in the development of college policy to facilitate integration, linking and bridging courses and the role of the co-ordinator for special needs. NBHS has an extensive publications and research programme, providing reports, information packs with guidance for students and staff, and a Journal 'Educare' published three times a year with a circulation of 1500. A network of regional groups holds regular seminars and meetings, in addition to national conferences. Increasing attention is being paid to staff development, and current projects include short courses for staff working with adults who have severe learning difficulties and teachers in T.V.E.I. (The Technical and Vocational Education Initiative) who have no previous experience with special needs. Special interest groups and working parties are currently considering pre-vocational training, information technology, and specialist needs in higher education.

If "After 16 - What Next?" provides an introduction to the range of opportunities available, it certainly cannot provide all the answers to steer the young person through the system. The difficulties facing Danielle, who has spina bifida, provide a good example:

Now 22, her story illustrates the complexities of the transition to an independent life. Currently in her second year of a Business Studies Degree course, she lives in the Hall of Residence and personally recruits and employs two personal care helpers on a rota basis. She has worked out a 'job description' for each of them and also receives District Nursing help twice a week. She is learning to use a small portable micro-computer to take lecture notes and edit essays, a valuable saving on her time and energy over laborious typing. She has made friends on campus and her adapted Mini is popular with fellow students for bulk buys at the supermarket.

3½ years ago the picture was very different. Danielle, having left residential special school where she had been a pupil since she was 8, had taken 'A' Levels at a specialist further education college, she had no contact with her family since her parents' divorce, hence no home to return to during vacations, which she spent in the homes of different friends. Her determination to find and to fund her own flat was her major concern during the last year of her 'A' Levels. As well as applying to Higher Education and discussing the ways in which she might organise personal care, she attended a short course to assess her mobility and driving skills, and immersed herself on pamphlets on disability benefits, and the 'Disability Rights Handbook' published annually by the Disability Alliance became her bible. Her search for appropriate housing concentrated on the county where she had spent most of her life and where she had made friends from her days at the special school. Her persistance was rewarded with a positive answer from a local Housing Association which was building three wheelchair accessible flats on a a new development; these were linked by intercom to helpers' flats on the first floor. Her hopes for independent living with personal care help were dashed when she discovered that her local education authority grant would not enable her to keep on her newly found permanent home. She faced a dilemma; take up her college place, face uncertainty and admission to a Home for the Chronic Sick and Disabled during vacations, and no home at the end of her course, or give up the chance of a suitable college course. She finally chose to defer her place on the college course and spent the intervening year in detailed correspondence with the DHSS to enable her to resolve the financial tangle, which finally she was able to do.

Danielle's persistance, confidence and ability to cope with bureaucracy was in many ways unusual. For most young people the growth in opportunities at further education level presents a complex maze. Their first point of contact will usually be a local education authority specialist careers officer who can offer information on specialist further education courses, support available in local further education colleges, youth training schemes, etc.

The next most important contact person is undoubtedly the college co-ordinator for special needs. A recent publication by Longmans "A College Guide — Meeting Special Educational Needs" prepared by the Assistant Director of NBHS, provides a comprehensive introduction to the types of college courses now available and the ways in which specialist support can be provided for young people with physical, sensory and communication handicaps.

For many young people with special needs, periods of missed schooling and hospitalisation have meant that they have fallen behind in the learning process. At the age of 16 their potential is only just beginning to be tapped and several years at college to consolidate physical skills around that time to decide what form of vocational training they should pursue.

Specialist residential further education colleges, whilst continuing to offer physiotherapy and assessment of mobility needs, emphasise the need to look at "aids to daily living" and these skills are often part of the curriculum. For some young people the choice of a further education course cannot be made in the course of a few interviews with a careers officer, and here a residential multi-disciplinary assessment such as that offered at Banstead Place may be appropriate.

A significant time for transition for many young people who are more academically able is their application for higher education. Since in this country this is traditionally when students move away from home, it is at this stage that many questions have to be answered. Perhaps for the first time the young person is asked to examine how personal care is organised and provided. For each individual student there is no short-cut to examining the options available, - which include extensive use of District Nursing services, one or more personal care helpers under the C.S.V. Independent Living Scheme, receiving help from care helpers employed or recruited by the college, - and deciding within reasonable constraints which is the 'care package' he or she would like to live with.

Further details can be found in the NBHS publication "Meeting the Personal Care Needs of Severely Disabled Students in College".

There is now considerable experience at national level of services which can be tapped for students in higher education, but increasingly we are aware that potential applicants do not have enough help from written information alone. A pilot "Transition to Higher Education" course was organised in Scotland in 1986 and a similar short residential course in England is planned for 1987.

Hereward College in Coventry runs short 2 to 3 day "Communication Aids Assessment Courses" which also allow students to discuss other aspects of studying in mainstream colleges. Less specific but equally valuable are the "Independence Weeks" run by A.S.B.A.H. (Association for Spina Bifida and Hydrocephalus) and short-term residential assessments run by several hospital Young Disabled Units where specialist advice is available from physiotherapists, occupational therapists and medical staff.

The recent Disabled Persons Bill sponsored by Tom Clarke M.P. highlighted the need for co-ordinating services at the vital school-leaving stage.

I am indebted to the principal of a specialist further education college who always reminds his colleagues that he knows many first-year university students who are physically independent and know how to wash clothes, but bring bulky suitcases to the long-suffering family washing machine on occasional visits home. "My students" he declares "have many years of having had care provided for them by care helpers, nurses and special school staff, may not be able to accomplish many of the tasks of independent living, but they have achieved independence by knowing how to organise the technical and ancillary help around them which will enable them to achieve independence". If paediatric physiotherapists can play their part in the multi-disciplinary effort to assist young people with special needs as they strive for independence, they will have played a significant part in transition.

For more information on the work of NBHS, publications list and membership, please contact:— NBHS, 336 Brixton Road, London S.W.9.

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Fig. 1.

Young People with Special Needs : range of services/organisations to be consulted

An introductory list ....

MEDICAL

GP
Consultants:
- orthopaedic
- neurologist
- opthalmic
- etc. .....

Physiotherapist
District Nurse
Dietician
Young Disabled Unit
? ? ?
? ?
....

ENVIRONMENTAL

Occupational Therapist (SSD)
Social Worker (SSD)
Social Worker (Disability organisation)
e.g. Spastics Society
Housing Adviser (Local Authority)
Assessment: Communication Aids
Mobility/driving
? ? ?
....
if student leaves home see below*

FURTHER EDUCATION/TRAINING/EMPLOYMENT

Teacher/Careers Teacher (School)
Specialist Careers Officer (LEA)
Careers Adviser (Disability Organisation)
College co-ordinator for Special Needs
Disablement Resettlement Officer (DRO)
YTS Supervisor/Manager (MSC)
FE/HE College — New Tutor
— College Counsellor
— Accommodation/Welfare
— Subject Lecturers
— College Careers Adviser
— *Social Services/Health Staff in new area
— if students leaves home

....

FINANCIAL

DHSS — Severe Disablement Allowance, SB etc.
LEA — Grant for Study, etc.
SSD — Adaptations, ...
Local Authority — Housing Benefit.
Motability.
Trusts/Charities — extra costs not met by statutory sources.
....

Sylvia Simmons
26th September, 1986

HELPING THE HANDICAPPED ADOLESCENT TO GET THE BEST OUT OF LIFE

Noreen Hare, Superintendent Paediatric Physiotherapist.

As a Physiotherapist one approaches the difficulties of adolescents with a physical eye! Physiotherapy by its very nature endeavours always to restore, re-educate or educate a level of physical ability necessary for individual independence, and, in the case of handicapped individuals, required for a degree of human dignity. In cases of lifelong handicap physiotherapists are engaged in "bridging the gap" in performance which is forever widening between the observed and expected levels of independence at any given time. This gap itself becomes the degree of handicap. It is possible however, by making the most of a persons potential and by structuring his environment so that he is only expected to perform when it is most conducive to his levels of ability, to reduce what may clinically appear to be a horrendous handicap to a minimal disability.

The physical activities and achievements of the handicapped adolescent deserve special attention, because this a period within a lifespan when normally physical exercise, prowess and competition in sport are tactics readily used by Parents and Headmasters to overcome other difficulties encountered. Programmes for swimming, archery and wheelchair activities are well known and handicapped adolescents should be duly encouraged to take part. It is also important to include under the title of handicap, conditions other than those affecting the physical welfare of the patient. For instance Cystic Fibrosis or Arthritis can be as disabling as the more severe problems caused by neurological impairment, and certainly the psychological overlay can in many ways be the same.

In a curious way, and upon reflection, the problems of adolescence seem to be closely aligned to the problems of handicap. Essentially both groups of individuals whether adolescent or handicapped, or both, seem to be struggling to discover the 'common denominators' of life. They seem to be different from anyone else; whether in communication or actual efficiency of movement. They look different, and the differences are obvious to other people. Is it any wonder then, that both groups either cling to security or discard it altogether preferring to band together and often resist the changes imposed upon them by society? When the two problems of adolescence and handicap are combined they would seem to be insurmountable. For some unfortunate few they are, and one is personally aware of distressing cases of attempted suicide, mental breakdown etc. But, perhaps the combination of the two factors in some individuals creates a strength of character which gives them wisdom beyond their years. One begins to recognise the unfortunate truth that breakdown occurs when extra pressures are put upon youngsters trying to convert them into people they may never be.

What answers are there to this dilemma? The first must be that it is too late to start worrying about the problem, when adolescence is upon them. Lifelong handicap, and in the management of lifelong disability, education of the parents and individuals must start on day one! There are two fundamental principles to be used in coping with these families: avoid feeling sorry for the person and always adhere to the unfortunate truth - that the handicap is not going to disappear. Honesty is the best policy is an old and time proven slogan, but I believe it to be very true in dealing not only with young children and adolescents with handicaps, but also with parents. There is nothing to be gained by glossing over what is unfortunately basic reality. A second answer to the dilemma is that assessment of the ability present, must reveal the degree of disability, and must reveal the degree of handicap. This exposed, every measure must be taken to bridge the gap in performance. Handicapped people must be given alternatives to speech, if needed, computers if needed, appropriate aids, chairs or wheelchairs, walking frames. Remembering always that an aid is only appropriate if it improves performance; there should be no argument or reluctance to supply or suggest means of bridging the gap.

A third answer and perhaps the most important is to develop from an early age a positive and responsible attitude in the handicapped person. If able to, he must take on his exercise routine, and the responsibility of having his calipers repaired or his wheelchair serviced. All are an important part of his life and contribute to his independence. In cases of extremely severe physical and mental handicap these same principles must be applied and adopted by those who are caring for the individuals - parents, therapists, care staff and teachers who in turn take on the responsibility for the individuals level of independent performance. A final most important point is the necessity for those caring for the handicapped to recognise their age level. If a young person is 16 - he is 16 - the alternatives to function, communication and mobility should be used to repair the gap in his performance level, so that with these alternatives, his performance reaches somewhere near his age level.

Independence is a question of choice, as non-handicapped, we are capable of multiple choice in practically every situation. In order to help the handicapped and adolescent to get the best out of life, perhaps it is necessary to consider the ingredients of independence in order that we may offer him as many choices as possible to enjoy. Human dignity requires three basic functions - ability to communicate, ability to use your hands for self-help skills, learning to work etc., and the ability to be upright and mobile. The most important of these must be the ability to communicate, this is often an area of considerable difficulty with most adolescents! With a handicapped person every effort must be made to establish communication, recognising that its real meaning is the exchange of information and not simply the despatching of messages. The ability to use your hands for self-help skills, obviously enables a person to do something for himself or others. The "doing" of such tasks requires physical activity and balance, and is therefore dependent on independence and being upright and mobile. In physiotherapy we talk constantly about 'muscle power' posture, and not often enough about the importance of position, and as stated earlier an important principle in dealing with handicap is always to assess the environment: how conducive is it to a person's performance? Is he falling? Is movement possible?

Limitation of movement and therefore limitation of physical independence can vary from one person who has difficulty in walking to another who cannot walk at all, another who cannot assume a position but when within that position can move quite happily, or a more limited person still who even when comfortably positioned is incapable of making any movement at all. It is this last group who cannot make any physical adjustment that demonstrate the fixed deformity and contracture, with which most of us who work with the severely disabled are so familiar. It is important to remember that there are three fundamental positions, lying, sitting and standing. All of us during development by learning balance and correct posture within these three positions gradually assume an upright mobile posture. In the management of the severely physically disabled it is most necessary to remember that they should be given the opportunity, if they cannot move themselves of being placed in all three positions during the 24 hour period. In order of precedence our aims in managing these individuals with physical handicaps should be:—

1. that they should have bodies which we can position with ease and comfort.
2. that they themselves should be able to assist us with movement.
3. that they should be able to perform movement themselves.

Abilities should be observed in each position and performance classified by the limitations seen. Then a constructive and appropriate programme can be designed in which the handicapped youngster can participate. He must be encouraged to do as much as possible for himself. This takes TIME but is rewarded by achievement and most important, motivation. It is definitely a mistake to set tasks too great or expect too high a standard of perfection, outside realistic achievement, as this will certainly lead to demoralisation and defeat.

In practical terms, when dealing with a handicapped adolescent, either for long or short term care, the following measures should be observed:

First, always obtain or make your knowledge of previous management and treatment routines, levels of independence etc. clear. Unless you know what the youngster is capable of, you may have difficulty meeting their own ambitions of independence.

Following from this, where it is appropriate, adapted furniture aids, and aids for communication or mobility must accompany the adolescent everywhere.

As we have discussed in cases of physical handicap, provision must be made for positioning, change of positioning, forms and routines of mobility to be included in their programme.

Make it a rule in cases of handicap, and particularly of physical handicap always to approach from the front and always say what you are going to do. Never deny them their own method of performance, only work to make it more efficient.

When dealing with profound physical handicap, remember that the basic problem is one of defective balance. A profoundly handicapped person is not easy to move, because he cannot assist you with the movement, and care and training will prevent you yourself suffering from back strain and injury.

A final point - when does adolescence end? How ready are any of us for adulthood? It may be the greatest service we can give the handicapped adolescent is a confidence in themselves and the reality of their condition, and an enthusiasm for the responsibilities of adult life. In helping them to get the most out of life, we must allow them, to grow up.

A CLINIC FOR YOUNG ADULTS WITH SPINA BIFIDA AND HYDROCEPHALUS

Dr. Gillian McCarthy, Consultant Neuropaediatrician.

Spina Bifida and hydrocephalus is a condition which has only been surgically treatable for the last 25 years or so. There are now many adolescents and young adults with severe problems related to the condition. Chailey Heritage is a Hospital and School for physically handicapped children in Sussex. In the last 20 years a large number of children with spina bifida and hydrocephalus have passed through the school, and we were becoming increasingly concerned by their problems after leaving school. The Sussex Association for Spina Bifida and Hydrocephalus (S.A.S.B.A.H.) were instrumental, both in arguing the case for a Clinic and providing funding for the pilot scheme which was set up in 1984. The clinic was client based with self referral via the SASBAH Field Workers. Initially it was provided for any past student of the School with spina bifida, or any person from East or West Sussex. The aim of the Clinic is to assess the medical, daily living and mobility problems of this group of people.

The staff of the Clinic comprise Consultant Neuropaediatrician, Nursing Sister, Occupational and Physiotherapists and two Field Workers - one each for East and West Sussex. We have access to the Orthotics Department and Rehabilitation Engineering Unit on site, and are also able to obtain advice from the Orthopaedist at Chailey Heritage. The family doctor is contacted where possible before the Clinic in order to explain its purpose and to obtain medical records. No doctors have objected to their patients being seen, and most have been helpful and enthusiastic.

The Clinic itself is run on informal lines, and lasts for a whole morning. It consists of a medical interview and examination, and a combined interview with Physiotherapist and Occupational Therapist, with variations according to particular problems. Screening blood tests, urine tests and X-rays can be arranged where necessary. The therapists liaise with their colleagues in the community and residential units where necessary. The Nurse attended a course on contraception and is able to counsel young people, and also arrange appropriate appointments with Family Planning Clinics. She organised a Study Day on Sexual and Personal Problems of the Disabled which was attended by all the Clinic team.

Although the majority of clients are aged between 16 and 25 years (57 in Year 1 and 26 in Year 2), the older people give an interesting insight into the problems which may occur later. In the younger age groups only a small number were married, the majority to disabled partners. In the 16-20 age group many were still in college or on Youth Training Schemes. Only a small number under 25 years (8 in year 1, 5 in year 2) were in full or part-time employment, examples of which were Telephonist, Medical Secretarial work, Electrical assembly work. One girl obtained a degree and is training in hospital administration.

Less than half (19 out of 42) of the under twenties, and 6 out of 15 of the 21-25 age group had an interesting or rewarding daytime occupation.

The Clinic is run on informal lines so that young people have an opportunity to discuss their condition and to ask questions about it. They are offered genetic and simple contraceptive advice, and advice on child-bearing which is often uppermost in their minds. They are also referred to appropriate consultants for further care.

Spina Bifida provokes the same medical disorders as spinal injury, but the associated problems of hydrocephalus causing varying degrees of mental handicap or neurological dysfunction make the condition different in practise. Some young people have a good understanding of their condition and past history, but this is not necessarily so, neither is the degree of understanding associated with intelligence. Some young people have relied on their parents, and have not taken over responsibility for themselves adequately. This problem of passivity is well known in adolescents with spina bifida, and the efforts of ASBAH to provide residential Independence Courses and weekends for young people are bearing fruit. Many young people are isolated from their peers and depressed by their lack of occupation.

Mobility

The majority of young people with paraplegia were wheelchair bound. Only 13 out of 34 in Year 1 (16 in Year 2) were ambulant; 16 out of 34 were ambulant some of the time. Although the degree of walking ability usually correlated with the level of the spinal lesion, there were some outstanding exceptions. Two young men and one young woman wearing KAFO'S with thoracic and pelvic support were ambulant with crutches. Most of the young people opt for wheelchair mobility because of the effort of walking with high orthoses and the associated problems of access, and the need to carry books and equipment on College. Among the girls in this group obesity was another cause for loss of ambulation.

Wheelchairs are often in need of attention, and wheelchair cushions are a source of pressure ulceration in some cases. A surprising number of clients were referred for orthotic help, some need repeat equipment, whilst others are interested in obtaining new polypropylene equipment. Most do not require orthopaedic referral, and the orthoses can be prescribed without involving the Orthopaedic surgeon. However, funding of the orthoses then becomes a problem. The main problem encountered was the lack of good fitting fashion footwear, and the lack of awareness of the need for warm footwear in winter because of poor circulation.

Pressure Ulcers

A major problem for wheelchair bound young people is the development of pressure ulcers. Although these can and do develop in children, supervision by therapists and parents whilst at school probably prevents their enlargement. In the first year of the Clinic, 14 out of 49 in the 16-25 age group had ulcers present at consultation. A further 13 had required plastic surgery for recurrent severe ulceration, and several had spent long periods in hospital for surgery and aftercare of the ulcers. This had been a cause for breakdown of a residential employment placement in one girl, with resultant severe depression. Correct cushions for the clients with severe deformities would often have avoided ulceration, but ulcers were also caused by trauma and heat. One severe case was the result of poor post-operative nursing care, and lack of understanding of anaesthetic skin. In some cases the progression of severe spinal deformity altered areas of pressure, and in this group it was felt that ulceration could have been avoided if pressure studies had been taken and the correct cushions prescribed.

Poor circulation in the legs is the cause of skin breakdown and ulceration in the feet, especially of heels, toes and malleoli. Sympathectomy may be indicated to try to improve circulation. Below knee amputation had been necessary in two older clients following intractable ulceration. The use of below knee plasters made of lightweight material, well padded and with a non-adherent dressing over the ulcer promotes healing. The plaster is left for at least a week before changing, and needs to be continued until the ulcer is well healed with a good skin cover. After removal of the plaster it is of course vital to ensure that the cause of the ulceration is removed or dealt with.

Urological Problems

The major problem in the largest number of clients, was lack of adequate urological follow-up. One third of the total were referred or re-referred for a urological opinion. In some cases the client had not been seen since discharge from Chailey Heritage. In quite a few more they had been seen on one occasion and discharged from follow-up with expectation of re-referral if there were problems. Neither the person or their G.P. seemed to appreciate the importance of regular surveillance, and serious problems had developed in some cases with hypertension, the appearance of staghorn calculi, and marked loss of renal function.

Some clients requested referral to a specialist Urological Centre with the hope of success from newer methods of management of incontinence. Insertion of an artificial sphincter is now possible. Careful investigation precedes the decision to insert a sphincter. It may be necessary to enlarge the bladder by using a patch of colon before the device is inserted. Surgery is major, and it takes weeks or months to adjust to the device afterwards. One young woman suffered psychiatric disturbance following the surgery, needing to adjust to being dry after years of incontinence. It is clear that adequate counselling and support for these young people is necessary if the surgery is to be a complete success.

Renal damage and progressive renal failure is a cause for concern for any person with a neurogenic bladder. In the first year of the Clinic one young person died from renal failure. Two others are just maintained on drugs and constant supervision from a Renal unit. A renal transplant has recently been carried out on a young man in renal failure. Decisions about renal dialysis and transplantation will have to be made in an increasing number of cases. The problem of what is medically possible and what is right for the individual is again rearing its head in the management of this complex condition.

Neurosurgical Problems

The ability to treat hydrocephalus was one of the reasons for the increased survival of people with spina bifida. The natural history of hydrocephalus in this condition is not however as simple as was once thought. Many people have had only 1 or 2 valves inserted for hydrocephalus, but the majority of these were ventriculo-atrial shunts. Some have been told that they are no longer using their valves. Our experience shows however that a number of these people have developed increasing hydrocephalus, and may present with problems many years after their last valve revision. In this age group most of the clients have not had a CT scan of their brain, and it has been possible to carry out a scan as a baseline on any new referral. In the last year 4 young people have required revisions of their valve systems; 3 required several operations as the valves and catheters are made of plastic materials it is not surprising that they may require renewing 20 years after insertion.

One young woman died from a massive pulmonary embolus associated with her ventricular-atrial catheter following very misleading and non-specific symptoms. The presence of a catheter in the circulation is a focus of infection and thrombus formation. The non-specific symptoms of an infected shunt can be very difficult to diagnose, and result in anaemia, bacterial endocarditis and nephritis.

Social and Emotional Problems

The young people attending the Clinic are of varied background and intellectual ability. Amongst the severely physically handicapped there is considerable isolation and frustration. The efforts of the SASBAH field workers have been of major importance in maintaining links with the families and in providing stimulation for change. The Association has just bought and converted a house in Worthing to provide bed-sitters for young people with spina bifida. The idea of the house is to provide independent, yet sheltered living for some severely handicapped youngsters.

The knowledge of the family background and continuity provided by the SASBAH field workers has been particularly important, since patterns of social work have changed over the last few years, and very few families are considered to need continued social work intervention. The field workers have also recognised the need for continued medical supervision, and have tried to educate the young people to be more self reliant. They have also had to educate some of their clients doctors tactfully in trying to obtain proper continuity of care.

Severe depression requiring treatment has been evident in 5 young women during the 2 years pilot scheme. Several young people who had urological surgery for artificial sphincter insertion experienced problems for several months post operatively.

Conclusion

It is clear that the young people and their families appreciate the Clinic. After many years of paediatric supervision they have often felt abandoned and concerned about whom to consult in times of anxiety, particularly with regard to valve problems and urology. Many family doctors too, have referred to the Clinic for advice, and I must reiterate that it is only acting in an advisory capacity. The day to day care must and should remain with the General

Practitioner. Clinics of this sort have been set up around the country - notably in Newcastle, Sheffield and Bristol. The need for such clinics, I believe has been clearly shown, and could be enlarged to include other young people with physical disabilities.

A recent report. Thomas et al, puts forward the view that multidisciplinary District based handicapped-adult teams should be set up with resource to all health services, and links with the Education and Social Service departments of Local Authorities.

A report from the Royal College of Physicians "Physical Disability in 1986 and Beyond" recommends a similar approach, with a written policy on the subject of the physically disabled school leaver for every Health District. The recommendation includes the assessment of each child during the year before leaving school. It also points out the need for an accurate register of disabled school leavers in each Health District in order to plan for their future needs. It recognises that disabled people aged 15-65 are not well provided for, and the report identifies this group as presenting a particular problem.

References

1. "The Health and Social Needs of Physically Handicapped Young Adults: Are they being met by the Statutory Services?" Andrew Thomas, Martin Bax, Kay Coombes, Edward Goldsen, Dianne Smythe and Kingsley Whitmore.
Spastics International Medical Publication.

2. "Physical Disability in 1986 and Beyond". A report of the Royal College of Physicians. Journal of the Royal College of Physicians of London, Vol. 20; No. 3. July 1986.

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Video on Recreation

Countryside Recreation for Disabled People is a video for those involved in the provision of recreation services, showing how to make the countryside accessible to people with disabilities. It costs £35 (plus VAT). Further information is available from Capel Manor Open Learning Unit, Bullmoor Lane, Waltham Cross, Hertfordshire, RN7 5HR. Tel: 0992 763849.

HELP NEEDED

A special message from Philippa Harpin:

"At NAIDEX I spoke to the manufacturers of urinals and explained how difficult it was for boys and men with muscular dystrophy, who can't move to the edge of their wheelchair, to use a conventional urinal. They hadn't heard of this problem before so if any of you experience difficulties, please write and tell me. I can then arm myself with evidence and encourage them to design something more suitable. Of course, your comments will be treated confidentially. I won't reveal your name unless you want me to".

Philippa Harpin, National Occupational Therapy Adviser, Muscular Dystrophy Group, Nattrass House, 35 Macaulay Road, London, SW4 OQP. Tel: 01-720-8055.

PAULA'S STORY

By Paula Gorman - assisted by her Tutor Miss Janet Harris

⋆Paula Gorman has to spend most of her life in an electric wheelchair. Yet despite her difficulties, she still attends a Sixth Form College like many able-bodied teenagers of her age. Life as a handicapped student certainly has its ups and downs, as she reveals here in this special article, which we are reprinting by courtesy of Image⋆

I first started at Arden College in September 1984, and at that time there were only four handicapped students in all. (There are more now). But the first day I started I was very scared because I did not know what was going to happen. It was my very first time having lessons with able-bodied students. At first the able-bodied students didn't really take to us because I think that they were afraid to say anything in case they would say the wrong thing to upset us. But once they got to know us and got used to us, they began to treat us just like able-bodied friends.

For the first few months when you would be coming up to a door, an able-bodied student was opening it, and without knowing that we were behind, they would let the door close behind them. But now they have got used to us because they will wait to open the doors for us.

On the 18th February 1986 I was coming down from Office Practice when the lift wouldn't work properly. It wouldn't stop at any of the floors, so my friends had to go all the way down to the ground floor to bring it up to the third floor, so that I could get down to the ground floor. When I did get down my taxi had been waiting for twenty minutes. But before I got into the taxi I had to go to the toilet. When I came out of the toilet the taxi driver told me off for being late and said "This is a four o'clock booking not a twenty past booking". So I said "I'm sorry about being late but the lift wouldn't work and I couldn't get down.

When I got out to the taxi, Leslie was just about to put me in the front seat when the taxi driver said "Put her in the back". Leslie the Care Assistant, said to him "she has to sit in the front seat with the seat belt on, because she has no balance in the back of the car". But he just said "In the back"! when we got near our house I told him to turn left at the shops but he completely ignored me, and then when he passed it I said "You have missed the turning". And when I said that he looked at me as if to say 'why didn't you tell me?' So when we got to my house my Dad got me out of the taxi, and when we got into the house he said "What were you sitting in the back seat for"? So I told my Dad everything about the lift being broken and about me coming down late. He phoned the Radio Cabs and told them everything that I told him. He wasn't nasty about it. He was nice to the woman on the other end of the line and she was very nice back. She said "I will look into this for you".

About half an hour later the phone rang and it was the taxi firm saying that the taxi driver who brought me home had gone off duty and they would have a word with him in the morning. All the taxi drivers who have brought me home or brought me to College are very nice to me, but he was angry with me for being late, and I hope I won't have him again!

One Tuesday morning I went up to typing, and when the lesson was over I went to the lift to get down to my next lesson, but when I got to the lift it was broken. So I went back to tell the typing teacher that the lift had broken down and I stayed in the classroom until the lift men had fixed the lift. Because the lift had broken down I missed my second lesson which was a tutorial. In the afternoon at three o'clock I had Office Practice, so at five to three I set off to go to the lift hoping that it would work, because I love Office Practice. I was waiting at the lift about three minutes and finally it came.

I got into the lift and this boy said "Which floor would you like?" and I said "the fifth floor please". So he pressed the fifth floor for me. When the lift doors closed the lift started to go up, but as it went up some boys tried to open the doors, and then the lift gave an almightly bang and stopped.

I was very frightened. I thought I would never get out of the lift and when I did finally get out, I found out that I was on the wrong floor. So I had to call the lift again and whilst I was waiting for the lift I could hear it banging, and the people that were in the lift were being silly screaming and shouting. When the lift finally came I was very angry because I was very late for my lesson. I got inside and the same boys were in it. So I said "Can I go to the fifth floor"? They sent the lift up to the fifth floor and I finally reached my lesson at ten past three.

When I went into the classroom I told my teacher what had happened and she was very shocked to think that people would do that to me when I was in the lift on my own. The teacher said that I was not allowed to go in the lift on my own again. So from that day I have not been in the lift on my own.

☆☆☆☆☆☆☆☆☆☆☆

Prior to going to Arden College Paula attended the Lancasterian School which she tells us about in the following account . . . .

SPECIAL SCHOOL COMPARED TO ARDEN

Originally I went to a Special School for the handicapped called the Lancasterian. I first started the Lancasterian School when I was just two years and nine months old, and I can remember my Mum and Dad bringing me in our car. There was snow on the ground. I had a little fur coat on and a hat and a very tiny pair of mittens which my Mum had made me. I can remember crying for my Mum, but after a bit I was sitting on the teachers knee laughing, and later on I was crawling on my hands and knees getting into mischief.

As years passed I went up class by class and I started to work a little bit harder as I grew older. Some of the teachers began to take an interest in me because they could see that I wanted to learn, and they began to give me harder work. The lessons were short and there were always interruptions so that you could never get a full hours work.

As I grew older, the time came when I had to take exams. Really they didn't think I was able to take exams but as I worked really hard at night the English teacher put me in for it at the very last minute, and to tell you the truth I think I shocked everyone of my teachers, as I got a CSE grade four.

The time finally came when I had to leave Lancasterian School and go to Arden Sixth Form College. Here there are no interruptions and the lessons are a lot longer. Apart from the differences in hours of lessons you have a lot more freedom at Arden. You can do what you want - you can go to the shops on your own without telling anyone. You couldn't go to the toilet without someone coming with you at the Lancasterian. I did three exams at Arden last year which took all my family's and my time to believe.

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Coach for Hire

Sandwell Borough Council has a 38-seater coach for hire (with driver) which can take some people in wheelchairs. It has full toilet facilities for disabled people, air conditioning, a refreshment bar, video equipment and a loop system. For further details contact Mr. L. Lopes, Sandwell Metropolitan Borough Council, Department of Social Services, 12 Lombard Street, West Bromwich, Sandwell, West Midlands. B70 8RT. Tel. 021 - 525 - 5899.

PHYSIOTHERAPY IN THE U. S. A.

Mrs. J. K. Williams, Snr., Paediatric Physiotherapist Wythenshawe Hospital

I was fortunate enough this year to be able to spend two weeks looking round various physical therapy establishments in and around Boston, Massachusetts. For several months I had corresponded with a therapist who lived near Boston and between us we had managed to put together an itinerary which hopefully would cover most aspects of paediatric therapy. Boston is world known for medical facilities par excellence and indeed it proved to be so.

My first visit was to the Valley Child Development Centre in Milford, a small town an hour's drive west of Boston. This unit ran an Early Intervention Programme for children from birth to 3 years of age. 'Clients' were referred by various sources including parents, paediatricians or nurse co-ordinators in neonatal units. The whole programme was financed by the state of Massachusetts therefore the parents did not pay for any of the services. Other similar programmes were being run throughout the state. The Programme Co-ordinator headed a team of educators, occupational and physical therapists, social workers, speech therapists and nurses. A case manager was selected for each client, usually it being the professional whose skills were needed the most for that particular case. Initially the parents were given an excellent questionnaire to complete. This made me realise how much more information could be obtained before treatment commenced especially when the parents had time on their own at home to think about and answer the questions. Parents were also able to accumulate their own "documentation" about their child as copies of assessments and similar reports were given to them. If for any reason there was a change of therapists the parents had an excellent record of therapy to date. The whole team met once every two weeks and I was able to sit in on one of these meetings. Periodic assessments were carried out in an interesting way. The case manager treated the child while the other disciplines watched. The team then discussed the case and a report was given to the parents. Videos were also made and if parents provided a tape therapy sessions were filmed so they could watch these at home. The extended family liked seeing these films hence encouraging more family involvement. Home visits were also integrated into the programme. In the Centre group activities were arranged and transport was provided. Because of the large catchment areas much travelling was involved for some quite small children but travelling great distances is a part of life in the States. I was amazed at the distance some therapists travelled to work not just in this unit but in other places I visited.

The next place I visited was the North Shore Children's Hospital in Salem a town north of Boston where in the 17th century a doctor diagnosed several girls as being victims of witchcraft! More than 200 hundred people were eventually accused of witchcraft. 150 people were imprisoned and 19 people were hanged before the hysteria came to an end a year later. I found no evidence of witchcraft today but instead some excellent medical facilities. The hospital was a 56 bedded unit attached to a general hospital. Respiratory therapists provided treatment on the wards for chest conditions. There was a large multidisciplinary out patient department and children attended there for 2 or 3 day evaluation sessions at a cost of 1500 dollars (or at the present rate of exchange £1000).

A certain percentage of this would be picked up by the insurance company but parents would possibly have to pay some of it themselves. I visited here with a therapist from the CDU I had previously been to and we were able to watch part of an evaluation being done through a floor to ceiling observation window, complete with sound system. The whole place resembled a delux hotel rather than a physiotherapy department. The senior physiotherapist said they were short staffed despite the superb working conditions.

A subsidiary of this hospital is the Center for Applied Special Technology (CAST) where we were able to visit an Adaptive Equipment Clinic. This facility in a building straight out of the Dynasty set provides for the disabled of all ages and offers specialised services in mobility, communication, seating and positioning, computer access other than a keyboard, leisure time activities and feeding. The adaptations to chairs, equipment, etc. were every therapists (and every technical officers) dream. Very advanced computer technology was being used especially for clients with little or no speech. The results were amazing.

Before setting off on the second week of visits I had a weekend break in Newport, Rhode Island, a resort once devoted exclusively to the very wealthy and now the sailing capital of the world. Fever was already spreading for next year's race to regain the America Cup. I still felt it was the home of the wealthy!

The next group of therapists whom I inundated with questions was at the famous Children's Hospital in Boston. This 340 bedded unit is the largest children's hospital in the USA. Patients come from all over the world especially for complex cardiothoracic surgery, hence two intensive care units with 20 beds in each. All the six floors gave the feeling of 'high tech' medicine. It was efficient, well organised paediatrics with much caring in evidence. No uniforms were worn so staff seemed to be identified either by a name badge or the inevitable stethoscope slung casually around their neck. I found it impossible to sort out who was who and to know visitors and parents from staff. Also the hospital cared for 'children' up to the age of 21 and even older in the case of patients with long term problems such as those with cystic fibrosis. This meant it was at times difficult even to identify patients from staff and visitors. Facilities were available for parents to sleep in and there was a Ronald McDonald home near by for families coming from a long way away with children undergoing long term treatments.

On average each therapist did 5 treatments in the morning and 5 in the afternoon which seemed to me a little on the low side compared to my own work in an acute unit. Although a thin line is drawn between respiratory and physical therapists I was pleased to see how adaptable the paediatric physiotherapists were. All aspects of physiotherapy were covered in this hospital and it certainly would be a superb place to gain good all round experience. The actual work was no different to what we do here but there was an excessive amount of paper work to be done each day mainly it seemed by the fact that each patient was 'charged' for each treatment and also the hospital accreditors had to know when a patient was treated and if not, why not. There seemed to be a multitude of forms. I felt at times the therapists approach was slightly different. Each day they arranged with the parent or with the nurse caring for the child or even sometimes with the patient, if old enough, what time would be convenient to treat the child, whereas our approach would be that the treatment time would fit in with our schedule. It appeared that sometimes it took quite a time to arrange ones day.

Americans on the whole seem to be far more knowledgeable about medical conditions and of how their bodies work. They quite naturally use the correct medical jargon and both parent and child, when old enough, will study in depth the condition that is requiring treatment. I felt this often made the situation much easier for the therapist. Perhaps one of the reasons for this is the fact that they do not have socialised medicine and have to 'shop around' for the best treatment.

After two stimulating days at the Children's Hospital I visited the Kennedy Memorial Hospital for Children in Boston. It is an affiliate of the Children's Hospital and sponsored by the Franciscan Missionaries of Mary, therefore being a non-profit making establishment. There are 100 beds for children from 0 to 21 years of age. Half the beds are devoted to rehabilitation medicine. The treatment of post brain trauma patients is a speciality. They also have a special programme for children who 'fail to thrive'. These are on the whole handicapped children who are admitted for intensive treatment of various kinds. The hospital also has a day school programme where about 80 children between the ages of 3 and 14 years with multiple handicaps receive medical treatment, physiotherapy and special education. After 14 years of age many of the children are transferred to the Massachusetts Hospital School where I was to visit the following day.

Some of the areas of the hospital had been delightfully upgraded, the remainder, still looked very institutional with tiled corridors and dark paintwork but all this was about to be modernised. The physiotherapy department was as I have never seen before. The delicate colour scheme of blues and pinks with matching carpet made it look absolutely non-clinical. There was even a television in the waiting area! It had been designed by an English lady who had studied Humanised Environments in the States. She was an expert in making the most of space and developing it for its functions and the needs of people who would be using the space. Although she now lives in Boston she frequently visits England on business. I did detect a little homesickness as she called in to the department especially to see me as she likes talking to native Brits!

The atmosphere in the department gave a feeling of quiet and calm, an ideal environment for treating the children there especially those with behaviour problems. Cognitive and behaviour rehabilitation programmes were another speciality of the hospital. The staff were so friendly and happy (no wonder working in surroundings like that) and also so enthusiastic in their approach to the children many of whom were profoundly handicapped.

There was a good inservice training series being held on brain injury and I managed to attend the last lecture entitled Team Concepts in Inter-disciplinary Thinking. It was given by a doctor working in another hospital also specialising in head trauma. The lecture was very enjoyable and put together so many home truths about interdisciplinary work.

The last of my visits was to the Massachusetts Hospital School, situated in beautiful rural surroundings about an hour's drive south of Boston near to the township of Canton. It was the last day of term and there were the usual cries of who's taking which chair home and who's leaving what at school! It is obviously the same the world over. All the same the Director of Physical Therapy was kind enough to show me round. In days gone by it had been an open-air school for the treatment of children with T. B. and other similar conditions but over the years buildings had been added and the role of the school had changed. The buildings were all linked by walkways, open in the summer and boarded over in the winter. These walkways went over the main driveways making the place look somewhat like a motorway junction but covered with much greenery and surrounded by huge trees. A large lake was included in the grounds, giving the school access to a nice beach for swimming and for water sports. There was also a nature trail along the water's edge, very adequately adapted for all wheelchairs. A small farm was also situated in the grounds, again with wheelchair access. Some prize goats were kept on the farm. Adaptations had been made to some wheelchairs to accommodate the special ring attachment required for leading and turning the goat in the show ring. Success had been the order of the day for some of the children showing these goats. The school itself was divided into elementary and high school sections just as mainstream American education is. The school had about 100 pupils, nearly all residential and more than half of which were in powered chairs, a small minority were ambulant and the rest were in manually operated chairs. At the time I was there some of the pupils were on an exchange visit in England at the Lord Mayor Trelor School and I would be interested to know what they thought of their visit to the school in America.

For any physiotherapist interested in sports for the disabled here were the perfect facilities. In addition to the large sports hall there was a bowling alley and a wonderfully equipped weight room. An olympic pool was nearby which was well adapted for entry and exit to and from the water. Also nearby was a refreshments area with tables set around. The equipment had been adapted to wheelchair height. This facility was run by the pupils. Within the school buildings was a large auditorium with only a small area of permanently fixed seating. The "rows" contained no seats and adequate wooden rims along the edges of the rows prevented any accidents as there was an incline down towards the stage. Graduations and other similar events were held here. The classrooms were large and spacious. Communication was a major speciality with voice synthesisers and other electronic equipment being used. Even severely handicapped children had picture/or word identification boards attached to their chairs. I liked the idea of photographs of their immediate family, themselves and even their pets being attached to these boards.

This brought me to the end of my visits. Everyone had been so kind, helpful and hospitable that 'thank you' became a totally inadequate word. Three weeks holiday followed so I could explore some more of the USA that I had not seen on previous visits. I was also able to join in the 100th birthday celebrations of the Statue of Liberty and the July 4th parties. New York was an exciting place that weekend, I can assure you.

The salaries and the work conditions may be tempting there. Salaries in fact vary from State to State and even from hospital to hospital within the same city but paid annual leave and sick leave is considerably less than in the U.K. I felt our jobs here were a little more secure and although a little reluctantly I returned to my job with a few new ideas and with the consolation of knowing whether you are a "P. T." or a "Physio" we think the same, do the same, have the same problems but most of all have the same aims to provide the best we can for our patients.

As part of the following article was inadvertantly omitted in our August Newsletter, we are reprinting it this month with apologies to the author.

MENTAL HANDICAP IN THE COMMUNITY
ESHTON TERRACE

Katherine Jones, Brockhall Hospital, Ribble Valley Physiotherapy Service

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 or to their homes. One child was admitted to a Dr. Barnardos Home, so exchanging one institution for another.

The committee consisted of Brockhall staff - a nurse manager, a psychologist, a social worker, the new sister of the home and an administrator. The committee had consultation with other professions, physiotherapy and occupational therapy. The committee decided upon the terms of reference for the hostel, how it was to be run who was to run it, how it should be financed and who the residents would be. On one point the committee was clear from the beginning - no amount of physical, mental or behavioural handicap would prevent a child being considered for a place at the hostel. Parents of children being considered for admission were consulted from an early stage. The venue of the hostel was to be a District Health Authority terraced house in Clitheroe. It had formerly been used as a nursing home and required the minimum of structural alterations. Having visited the property the committee decided upon alterations and equipment and furnishings, and the maximum number of six residents. Recruitment of staff was under way, qualified staff from Brockhall itself, and unqualified staff through local channels. Nurses were appointed as home leaders and care assistants supplemented the staff.

All staff were to act in loco parentis, even though it was estimated that 13 staff were required for the home. At interview applicants were considered for their extrovert qualities, their honesty, humour and inititiative. Maturity was considered important and some attempt was made to recruit men. It was made clear at interview that all staff would run the home as well as care for the children - cooking, washing, cleaning, shopping and all household chores would be the joint responsibility of all the staff.

The hostel finally opened in June, 1983. The six residents varied in age from 9 to 15. As well as all suffering to a varying extent from mental handicap there is a microcephalic, a spina bifida, a Smith-Lemli-Opitz Syndrome and behavioural problems.

The hostel is run as much like a family home as possible. From the outset parents were welcome to visit freely at the hostel with no time or other restrictions. The staff members work from 7 a.m. - 2.30 p.m. or 2.00 p.m. - 9.30 p.m. One member of staff sleeps overnight at the hostel on a rota basis. The senior and junior home leaders work 9 a.m. - 5 p.m. with one day in every 10 from 2.00 p.m. - 9 p.m. The home leaders also work one weekend in six. The hostel is a 'satellite' of Brockhall Hospital and the children have never been discharged from the hospital. The finances are supplied too through Brockhall, who also pay the rates, building repairs and supply the gardening care. All members of staff have access to the weekly housekeeping money, and children accompany staff on shopping expeditions for groceries, cleaning materials and everyday requisites. Members of staff are linked with individual children to become that child's 'key worker'. The key workers have a special responsibility for their own children and write a summary daily on behaviour, social involvement and any problems. The key workers monitor teaching programmes on toileting, feeding or play. Staff take the children out for a day, a night at home, and accompany them on holiday. Frequently staff take one or more children out when they are off duty.

The children all attend Brockhall Special School, at present, and they are bussed into school daily during term time. At the age of nineteen they will be transferred to an Adult Training Centre. These institutions are run by the Social Services.

The childrens day to day health is looked after by a local G. P. and all the residents share the same doctor. Members of staff in charge take the responsibility to call in the doctor or make an appointment to take the child to the surgery in the same way as parents do in a family setting.

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 in spite 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 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 committment 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.

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POST REGISTRATION EDUCATION

ADOLESCENCE : THOUGHT FROM 1986 C. S. P. CONGRESS

P. M. Eckersley, Advisor, Post Registration Education, A. P. C. P.

During the 1986 CSP Congress a morning was devoted to the presentation of scientific papers. Angie Titchen (Education Advisor, C. S. P.) presented a Study of Continuing Education in which she discussed her findings on the attitudes of physiotherapists towards their own post-qualification education. One of the many aspects included was that of self-directed and self initiated study.

It is perhaps in the approach to working with the adolescent that the most determination is required. It can be a highly motivating, enjoyable and provoking aspect of physiotherapy but perhaps does not always have the same "following" as working with babies and younger children. Information and courses dealing with the physiotherapists role are more thinly spread and there may be a danger that we see adolescence purely as a continuation of infancy which fills the gap before leaving school. The older child - or - the young adult.

Burns (1) defines adolescence as a 'form of modern day apprenticeship' and states that as a society advances there is a "prolongation of the non adult status". It is a period in which to practice social and economic skills for the future. It is also a time when the dependence/independence self value/peer value/adult value conflicts are sorted out.

Ilkind (2) discusses the personal fable that many teenagers develop the "it won't happen to me" syndrome which could lead to denial of a chronic illness. He also introduces the types of manipulation behaviour which can affect interactions. Teenagers come to realise that information can be given purely to benefit the information giver. This may lead to a "You're only saying that to get me to do my exercises" type of approach.

These aspects and more, are all part of normal adolescent behaviour but can play a crucial part in the work of the physiotherapist and need to be part of our understanding. Much of the above information, attitudes and aspects of curriculum can only be gleaned through self directed study and discussion. But the rewards are considerable and can open up new horizon in physiotherapy.

The two authors above are given as a beginning:—

1) Burns Robert B. Child Development
Croom Helm 1986 Chapter 11.

2) Elkind D. Cognitive Development and Adolescent Disabilities.
Journal Adolescent Health Care 1985 : 6 : 84 - 89.

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GRANTS TO GROUPS

The Prince of Wales' Advisory Group on Disability is seeking applications for grants of up to £200 using money raised by the Sunday Times Fun Run. Those most likely to benefit will be local groups including people with mobility/ communication disabilities, those not receiving regular funding and those who encourage activities, particularly swimming. (Grants will not be given towards large capital projects such as buildings or minibuses). For an application form send an SAE to The Prince of Wales' Advisory Group on Disability, (Depart STFR), 8 Bedford Row, London, WC1R 4BA. Tel. 01 - 430 - 0558.

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ABSTRACTS

A.

Child Health Services in the Community-making them work.

Author - Adrian MacFarlane, Consultant Community Paediatrician, Radcliffe Infirmary, Oxford. B. M. J. Vol. 293 July 26 1986.

Britain's community health services are in confusion - a survey in 1983 revealed each of the 192 health service districts ran its independant child health surveillance programme, there being three main reasons for this, historical, administration by a wide variety of professionals coming from different backgrounds and because little research has been done on which to base programmes.

These varying practices lead to confusion amongst parents moving from one Health District to another - differing advice being given, especially with respect to immunisation schedules and hearing tests. Community Child health services include clinical work, teaching, a small amount of research and much administration - the two main clinical elements are child health surveillance and the management/treatment of children with special needs.

There are now clear national guidelines for immunisation policies as there have been studies recently funded, but in other screening procedures there needs to be increased research, it being more costly not to do it - than to do it in the long run. It is felt parents should be listened to more carefully with their comments about their child's hearing and vision which greatly help to identify the sproblem.

With regard to the management/treatment of children with special needs, it is essential for parents to be able to understand their children's problems and to be able to communicate their needs to the many professionals now involved - it is felt this should be the role of the medical services to make sure the parents of these children fully understand the problems and to be able to transfer their knowledge.

The 1981 Education Act, by moving children into mainstream schools has much increased the time spent on travelling by those offering therapeutic support, increased the number of professionals with whom the medical services have to deal and increased need for specialised equipment, all on many different sites. None of these factors have been allowed for in government financing. In many districts this has led to gross underfunding, leading to bitter battles between colleagues who used to work amicably together. If we are to run an efficient service, information systems are needed in order to identify problems, trends etc. and also to record the services required by children with special needs, and those actually provided. Therefore the shortfall can be accurately recorded and advertised. Without such developments the most vulnerable section of our population will inevitably suffer.

B.

Clumsy Children - a review of recent research

Authors - Charles Hulme, Richard Lord, Dept. of Psychology, University of York. Taken from Child - Care, Health and Development., Vol. 12, No. 4 July/ August 1986.

Clumsy children are those who have severe problems in developing adequate skills of movement in the absence of general sensory and intellectual impairments and without showing signs of overt neurological damage.

A number of studies of clumsy children are reviewed in the article, a number of points emerging from them. As the recognition of problems increase, more children will be referred. There is no absolute definition of clumsiness, these children represent a low scoring group for whom the mastery of motor skills is sufficiently retarded to warrant concern.

Comparatively little experimental work has been designed to clarify the causes of childrens motor problems in functional terms. Studies, so far, have concentrated on perceptual problems. There is no evidence they have visual/ spatial impairment but it has not been established these are linked with motor deficits. There is a suggestion kinaesthetic impairments are common in these children. At present little is known, it will become important to over come the difficulties in demonstrating these causes.

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LOOKING FOR A JOB?

Central Birmingham Health Authority, Childrens Hospital

State Registered Physiotherapists who wish to learn more about physiotherapy in paediatrics are welcome to apply for the posts which have just become available.

This teaching hospital has about 200 beds which are used for regional specialities and generalised paediatric work. The Physiotherapy Department provides a service to both in-patients and out-patients with a strong link with the Community service, which can be a rotational placement. The work includes cardio/thoracic surgery, neurology/neurosurgery, rheumatology, orthopaedics and medical conditions. There is a very active Child Development Centre where the physiotherapists are closely involved in the assessment, management and treatment of children with all types of developmental problem.

Informal visits are welcomed and can be arranged by contacting: Miss V. Naylor, Superintendant Physiotherapist, Childrens Hospital, Ladywood Middleway, Birmingham B16 8ET. Telephone 021 454 4851.

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NEW HIGH CHAIR

A new high chair for handicapped children has been produced by Jenx Ltd., thought to be the only specialist high chair available.

Standard features include high sided seats, the height, depth and angle of which are independently adjustable. Separate adjustable foot rest, flat base for extra stability, detachable cut out tray with rim, adjustable harness, cushions in flame retardent materials.

For brochure and further information: Mr. Clive Jenkins, Jenx Ltd., 74, Hoyland Road, Sheffield S3 8AB. Tel: (0742) 756312.

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FORTHCOMING COURSES

November 10th

Orthopaedic Footwear.
Applications to:— Professor J. Hughes, Director, National Centre for Training and Education in Prosthetics and Orthotics, University of Strathclyde, Curran Building, 131 St. James Road, Glasgow G4 OLS.
Price: £80 — NHS Staff FREE.

November 10-12

Introductory Bobath.
Details:— Mrs. J. Peake, Secretary Exeter Demonstration Centre, Royal Devon and Exeter Hospital, Exeter Devon. EX1 2ED.
Price: £30.

November 13th

Cerebral Palsy in Children.
Half day p.m.
Details:— The Secretary, Pinderfields National Demonstration Centre, Pinderfields General Hospital, Wakefield, WF1 4DG. Tel: 0924 375217, extension 2510.
Price: £6.50.

November 15th

Cerebral Palsy.
Details:— Mrs. C. Ireland, Supt. Paediatric Physiotherapist, Southampton General Hospital, Tremona Road, Southampton S09 4XY.
Price: £10 APCP members, £15 non-members.

November 17th

Care of the Handicapped Child.
Details:— Miss Laura Roach, Demonstration Centre, Rookwood Hospital, Llandaff, Cardiff CF5 2YN. Tel: 0222 566281, extension 66.
Price: £15.

November 20th

Feeding and Swallowing Problems in the Adult and Child.
Details:— Mrs. B. Hindley, Higher Clerical Officer, Rehabilitation Unit, Withington Hospital, Nell Lane, Manchester M20 8LR. Tel: 061 447 3409.
Price: on application.

December 8th

Spasticity.
Details:— Miss L. Roach, Demonstration Centre, Rookwood Hospital, Llandaff, Cardiff, CF5 2YN. Tel: 0222 566281.
Price: £15.

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APCP CONFERENCE PROGRAMME 1987

The Management of the Neurologically Handicapped Child.

April 23rd - 25th 1987.

College of Ripon and York, St. John, Lord Mayors Walk, York.

Thursday April 23rd

12.30 Lunch
2.00 Opening of Conference
A revision of the Neurology and Aetiology of Cerebral Palsy.
Dr. I. A. McKinlay, Consultant Paediatric Neurologist, Booth Hall Childrens Hospital, Manchester.
3.00 Tea.
3.30 The work of the British Institute for Brain Injured Children.
Speaker to be confirmed.
4.30 Questions.
5.00 Finish.

Evening Optional visit to the Jorvik Centre Viking Museum.

Friday April 24th

9.30 The Bobath Concept.
Mrs. J. Bryce. Principal of the Bobath Centre.
10.15 The Use of Computers with the Profoundly Handicapped Child.
Miss R. Hirst, Deputy Head, Galtres School, York.
11.00 Coffee.
11.30 The Principles of Conductive Education.
Mrs. E. Cotton
12.00 Discussion for Members only.
12.30 Buffet Lunch.
2.00 Group Sessions - first choice.
a) The use of the hand in the treatment and education of the Cerebral palsied child. Mrs. Esther Cotton.
b) Bobath physiotherapy demonstration. Mrs. J. Bryce.
c) Eating problems and speech therapy. April Winstock.
Speech Therapist for the Bobath Centre.
d) Serial plastering of the foot for cerebral palsy. Mrs. M. Jones.
e) Sensory stimulation with the profoundly handicapped. Miss R. Hirst
3.15 Tea and Trade Exhibition.
4.15 Group Sessions second choice (as above).
5.30 Finish.
7.30 Conference Dinner.

Saturday April 25th

9.15 Vision — its effect on motor development.
Mrs. W. Harrison, Senior Orthoptist, York District Hospital.
10.00 The Portage Home Teaching System.
Speaker to be confirmed.
11.00 Coffee.
11.30 Discussion meeting for APCP members only. Videos will be shown for non-members and the Trade Exhibition will be open.
12.30 Lunch.
1.30 The Biomechanical aspects of cerebral palsy.
Dr. H. Meadows, Dep. Director, Princess Margaret Rose, Orthopaedic Hospital, Edinburgh.
Questions.
Close of Conference.
3.00 Tea.

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Application forms are available from:—
Mrs. C. Jackson, 4 Abbotsway, York, Y03 9LB.

NEW PUBLICATIONS

Disabled Child.
5th Edition. 1986 A4 112p Fully Illustrated at £3.95 + 85p. p. & p. (UK only) £8.50 + £1.25. p. & p. (Overseas). From: Equipment for the Disabled (Dept. EU), Mary Marlborough Lodge, Nuffield Orthopaedic Centre, Headington, Oxford, OX3 7LD.

The following reports are available from: The Handicapped Persons Research Unit, Newcastle-Upon-Tyne Polytechnic, 1 Coach Lane, Newcastle-upon-Tyne, NE7 7TW.

- **The Concerned Technology Catalogue.**
  Electronic Aids for those with Special Needs.
  Consisting of over a hundred illustrated descriptions of items of hardware, plus a directory of nearly three hundred descriptions of wide ranging software. 125 pages, illustrated. £4.00 inc. p. & p.
- **The Use of Microelectronics in the Education of ESN (S) Children.**
  Jim Sandhu.
  In response to the increasing interest of the use of microelectronics, it highlights some of the problems and suggests possible solutions. Includes a comprehensive list of contacts and sources of information.
  98 pages, illustrated. £4.00 inc. p. & p.

- **Playaids Catalogue.**
  In this the ideas range from variations on existing playaids, radically innovative ideas to unique designs made from throwaway materials.
  67 pages, illustrated. £3.00 inc. p. & p.
- **Research into the Clothing Needs of Mentally and Physically Handicapped Children and Development of appropriate designs.**
  Frances Colman.
  Contains detailed descriptions of design requirements, anthropometrics, Clothing Technology, Research Methodology, design development and evaluation and examples of practical clothes for handicapped children.
  200 pages, illustrated. £6.00 inc. p. & p.
- **The Education of Children with Severe Learning Difficulties. Bridging the gap between theory and Practice.**
  Edited by Judith Coupe and Jill Porter.
  Croom Helm 1986 £9.95.
  This book, planned and edited by teachers, nevertheless has contributions from many other disciplines, reflecting the need of an indepth understanding of the needs and problems presented by these children in the classroom. Divided into three sections on Curriculum Method and Organisation, Factors Influencing Learning and Development, and The People Involved, there is a wealth of information provided which should make it a must for anyone working in Special Education. For paediatric physiotherapists the Chapter by Ann Grimley, our past Chairman will be of special interest, as it details the role of the remedial therapist.

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APOLOGIES

It is regretted that in the August Newsletter the address given to obtain the poster 'Play Helps Children in Hospital' was in error, — it should have read:

The National Association of Hospital Play Staffs,
Thomas Coram Foundation for Children,
40 Brunswick Square,
London, WC1N 1AZ.

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DO YOU KNOW THAT:—

☆ A research project by the Spastics Society shows that employers do discriminate against disabled job applicants? Not very encouraging for disabled youngsters looking for employment.

☆ The Jubilee Trust's 3-masted barque The Lord Nelson, has been specially designed to be crewed by physically disabled people in conjunction with able bodied people, and has tracking and lifts for wheelchairs.

☆ The South Western region has developed a computer data system enabling comprehensive recording of child health data.

☆ A short term respite care facility for mentally handicapped children has been set up in St. George's Hospital, London at a cost of £2,500 which was donated by local and national charities.

☆ A new company who make traditional wooden toys, also make a particularly nice made to measure tricycle in pine with a red painted seat, cost about £30. Specialist toys for handicapped children also designed and made to order. There is an upholstered pine chair £28 and a push along trolley £25. For further information contact : Noel Garnham, 3 Crown Road, Kenfig Hill, Mid Glamorgan. Tel. 0656 743150.

A report in the Lancet claims that smoking by fathers during their partners pregnancy can reduce a baby's birthweight. A Danish study revealed that birthweight was reduced by 120g per pack of cigarettes smoked per day by the father.

☆ Papworths youngest heart and lung transplant - the fourteenth double transplant to be carried out at the hospital - is recovering well. The six year old who is the youngest ever heart transplant patient returned to school this term, after surgery four months ago.

☆ The Cell Barnes chair is no longer in manufacture and stocks at regional ALACS are either very low or totally exhausted.

☆ The Scott RDA group is based within a residential Further Education Unit for severely mentally handicapped teenagers between 16-22. An activity for adolescents much appreciated.

☆ A London firm Sid Patey (London) Ltd., Amelia Street, London SE17 recently made a special riding hat for a girl with hydrocephalus - cost £100 inc. VAT but well worth it for the comfort provided, not to mention safety and good looks.

☆ Mesh bags for Zimmer frames can be obtained from Homecraft Ltd., 27 Trinity Road, London, SW17 7SF Price £1.98. Also from Homecraft SOESI elasticated shoe laces to convert lace up shoes into casuals. Easier to take on and off

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EQUIPMENT

Warm and Wet

One thing that puts many people - disabled and otherwise - off learning to swim is the cold; now there's a buoyancy aid which keeps you afloat and warm at the same time. And the Bubble Jacket enables disabled swimmers to relax in the water without having to struggle to stay afloat. £6.99 for child (size up to 34" chest); £9.99 for adult size (up to 44" chest), plus 51p p & p from Airlines Innovation Ltd., Unit C1, Northover, Glastonbury, Somerset, BA6 9XA. State chest and hip size and whether average or long body length.

Letter Box

Designed to help not just with writing, but with dexterity in general, this 'Visuo-motor scanning kit' has a stylus which is traced around the letters and patterns on the etched plates; go wrong and a buzzer sounds. Includes 14 different exercise plates, from the alphabet to more abstract shapes and patterns. £109.25 including p & p from Toys for the Handicapped, 76 Barracks Road, Sandy Lane Industrial Estate, Stourport-on-Severn, Worcs. DY13 9QB. Tel: Stourport 78820.

Dry Measures

The Night-Trainer bed-wetting alarm incorporates a tiny moisture-sensitive plate (worn with absorbent disposable pad) connected to an alarm, which sounds a loud buzzer to wake you up before it is too late. Eventually, the alarm should train the brain to control the bladder during sleep. £33.55 including p & p, absorbent pads and batteries from Nottingham Rehab Ltd., 17 Ludlow Hill Road, West Bridgford, Nottingham, NG2 6HD. Tel: Nottingham 235190.

Phone Rest

British Telecom have developed a new phone rest which fits comfortably between your ear and shoulder - so you don't need to use your hands.

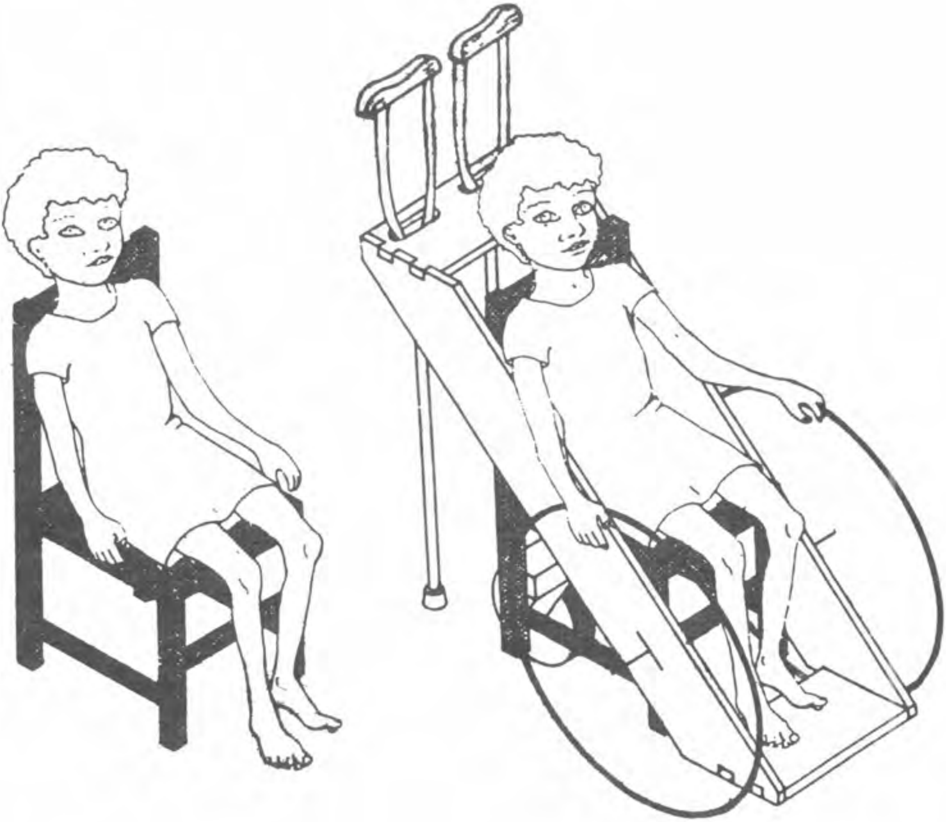
New Travel Seat

Market Ability have developed the New Travel Seat which not only swings round but swings right out!

Ahrtag

AHRTAG (Appropriate Health Resources and Technologies Action Group) was set up in 1976 to promote low cost measures which could be used in primary health care programmes in developing countries.

How to turn a wooden chair into a wheelchair (below) - an illustration from AHRTAG's Personal Transport for Disabled People.

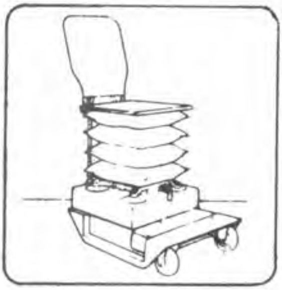


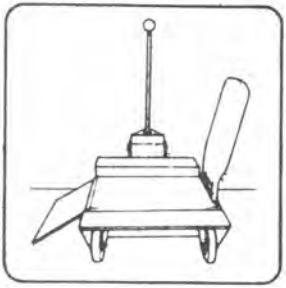
Polo - A New Fun Trike

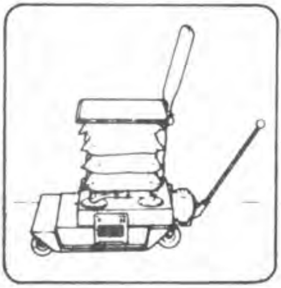
A new fun trike for the 8 - 14 year old. Stability is ensured and handling is simple. The saddle and handlebars have a wide range of adjustment. From: W. R. Pashley Limited, Masons Road, Stratford-upon-Avon, Warwickshire, CV37 9NL. Tel: 0789 292263.

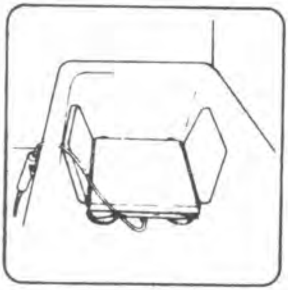
Mangar Booster and Booster-Trolley

Powered by Pure Air the new Mangar Booster and the new Mangar Booster-Trolley. For a free brochure or demonstration contact: Mangar Aids Limited, Units 1 & 2, Presteigne Industrial Estate, Presteigne, Powys, Wales. Tel: (0544) 267674. (Illustrated below)









Carters Cruiser Wheelchair

This is a new model of Carter's indoor-outdoor electric wheelchair. It has adjustable arm rests and a control box which can be put in different places which makes it particularly suitable for muscular dystrophy sufferers - children and adults.

Pendragon Chair

This chair, manufactured by Joncare, has an elevating seat to help you reach up to a high cupboard. It differs from other models because the height of the seat is alterable. The chair is suitable for adult sufferers with good arm muscle control.

Inva-dex Showers

Inva-dex Showers have brought out a new ambideck shower tray. The previous model was too steep for a shower chair to be pushed up with ease but the new model overcomes this difficulty.

ARTICLES OF INTEREST

Copies of the following articles can be ordered 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 9p per sheet. Send no money with order. An invoice will be sent with the photocopies.

July/August 1986

39
Beddoes MP
Design features of a C-based software talking aid for the blind and handicapped called SPEECHEX.
IEEE Trans Biomed Eng 1986 Apr; 33 (4) : 463 - 7.

45
Sullivan-Bolyai S
Practical aspects of toilet training the child with a physical disability.
Issues Compr. Pediatr Nurs 1986; 9 (2) : 79 - 96.

50
Bodzioch J. et al
Promoting independence in adolescent paraplegics: a two week 'camping' experience.
J. Pediatr Orthop 1986 Mar-Apr 6 (2) : 198 - 201

52
Olsen Ra et al
A versatile and easily fabricated mouthstick.
J. Prosthet Dent 1986 Feb; 55 (2) 247 - 9.

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Porter PB et al
School and the medically handicapped child.
NC Med J 1986 Feb; 47 (2); 82 - 3.

67
Diamond N.
Rehabilitation strategies for the child with cerebral palsy.
Pediatr Ann 1986 Mar; 15 (3) : 230 - 6.

68
Bohannon RW Jones PL
Results of manual resistance exercise on a manifesting carrier of Duchenne Muscular Dystrophy: a case report.
Phys Ther 1986 Jun 66 (6) : 973 - 5.

70
Harris SR Riffle K
Effects of inhibitiveanbkle-foot orthoses on standing balance in a child with cerebral palsy: a single subject design.
Phys Ther 1986 May; 66 (5) : 663 - 7.

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Colbert Ap et al
DESMO seats for young children with cerebral palsy.
Arch Phys Med Rehabil 1986 Jul; (7) : 484 - 6.

69
Manger G. Speed E.
A coordinated approach to the discharge of burned children.
J. Burn Care Rehabil 1986 Mar-Apr; 7 (2) : 127 - 9.

76
Auditory feedbnack in spastic diplegia.
J. Orthop Res 1986; 4 (2) : 246 - 9.

84
The young handicapped, over looked and undercared for. (Editorial)
Lancet 1986 May 17 : 1 (8490) : 1131 - 9.

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Juvenile Rheumatoid arthritis and home physical therapy program compliance.
Phys Occup Ther Pediatr 1986 Spring 6 (1) : 55 - 63.

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Moore TL
Juvenile Rheumatoid Arthritis.
Rehab Lit 1986 May-June; 47 (5 - 6) : 119 - 21.

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REGIONAL REPORTS

Wales **Reg. Rep. Mrs. V. Williams, 5, Larch Grove, Lisvane, Cardiff. CF4 5TH.**

The theme of this years meeting is 'The teacher, the therapist and the child with special need. 'To be held in conjunction with lecturers at the South Glamorgan Institute of Higher Education, Cyncoed, Cardiff.

November 1st 1986. "Move and play to grow, for pre-school children with special needs".
January 1987. Movement for the school child with special needs.
June 1987. Movement and recreation for the Clumsy Child.
March 1987. Weekend Halliwick course at the Children's Centre, University Hospital of Wales.

South East **Reg. Rep. Miss C. Young, 3, Charlton Place Cottages, Mouse Lane, Steyning, West Sussex.**

The Study day on October 4th at Farnborough was well attended and was a most helpful and interesting day. It was good that we were also able to attract many who had not previously been members. At the Annual meeting some committee members were due to retire and new members have been elected. We are pleased to welcome Mrs. Isobel Johnson from Canterbury as the new Chairman, and Miss Christine Young from Brighton as the Regional representative.

Scotland **Reg. Rep. Mrs. E. Breckenridge, 19, Langside Drive, Newlands, Glasgow.**

The local Constitution has been ratified by the National Committee, and is now available to all Scottish members. The Temple Fay and Vibration study day at the Astley Ainslie Hospital, Edinburgh in June was fully subscribed and highly successful.

On October 24/25 the AGM and the study day on the Management of Respiratory Problems, were both held at the Royal Hospital for Sick Children in Edinburgh.

Videos are currently being prepared for submission to the Scottish Local Board Congress, scheduled for April 1987 in Edinburgh. These are to be part of the Specific Interest Groups slot, and topics will include:

1. Serial Plastering. 2. Halliwick. 3. Strapping for the Neurologically Impaired Child.
4. The Management of the Child with Spina Bifida.
5. The Management of Cystic Fibrosis.
6. The Orthotic Management of the Hemiplegic Child.

Following the contribution of £1000 after the 1985 Conference the Scottish Branch made a further contribution of £1000 in May 1986 to the National Association.

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

Our Day Course on Paediatric Hydrotherapy will take place on November 8th at the John Jamieson School in Leeds. We apologise for the change of venue. This should be a very interesting day. The 'Bad Ragaz' method will be demonstrated in the morning by Bridget Davies, who has been the Superintendant at the Swiss Spa. In the afternoon John Stevens of the Bobath Centre will discuss his use and adaptation of the Halliwick method. On November 20th we shall be having an evening lecture by Mr. MacFaul in the X-Ray South Lecture Theatre, St. James Hospital, Leeds commencing at 7.30p.m. when the subject will be 'Epilepsy'.

Trent **Reg. Rep. Mrs. Trish Palmer, 12, Vernon Ave., Ravenshead, Notts. NG15.**

A successful day course on Muscular Dystrophy was held on 25th September at Derby Royal Infirmary. Our AGM is to be held at the Nottingham School of Physiotherapy on March 18th 1987 at 6.30p.m. This will be followed by a Buffet supper, and at 8p.m. Dr. Makin Thomas will talk on "Feet".

Plans are in hand for future study days in the Spring and Autumn of 1987.

West Midlands **Reg. Rep. Mrs. C. Dunn, Cockshute Farm, Wichenford, Worcester. WR6 6YL.**

At a meeting at Chadsgrove School, Bromsgrove, Worcs on July 10th Mr. Jack Thackery of the Birmingham Accident Hospital gave a demonstration on "Ball Therapy".

On September 25th Dr. Stuart Green MRCP of the Birmingham Childrens Hospital gave a lecture on "Classification of Spinal Muscular Atrophies".

On November 15th 1986 at SENSE in the Midlands, Church Road, Edgbaston, Birmingham there will be a Day Course on the Multidisciplinary approach to the Management and Treatment of the Deaf, Blind and Multiply Handicapped Child.

The West Midlands Committee is sorry to, lose Mrs. Jackie Reynolds who is moving to East Anglia and has been our Regional rep. She has been a very valuable member of our committee and we hope she will be very happy in her new place of work.

North West **Reg. Rep. Mrs. K. Jones, 66, Mellor Brow, Mellor, Blackburn, Lancs.**

At a recent very successful APCP course in Liverpool given by Colin Stevens on the Cerebral Palsied Child, there were 70 participants, only 26 of whom were APCP members! As a result the Region plans to stage a campaign to stimulate interest in membership of the Association.

Plans for the AGM on March 8th 1987 are advancing satisfactorily the subject will be the Visually Handicapped Child, and the venue is to be announced later. An Audio Visual day organised by Sheila Bliss was held at St. Martins College Lancaster on October 18th. The committee will be holding its next meeting at the Royal Liverpool Childrens hospital when a Social evening for the exchange of views and information is being planned.

The Region had two applicants for the £25 grant to attend Congress, both were paid and we hope their Congress was enjoyed.

South West **Reg. Rep. Miss G. Riley, Meadows, Bowerchalke, Nr. Salisbury Wilts.**

A Study Day on the differing approaches to the treatment of Handicapped Children is being held at Southampton General Hospital, on November 15th. Because of severe cutbacks leading to funding problems, this is being organised by the paediatric Physiotherapy staff there, to help raise funds for their training budget. APCP members are being allowed to apply at reduced rates. Paediatric Superintendent Physiotherapists in the Wessex region are meeting in early November to discuss the best form of organising study days, both totally and throughout the region. APCP members in the Avon area are in the process of organising a series of evening meetings throughout the winter. The Study Day on Orthopaedics organised by them in the summer, was most successful and well attended.

"Galaxo" Pharmaceutical Co are funding a full time Senior 1 post in paediatric respiratory research and out-patients. The post is at Southampton General Hospital.

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

Our next Study Day which will take place on Saturday, September 27th and entitled 'A discussion - Orthopaedic Surgery in Cerebral Palsy; Why and When?' will be reported on in the November issue of the London APCP newsletter. It promises to be an interesting and stimulating day with the guest panel consisting of: Mr. John Fixsen, Consultant Orthopaedic Surgeon, Great Ormand St. Hospital for Sick Children, Miss Jenny Bryce, Principal of the Bobath Centre, and Mr. David Scrutton Superintendent Physiotherapist at the Newcomen Centre, Guys Hospital.

The AGM this year will take place on a January evening in the format of a cheese and wine buffet, with a guest speaker.

With the success of our evening lectures this last May and June we are going to keep to a mixture of these and Saturday Study Days.

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– AND FINALLY –

Supplementary Benefits

We hear that the DHSS can accept claims, from a persons 16th birthday, if they suffer from a level of physical or mental handicap that would probably prevent them getting a job if they were to leave school. For advice about allowances for which disabled youngsters can claim contact the local Welfare Rights Office or Citizens Advice Bureau.

Mobility Advice and Vehicle Information Service

'Mavis' for short, is run by the Department of Transport, and is a centre to help disabled people overcome their mobility problems. Based at the Transport and Road Research Laboratory at Crowthorne in Berkshire, it offers advice and assessment on aspects of car adaptations and driving ability, plus information on outdoor mobility and public and private transport. To contact tel. 9344 779014.

Pat Saunders Drinking Straw

This straw can benefit anyone who needs to drink through a straw, as it features a one way valve which prevents the liquid draining from the straw when the user stops sucking. A clip on the side allows the straw to be hooked on a cup or glass, whilst the straw itself is reusable and can be washed or sterilised by boiling.
Further information:-Medipost Ltd., Unit 1 St Johns Estate, Lees, Oldham, Lancs. OL4 3DZ tel. (061) 6780233.

Latin American C. F. Congress

At the first Latin American Cystic Fibrosis Congress held in May in Buenos Aires. One of the invited speakers who had an enthusiastic reception was Miss Diana Gaskell, Superintendent Physiotherapist of the Brompton Hospital, her subject was the techniques used, and the physical treatment of babies, older children, and adults. She also gave a practical demonstration for patients and their relatives.

Children in Need

The Annual BBC appeal for Children in Need is to be held on November 21st and we hear that the Lancaster Choral Society are going to sing throughout the afternoon and evening for sponsorship, to raise money for the event.

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RESEARCH PROJECT

A two year research project, funded by British Petroleum, has been begun by RADAR, to identify methods of promoting self care and independence training for children and young people (0-25) with physical disabilities.

The research will examine and document examples of good practise around the country through consultation with disabled children and young people, parents, teachers, medics, paramedics and others.

The project is an extension of previous work carried out by RADAR and information has already been obtained from a large number of people with known expertise in self care and independence training. However, in order to update information RADAR would like to consult more people and hear from any readers with an interest in this area. They would particularly appreciate contact with anyone who has some involvement with implementing or working on a scheme of self care and independence training.

For further information on this project contact:- Pippa Hughes, Research Officer RADAR, 25 Mortimer Street, London. W1N 8AB. tel. 01 637 5400.

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