ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS

NEWSLETTER

Association of Paediatric Chartered Physiotherapists
Newsletter No. 42 February 1987

CHILD ABUSE

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EDITORIAL

In the weeks prior to Christmas two diminutive children stood at the front door singing a carol and holding a saucer of coins, it was dark and nearly 9 o'clock. Concerned for their safety I opened the door wider to be confronted by a very large black Alsation dog - their 'Mum' had sent it to look after them! Had 'Mum' been made aware of the dangers lurking at night for unaccompanied small children I wondered, and made an effort to protect them? If so, perhaps there is a ray of hope for abused children in these times when hardly a day passes without the press or media carrying a story about some incidence of child abuse, often perpetrated by those closest to the child, who should be caring.

The vigorous campaign by the NSPCC to make people aware of the growth of the child abuse problem must be applauded, and it is hoped that by increasing public awareness children will be safeguarded more closely, and the network of caring agencies will be strengthened. Only in more recent years have physiotherapists found themselves becoming involved to any extent with these abused children, and it is essential that their awareness too, should be enhanced by the knowledge of what to look for and what to do if the necessity for action arises. Children who come for physiotherapy treatment need to be able to trust the adults who treat them, and the adults in their turn, must take care that the trust is maintained and the children do not see treatment as just another form of abuse.

This edition of the Newsletter is concerned with the physical, sexual and emotional abuse of children, but it is recognised that a child has rights, which can also be abused, causing equal distress, and it is hoped to devote a further edition to this aspect of child abuse.

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Did you notice in the November edition that February 1988 is to be the month when YOU THE MEMBERS OF APCP are being asked to write the Newsletter? Articles of any length between 500 and 2000 words will be welcomed, on any aspects of paediatrics that you care to choose. We look forward to hearing from you - up to now there is only a blank! Don't forget contributors will get a free copy of the Newsletter if the article is over 500 words.

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The last date for submission of material for the MAY 1987 Newsletter is April 5th.

IMPORTANT

WILL ALL MEMBERS PLEASE READ NOTE AND ACT NOW ! ! ! !

THIS IS YOUR CHANCE TO PARTICIPATE

The Annual General Meeting of the Association will be held in YORK on **Saturday April 25th** at 11.30 a.m. for members only.

Nominations for committee members should be sent to the Secretary : Mrs. Sandra Holt, 43 Westwood Park, London SE23 3QG together with the name and membership number of the proposer and seconder not later than **MARCH 15th 1987.**

Members attending the Annual General Meeting, should have their current membership cards with them.

Have you booked your place for the
ANNUAL CONFERENCE? ? ? ? ?
April 23 - 25th, The College of Ripon and York, St. John, York.

CHILD ABUSE — THE WORK OF THE NSPCC

By Susan J. Creighton, Research Officer

Maxima debetur puero reverentia - A child deserves the maximum respect. Juvenal xiv 47.

The Nation Society for the Prevention of Cruelty to Children (NSPCC) was founded in 1884 by the Reverend Benjamin Waugh in order to: "prevent the public and private wrongs to children and the corruption of their morals".

Some 102 years later this aim remains tragically topical and the NSPCC still has a vital role to play in the protection of children.

What is Child Abuse?

Child abuse has been defined in various ways. The legal definition used is: "his proper development is being avoidably prevented or neglected or his health is being avoidably impaired or neglected or he is being ill-treated". (1)

Kemp (2) the paediatrician who used the phrase "the battered baby syndrome" to draw attention to the problem in the early 60's defines it as "children who are in need of protection by society". The most widely used definition in England and Wales today is that recommended by the Department of Health and Social Security (3) for the inclusion of a child on a local register of child abuse. This breaks child abuse down into its various manifestations such as physical, sexual, emotional and neglect, and defines them as follows:

Physical Injury

All physically injured children under the age of 17 years where the nature of the injury is not consistent with the account of how it occurred or where there is definite knowledge or a reasonable suspicion, that the injury was inflicted (or knowingly not prevented) by any person having custody, charge, or care of the child. This includes children to whom it is suspected poisonous substances have been administered. Diagnosis of child abuse will normally require both medical examination of the child and social assessment of the family background.

Physical Neglect

Children under the age of 17 years who have persistently or severely neglected physically, for example, by exposure to dangers of different kinds, including cold and starvation.

Failure to Thrive and Emotional Abuse

Children under the age of 17 years who

i) have been medically diagnosed as suffering from severe non-organic failure to thrive, or -

ii) whose behaviour and emotional development have been severely affected: where medical and social assessments find evidence of either persistent or severe neglect or rejection.

Children in the same household as a person previously involved in Child Abuse.

Children under the age of 17 years who are in a household with or which is regularly visited by a parent or another person who has abused a child and are considered at risk of abuse.

Sexual Abuse

Children under the age of 17 years who have been involved in sexual activity with the parent or care giver, to which they are unable to give informed consent because of their dependence or developmental immaturity.

This latter category was not included in the circular but was added by many authorities.

Child Abuse Registers

All children living in an area who are found to fulfil the criteria for registration should be included on the child abuse register. Child Abuses registers are the responsibility of local Area Review Committees. These consist of senior representatives of all the agencies concerned with children in the area. They were set up in 1974 and 1975 on the recommendation of a circular from the DHSS (4) following the Maria Colwell Inquiry report. The inquiry drew attention to the number of agencies involved with the Colwell family, and the fatal breakdown in communication between them. The circular, in recommending the setting up of Area Review Committees, encourage better communication between agencies - a multidisciplinary approach to child abuse. This means that regardless of who first draws attention to the abuse of a child, its teacher, parents, neighbours, health visitor or a physiotherapist, there are agreed guidelines between all the agencies about how to proceed and help the child.

The day to day management of the register, and child abuse, is usually delegated to the local Social Services Departments by the Area Review Committee. In eleven local authorities, however, including over 9% of the child population of England and Wales, the NSPCC is responsible for this day to day management. Research information is collected on all the children who are placed on these NSPCC registers. The NSPCC's register research is thus the largest, continuous study of child abuse being collected in this country today. (5)

Findings of the NSPCC Register Research

The distinguishing characteristics of the abused children, their parents and families have been identified. Infants, boys, and low birth weights are over-represented amongst the injured and neglected children. Girls between 10 and 14 are over-represented among sexually abused children. The childrens parents are characterised by their youth, early parenthood, large families and marital instability. Nearly half the fathers had a criminal record of some kind, with a high proportion involving crimes of violence, and only a third of them were in paid employment.

The main trends to have emerged over the years have been the annual increase in reports of physical abuse since 1979 and the more recent dramatic rise in reports of sexual abuse. The percentage of physically injured children with serious injuries (all fractures, head injuries, internal injuries and severe burns) has decreased steadily from 17% in 1977 to 8% in 1984. In 1985 this percentage increased to 11% a worrying reversal in a downward trend.

Various authors (6,7) have estimated the percentage of the mentally retarded population that has been caused by child abuse. These estimates range from 37% to 3%. The decline in serious injuries, and serious head injuries in particular, shown

in the register research allows cautious optimism that fewer children will become retarded as a result of abuse.

Prevention

The NSPCC's main preventative role has been its casework with parents and children where abuse has taken place or is thought to be highly likely. Casework involves helping immature parents to understand the needs of their children and how to meet these - how to enjoy their children. This may mean helping parents to meet their own needs first, both emotional and material. In the final analysis it may mean removing the child from its home to the care of substitute parents. The child must come first.

Recently the NSPCC has extended its preventative role into the area of public education - the 'public wrongs to children'. Its 1986 autumn campaign on "The Forgotten Children" focused on all aspects of neglect. The campaign was, and is, aimed at parents, the public and professionals. There are nationally available public and professional information packs, a professional conference arranged and a continued publicity effort.

The care and control exercised by the NSPCC could not function without the help and support of colleagues in other agencies and disciplines concerned with children. Together we can try to ensure that todays abused children are not handicapped in life and that future generations of parents will both love and repect their children.

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ABUSED CHILDREN

By Bob Needham, Social Services Area Officer

The above title focuses on the child. This transmits some of the feeling of pain to us, and as we are left in discomfort, we can often prefer the abstract and desensitising term, child abuse. We are hurt to hear that many of our mentally handicapped children were brain damaged during abuse in infancy.

What do we know about child abuse? We read an article to find out; to find out about a subject. But consider finding out about a child. Different, is it not? Does every reader of this paper realise they probably know - at work, among friends and acquaintances, or in one's family - a child who is being, or has been, abused; or someone who is or was abusing a child?

What closes our eyes to such situations is the emotional pain for us when we discover them. No one likes pain. We want to believe things are otherwise. This has delayed recognition of the need for work with abused children until the last couple of decades; we wanted to recognise only the grosser physical sorts of cruelty, and even then only the working class ones. The Victorian photographs taken by the N.S.P.C.C. and Barnardos bequeathed us an image to which we wanted to cling.

Unhappily research, both contempary and historical, now indicates convincingly that abuse has occurred, and still occurs, in all social classes and all cultures. Some merely accept it as unremarkable, others are good at concealing it.

Although enlightened statements about children have always been made, for example by Jesus of Nazareth, Shakespeare and Rousseau, laws were still being passed in England in Victorian times which valued damage to farm livestock more highly in terms of fixing maximum fines, than the value placed on a child to whom someone had been cruel. The only beacons of light were then shining from individual philanthropists such as Lord Shaftesbury; despite in his case being a landowner.

In art galleries, look at all the portraits where the faces of children are painted as if they are small adults. Only in this century have we seen the slow process of children starting to be viewed in their own right as real people. The impetus originated with Austrian and Swiss psychiatry and pedagogics, and their effect seeping through into the general thinking in Western societies. We are becoming more child centred than our ancestors were. Corporal punishment is being abolished in country after country. Bereft of it, higher performance skills than hitherto are being required of teachers, boarding schools are being looked at very closely indeed, especially single sex ones with single sex staffs. We are now discriminating about the perhaps limited sorts of children for whom they are more suited than day schools: and especially about ages below which it is highly ill-advised, in terms of emotional maturation and mental health later in childhood, to remove a particular child from a home which the child - at least - loves.

Today we know that there are three kinds of abuse: physical, sexual and emotional, all are illegal. We also know that professional social work agencies, for example the local authority Social Services Department, find a tendency for only cases at the working class end of the spectrum to be referred to them. Unfortunately, plenty of anecdotal evidence from people in other social economic groups has been elicited by media agencies running general features on this subject over recent years.

How do we know that a case is one of abuse? Well the child knows. Does the child tell anybody? Is the child afraid to, so he or she has to resort to hints which a hearer needs to be sensitive enough to pick up? Has someone else noticed something about the child, say a teacher or the family GP? If so, with whom does such an observer or potential observer deem their prime relationship to lie; the parent? Or the child? Exactly who is being viewed as the client, the patient?

It is no surprise that many instances of people abusing children do not come to light until years later, if at all.

What when they do come to light at the time? There is a choice of three agencies to tell; the social services, the NSPCC or the Police. They and no one else, have the power to act.

And it can take the legal power; if the abuser denies the abuse and leaves the child vulerable. Legally no abuse has occurred until one of the three agencies has successfully proven in court that it has.

This proof always rests on medical evidence. Every child on whom abuse is suspected needs to be taken to see a hospital consultant paediatrician as soon as possible after the matter has first come to the light. In many parts of the country the three agencies have been given by the consultants a priviledge of direct access, without time wasting involvement of a G.P. who may sometimes be reluctant to jeopardise a patient - relationship with the child's parents.

The other point about early consultant involvement is the early identification of that proportion of the cases which at first look like abuse but turn out not to be, for example instances of genuinely accidental injury or illness.

An experienced paediatrician can usually identify the non-accidental injuries on sight. Such injuries show well established patterns, different from those of accidents. Only a medical man can give medical evidence. A social worker cannot, unless the worker was present when the injury was inflicted, for example during a family altercation or home visit. These cases therefore usually stand or fall on what a doctor is prepared to say in the witness box, and on how far he is prepared to face hostile cross examination and questioning of his professional judgement by the suspected abusers lawyer.

It is thus regrettable that in the early stages of a child abuse matter, more than half the attention is on winning the court case, and not on therapy for the child. The latter seldom starts at all if one has lost in court. And one does not win all the time.

Generally speaking with physical injuries there is a good chance of winning. The evidence is usually clear cut and irrefutable. The interest then turns to the question of who inflicted it. In a multi member household this may never be proven. The law therefore allows for care proceedings in juvenile court to protect the child without these necessarily being accompanied by criminal proceedings against an adult in a criminal court on another occasion. In juvenile court one only has to prove the existence of the abuse, not the identity of the abuser.

Or one can have the reverse outcome; where an adult abuser is found guilty in a ciminal court, and is imprisoned and thus removed from the scene; so that no juvenile court care proceedings in respect of the child may be thought necessary.

Until his sentence has ended; at which juncture the Social Services have to ascertain where he proposes to live. This can sometimes mean a mother choosing between her children and her husband, or cohab.

It will be seen from all this that a child care social worker has to have the ability to think like a lawyer, especially during those early interviews soon after the child has been referred. The social worker may have to give evidence in court against the parents. This segment of her job which is one of policing family life has increased substantially in recent years. Society is very ambivalent about it and state social workers are now viewed with mixed feelings by many people, who want them to have greater powers to enter the homes of 'problem families', but none to enter their own!

To win a case of sexual abuse, medical evidence on its own is not always good enough - to prove intercourse is not to prove incest - and one can find oneself having to depend on the child's willingness to make a statement, and then resist blandishments from horrified relatives to withdraw it.

Emotional abuse is the hardest of the three actually to prove. Success usually depends upon the particular lay magistrate being well disposed to the idea of a child psychiatrist appearing in the witness box. Psychiatry, like social work, has a mixed public image.

But suppose one thinks abuse is going on, but one lacks evidence that would stand up in court, or the parents refuse to admit it, or worse still, one took the case to court and lost? One was defeated by the parents in a court contest.

All we can do is place the child's name on the Child abuse Register. There is one for every local authority, and copies are held in all hospital Accident and Emergency Departments in that area. The system depends on someone being free to check against the Register, the name of every child being brought in, for whatever reason, and regardless of the hour; so that the duty doctor is told the advisability of questioning more closely than usual the person who came with the child. In as yet unproven cases, there is nothing more one can do, and where no one checks the Register, one is not even doing that.

Most times in court we do win, however. Full attention is now freed for the child at last.

Basically, there is a choice of three options. Acknowledgement of the abuse, and motivation to co-operate, is always looked for from the adults. Where the impression is one of a less than wholehearted response, the benefit of the doubt is always - or should always be - given to the child, not to the parents. Most of the cases which have hit the headlines, have come unstuck, because this principle has not been followed. But given motivation, the child may be returned to the parents, under a Supervision Order. This gives the social worker the right of entry into the house; though as the worker does not live there, it is of course not surveillance. Consequently, it is advisable for the worker to take the child for regular medical inspections. No one can deny that this is an authoritarian intrusion into the family's life, and the work has to be firmly focused, issue by issue, if the parents' motivation to change is not to be undermined by a general sense of oppressiveness, leading to depression and thus again placing the child in jeopardy.

Second, the above work can still go forward; but away from the child who will be in local authority care temporarily. A horseracing judgment is then made about the

juncture at which to return the child. Social workers are bookies, basically; the particularly choice of mammal does not change the basic elements utilised in assessing future likely performance. As at Aintree there are no certainties in the matter.

Third, just because there are no certainties, the choice is sometimes made of retaining the child in local authority care for good, namely till the eighteenth birthday. In this event, an objective appraisal has to be made of exactly with what resources the local authority has furnished its Social Services Department, and whether these are suitable for the particular child. They vary from one local authority to another, and within one local authority from time to time. There is an element of emotional trauma, if not abuse, in taking a child away from his or her family; it has to be coldly weighed in the balance against the possible trauma in other courses of action. The saddest thing of all, in these cases is the well documented finding that abused children tend to grow up to abuse their own children.

This is not surprising, but what sort of research is required to look at it and try and ascertain exactly what can be done to break into this cycle successfully? We want to break into it; do the abusers want us to?

If some do not, is this their civil right in court? How much does a child matter? Or are these cases, of their very nature, always foredoomed to be messy? Is the universe so constructed that there are only second rate substitutes for a happy family?

* *

THE RESULTS OF CHILD ABUSE AND THE PLAY THERAPIST

By Ann Milston, Occupational Therapist and Psychotherapist, Lancaster.

Child abuse may be physical or emotional but is usually a combination of both. Abuse may be battering (damaging hitting or thumping) as when a parent gets to their wits-end with a disobedient or crying child, and can no longer tolerate the noise or behaviour, giving vent to prolonged beating or throwing a baby across a room. It may be malicious and thought out; it may be constant denigration and humiliation, it may be sexual abuse.

Whatever the abuse, the prime consideration is the safety of the child, and this of course is where the social services come in. Once the child is safe, the social worker may begin therapy with him/her, or may refer to a child psychiatrist, or someone like myself who has experience in play therapy. Therapy becomes particularly pressing in long standing abuse, or where the child is non-achieving, withdrawn, pre-delinquent, and so on. In an ideal world, as well as helping with housing and material circumstances, individual, marital and family therapy would be offered with the aim of re-integrating the child, once change within the family had been shown to be occurring.

Unfortunately, resources are scarce, and intensive additional trainings are needed for the professional to be able offer such therapies.

Results of Abuse

These are extremely varied and may include virtually all of the symptoms seen in the child psychiatry clinic. These may be:— Persistent night terrors - bedwetting - soiling - poor or sudden drop in school performance - stealing - temper tantrums or withdrawal - aggression e.g. unprovoked attacks on peers - truanting, running away from home etc.

Sexual abuse may produce any, or a combination of the above, but in addition there may be:— Recurrent urine infections - soreness of the anus or genital areas - open masturbation - exposure of genitals to peers - general sexualised behaviour - pseudomaturity "the little housewife syndrome" - lack of inhibition re-touching and cuddling grown ups.'

In cases of incest or sexual abuse within the family, the patterns of interaction between family members will always be disturbed, although often not obviously so to the uninquiring outsider. Stepfather or father may be weak or dependent on his wife, or may be very strict and controlling of the family members. Mother and daughter usually have a poor relationship which is often described as 'frozen'. Mother may lack social skills and her own friends, and may complain frequently of feeling unwell.

With one soiling girl of seven I saw, who had been subjected to simulated intercourse by her stepfather, mother subsequently said she knew when he had been abusing her because it was the only time he played with the child. The child told me that when she would not co-operate he used to break her toys and stamp on her felt tips. Mother - a deprived lady with a very ambivalent relationship with her own mother - had unconsciously colluded in the abuse by leaving her daughter alone with the stepfather, and ignoring the childs requests not to be left alone with him, thinking she was simply attention seeking and manipulative. In common with many such mothers, she had not believed her daughters complaints about the man, and had blocked off any suspicions in her own mind. Denial is a strong defence mechanism in such families (as it can also be in us as professionals who come into contact with them). It is highly probable that mother had been abused herself as a child - and in fact this is a commonly recurring generational pattern.

When considering the mechanics of any kind of abuse we must look at the early formative years of the abuser, the spouse and the victim. Almost without exception (e.g. later brain damage) there is great pain, loss and deprivation, and sometimes similar abuse, somewhere along the line in the abuser and spouse's childhood. People do not come out of the womb as abusers.

What do I do to help?

First of course is the assessment of the child's strengths, anxieties and potential. My overall aim is always to raise the abused child's self esteem. This is a much-used word and therefore often devalued. But I believe, and experience has proved, that the more we feel and know ourselves to be worthwhile, valuable and loved individuals, the more worthwhile and rewarding our external circumstances become. We can only truly change our lives in any permanent sense by changing our inate view of ourselves. The results of this are easier to see in adults, but I believe children can also gain some degree of power over their lives in this way.

However, while this general aim is always at the back of my mind, I must focus down on specifics in order to help the child in his or her current difficulties. Sessions in the playroom are an hour for children coming from outside, and usually three quarters of an hour in the residential unit where I work, and are weekly. We work together in a well stocked playroom and we are not disturbed. The child is the boss, and I warn him/her when the session is coming to an end. The assessment period sees me using a reflective technique taken from the work of Virginia Axline 2 where I refrain from questions not about the play itself, where my own personality and views take a back seat, and where I reflect back to the child all he says and does - acting as a mirror to enable him to see himself more clearly. I try to go at the childs own pace.

With abused children there may be varying degrees of denial (everything is fine - isn't it great in here!') distancing from me (I'll reject you before you reject me'), passivity ('I don't know what to do - you tell me'), and inability to play creatively (I'll do the jigsaws again - the sand, puppets, Wendy House, etc. are too risky'). The sexually abused child may be coy and disinhibited or shut off and very angry.

Thus it can be seen, that once I feel the child and I know each other a little, I will need to address the above issues, plus feelings of sadness, hopelessness, aggression, loneliness and fear. I feel that the best way to help a child is to offer him a new relationship - one in which I do not judge, in which I bounce back despite sometimes great violence and anger towards me from the child (displaced on to me from where it is unsafe to express it - e.g. the unsafe mother, father, sibling etc.), and in which I seem to understand what the child's bad feelings are like. I may therefore move on from the assessment to using interpretation and a more analytical approach - where I speak more clearly to the unconscious mind of the child (a wise and vast storehouse) to help him to see why he feels and acts as he does. In the child's case his parents or carers also need some understanding of themselves, otherwise he will become locked up again and back to square one, hence the crucial need for family work alongside play therapy. In addition to this, I will set aside time at the beginning of the sessions to work with the child, affirming in speech and writing that he/she is good and worthwhile, deserving of love, and that it is safe to say 'No'.

In cases of sexual abuse, I will setup a role - play where I pretend to be up to no good, and the child has to practice yelling at me and running off. Although a frightening experience initially children always enjoy this powerful feeling immensely, and the play acting is in the end accompanied by much laughter. The shouting is usually 'No, I won't!'; Go away, 'I'm telling about you'. I always do quite a bit of teaching alongside the roleplay, and tell the child that if the first grown-up they tell does nothing or doesn't believe they must go on bravely until they find someone who will believe and help 3. Nowadays these methods are frequently used in schools to teach children to protect themselves. Thus if this acting brings up feelings from the past, that are bewildering and painful, they can be dealt with and then repressed again during the subsequent play period,. I will also occasionally use painting to help a child express his/her experiences and resulting pain and confusion.

While in no way can therapy ensure that a mature and fearless child moves on to enjoy the rest of his life, I am sure that the messages that the child absorbs during play therapy will stand him in good stead for rest of his life. Perhaps for the first time the child has experienced power, self direction and approved creativity within an

intimate relationship. Perhaps the greater self esteem will be reflected in the child's contact with his outer world, and will result in more rewarding lifes experiences than might otherwise have come his way.

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HEALTH VISITORS + TIME ABUSE

Anon.

Health visitors are said to be key persons in the community when working in the field of child abuse, using their skills in identification and prevention to protect chiuldren and help parents.

Research has shown that children subjected to abuse have a tendency to fall below their expected growth curve, and fail to achieve their full potential. Using professional knowledge and practical skills health visitors are in an ideal position to monitor growth and development and provide support to the family.

Family strengths and weaknesses can be assessed during home visits and on going developmental screening, physical, mental and emotional achieved as part of the daily routine of health visiting.

Immunisation, the home environment including diet and hygiene, the number of accidents, are also monitored. Recording weight is essential where there are a number of 'at risk' factors present in a family. Failure to thrive requires removal to hospital for assessment. Sharing concerns with other professionals i.e. social workers, GPs helps to assess how the situation is developing, and whether to take action if child abuse occurs.

The threat to parents in a neglecting situation, of the children being removed from the home by the social workers is a very real one. Added pressure and not enough support can lead to actual abuse. Being placed on the child abuse register increases the level of support to these families, and together parents and professionals can work towards a more stable relationship, monitoring carefully family dynamics.

Parents may at first resent the intrusion and feel angry, but most realise later that the help given benefits parent and child, and as such will then work towards the removal of the childs name from the register.

Prevention of child abuse depends heavily on time and commitment. Large caseloads and a high percentage of families 'at risk' leaves the health visitor with time only to work, like social workers in 'crisis' situations. What price prevention than?!

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THE MECHANICS OF CARE AND PROTECTION

By Mr. M. Whitehead - Social Worker

Any investigation into a case of suspected child abuse is only as effective as the formal structures laid down between departments which allow the investigation to be co-ordinated and monitored effectively. Within this procedure, the Child Abuse Case Conference is the centre around which every other activity rotates. Lancashire County Council has laid down specific guide lines how a suspected child abuse case should be investigated, and the following article attempts to describe this process. The article concentrates on the procedures, and does not attempt to discuss the professional issues of child abuse. However, it should be noted that a thorough investigation of the case will have been undertaken by Social Services and/or the Police prior to the following procedures being implemented. All matters relating to the investigation of child abuse and all personnel who are involved in any way must maintain absolute confidentiality at all times.

The Lancashire Area Review Committee has been set up as recommended in the DHSS circular 'Non-accidental Injury to Children.' The membership of the committee consists of senior officials of the Lancashire County Council's Chief Executive/Clerks Department, Social Services and Education Departments, together with representatives of the Police Authority, Area Health and District Housing Authorities, the NSPCC, the Probation and After-Care Service, plus a magistrate, magistrates' clerk, a G. P. (representing the local Medical committee) and hospital consultants from different specialisms.

District Review Committees have been established, based on the Area Health Authority Districts, with similar representation. It is from the Lancaster District Review Committees procedures that the following are taken.

Lancashire County Council Social Services maintain a child abuse register which is held centrally at Social Services Headquarters. If a case of suspected abuse is identified, the matter has to be responded to immediately and not delayed to the following day. The procedures are laid down in an attempt to help workers dealing with cases of suspected child abuse feel less isolated. The criteria for registration include:

(a) Physical Injury - where the nature of the injury is not consistent with the account of how it occurred and where there is definite knowledge for a reasonable suspicion that the injury was inflicted, or knowingly not prevented by any person having custody, charge or care of the child. This includes children to whom it is suspected poisonous substances have been administered. Diagnosis of child abuse will normally require both medical examination of the child and social assessment of the family background.

(b) Physical Neglect - children who have been persistently or severely neglected physically for example, by exposure to dangers of different kinds including cold and starvation, can be considered for registration.

(c) Failure to Thrive, Emotional and Sexual Abuse - children who have been medically diagnosed as suffering from severe non-organic failure to thrive, or whose behaviour and emotional development have been severely affected. Medical evidence and social assessment would be needed to find evidence of persistent severe neglect or rejection.

(d) Children in the same household as a person previously involved in Child Abuse - children who are in a household with, or who are regularly visited by a parent or other person who has abused a child, may be considered for registration as at risk of abuse.

Who may request a Child Abuse Case Conference?

A recognised representative of any of the agencies who are members of the District Review Committee, may request the appropriate Chairman to convene a Child Abuse Case Conference for any child considered to fall within the criteria listed above.

The Chairman of the Case Conference will be the appropriate District/Area team officer of the Social Services Department, and in his/her absence, the Assistant District Team Officer or Senior Social Worker (Child Care). The person wishing to call the case conference should 'phone the appropriate Conference Chairman and tell him/her the basic information about the child or children concerned, and ask for a case conference to be called. Excluding week-ends, this has to follow within 72 hours, the grounds for the case conference being called, being those laid out under criteria for registration.

The person who asks for a case conference to be called must forward a copy of Form NAI 1, which has been completed and signed, as soon as possible to the appropriate Conference Chairman, with a further copy to the Chairman of the District Review Committee, and it is the responsibility of the case conference Chairman to see that this is done. It is recognised, that at short notice, it may not be possible for all agencies and members of the medical profession to attend, but this should not delay the calling of the case conference.

Organisations and individuals who are expected to attend.

These are sub-divided into three groups as follows:

Group A.

A representative from each of the following must be invited to attend each Case Conference or Case Review Conference - Social Services, G.P. Community Physician or Senior Clinical Medical Office (Child Abuse) NSPCC, District Nursing Officer or representative, the Probation Service and the Police.

Group B.

The following must be invited if involved with the child or the family; Day Nursery Matron, Dental Surgeon, Clinical and/or Educational Psychologist, Consultant Paediatrician/Psychiatrist, or Medical Oficer in charge of the case if in hospital. District Education Officer and/or representative Head Teacher if the child is of school age or attending Nursery School, Head Teacher and/or representative of siblings schools. Chief Executive/Clerk's Dept., Housing Dept., Professional caseworkers recognised voluntary agencies.

Group C.

The conference Chairman may invite to an initial case conference or case review conference, the representative of any agency, or anyone not named above whom

he/she considers may have a contribution to make. This person may be asked to leave the conference after making their contribution, and will be told verbally later about recommendations that have been made. Anyone who is invited and is unable to attend should send a substitute, or a written report direct to the Chairman. Where time does not permit a verbal report should be given and confirmed in writing later.

It is important that the Case Conference has as much information as possible to hand when considering whether or not the child should be placed on the Child Abuse Register, and the Chairman has to steer the Case Conference through a number of steps before it can reach that decision. All the people present must be reminded of the need for strict confidentiality, and that although the report of the conference will not be produced in any future Court proceedings individual representatives, may be asked for separate statements at a later date for the Court.

The Conference Chairman who must be impartial, has to ensure that all the procedures laid down by the NAI District Review Committee are carried out. He must also ensure that all Agencies are enabled to freely present their information. It is therefore important that he notes who has not had previous experience of a Case Conference and may be feeling overwhelmed at having to give information to a large group of fellow professionals some of whom enjoy high professional status. It is always better if someone giving information to a Case Conference puts it down in writing prior to the meeting, so that they may refer to their notes if questions subsequently arise from the body of the Conference. There should be logical progression starting with a full family background and following to the incident itself, and finally a discussion of the family history and situation generally.

From these discussions the Chairman should draw the conference members to a decision as to whether the childs name be included on the Child Abuse Register, to identify a key worker and allocate to each agency responsibility for their part in the supervision of the case, finally formulating immediate treatment plans and long term aims. At the end of the conference the Chairman decides on the frequency and nature of any subsequent Case Review Conferences. It is general practice to tell parents of a decision whether or not to place the childs name on the register, and to tell them who has access to the register and the general nature of the information held, and for what purpose. Parents who have been told of their child's registration must also be told of the arrangements for deregistration, and when their childs name is removed.

Within 72 hours of a Case conference records must be sent to all participants. A similar procedure operates when the Custodian of the Register receives notification of any child or children from another local authority moving into the area. The appropriate District/Area Team Officer of the Social Services Dept., is notified and a case conference must be convened not later than 21 days following receipt of information from the Custodian. When a child whose name is on the Register moves to another area, the Chairman must inform the Custodian, if possible give a new address, and ensure that all individuals and agencies concerned inform their opposite numbers in the receiving area of the childs movement and concern expressed.

In conclusion, what I have attempted to describe is a factual account of procedures as they are laid down. At the present time, Lancashire Area Review Committee is undertaking to produce a new set of procedures to be used in Child

Abuse cases, and whilst it is envisaged there will be no dramatic alterations, some changes may occur. The procedure as laid down may seem on occasions to those having to implement it, to be both time consuming and laborious, however, it has to be recognised that such procedures do help to protect children from all kinds of abuse. Much work has been undertaken by professionals out in the field before the procedure needs to be implemented and the request for a Case Conference to be held is not taken lightly. The above procedures help to guide and clarify the work being undertaken by professionals in Child Abuse, and whilst it is the quality of their work which protects the children most, it has to be recognised that the quality of the procedures can assist in the protection of both the worker and the child.

* *

POST REGISTRATION EDUCATION REPORT

Child Abuse - Implications for Physiotherapy In-Service Training.
By P. M. Eckersley, Advisor - Post Reg. Education APCP

On the 9th December, 1986 the National Society for the Prevention of Cruelty to Children released figures based on the records of eleven local auhority areas for 1985. These figures showed:—

* 126.5% increase in sexual abuse.
* 68% increase in reports of children fatally or seriously injured.
* 42% increase in numbers of children placed on abuse registers maintained by the NSPCC.

The survey showed that physical abuse accounts for almost 75% of cases on registers, compared to 18% for sexual abuse and 6% for neglect. Although increased publicity and awareness accounts for some of the rise, nevertheless this is not a full explanation. Figures in the USA give an estimate of sexual abuse of 1.4 girls and 1.10 boys (Finkelhor) but these figures are thought to be underestimated.

Why is it important for Physiotherapists working with children to be well informed on this topic?

1. We see children regularly, they come to trust us and may therefore open a conversation on the subject.
2. It is a normal part of therapy to have children in shorts and vests for activities - we are therefore in an ideal position to observe any injuries or difficulties.
3. Abused children frequently develop chest infections - and what do physiotherapists do - percussion? postural drainage? - think of the trauma to the child if the 'treatment' seems to be another injury.
4. Physiotherapists are closely involved in hands on therapy - we need to be aware of the effect this might have on the abused child.

As a profession this is a field which is new to us; but sadly it is one in which we must become involved and knowledgeable. Everyone of us is knowingly, or unknowingly, treating an abused child. All members of staff should have a copy of their City Council document on Child Abuse Procedures (available free from Social Services) should be aware of the route followed in their authority when abuse is suspected.

The Paediatric Superintendent could attend the excellent courses run by the NSPCC, often in conjunction with the Social Services, on Physical Abuse, Sexual Abuse and neglect and should follow this up with In Service training.

Handicapped children are vulnerable and we are part of the team caring for them. We must take on board the implications of being a profession which may find itself treating by physical means, the child who has been physically abused.

Reference

Finkelhor D. Child Sexual Abuse. Theory and Research.
New York Free Press.
Forward S. & Buck C. 1979 'Betrayal of Innocence'.
Penguin.

* *

EQUIPMENT

A new low-cost wheelchair, suitable for use both indoors and outdoors, made a successful debut at NAIDEX. The Squirrel is £750. Designer Jeremy Fry has produced a wooden version which, he claims, is far more stable and easily steered. It also folds up. One enthusiast is Professor Ian McColl, who was scathing in his report about current outdoor powered chairs supplied by the DHSS (currently the DHSS supplies no wheelchairs for both indoor and outdoor use).

Chairpower Ltd., Avondale, Freshford, Bath, BA3 6BX. (Tel. 022 122 3755).

Peto Plinths

G. & S. Smithwaite is making a range of Peto plinths. Two sizes are available, with fixed or folding legs. Accessories include horizontal and vertical hand rails and grabs, and a multi-position laminated plastic tray. Adjustable sides and backs enable the plinth to be used as a bed or for side lying. A variable height ladder back chair has been specially designed for use with the plinth, and there is also a variable height crawler and crawler chair.

Prices range from £82 for a 42 inch fixed leg plinth to £130 for a 60 inch folding leg type.

Bedspecs - Prisim Glasses

Bedspecs provide just the right angle of vision for bedridden patients who want to read or watch television. Bedspecs are approved by eminent opthalmologists, optometrists and opticians and are readily adjustable to head width. Modern frames hold precisely aligned opthalmic crown glass prisms ground to the closest tolerances. Vision angle of 72°. Bedspecs may be worn over ordinary glasses. Weight is only 5 oz. (142 gm). Shipping weight with hard case, lb. (454 gm). Price £53.20 each. Ref: H73378. Address below.

Bathtub Grab Bar

Bathtub falls account for numerous injuries in the home that can be avoided by the use of well designed accessories. The Maddahold bathtub grip, cast of high strength aluminium and coated with an attractive baked-on epoxy is easy to install and gives maximum security and confidence to the user. Maddahold has two gripping handles, one at the top and one on the side that extends into the bathtub. The clamps are adjustable for various thicknesses of tub. Clamp grip is adjustable from 3⅞" to 5¾" (9.8 to 14.6 cm). The Maddahold can be attached to the bathtub by tightening with a 9/16" open end spanner. Overall dimensions 13¾" (35 cm) wide x 14¾" high (37 cm), outer clamp width 6⅛" (16 cm). Price £59.80 each. Ref: F72720.

Address for the above two items: Radleys, London Road, Sawbridgeworth, Hertfordshire, CM21 9JH.

The Jenna Chair

A highly adaptable high chair designed with CP children in mind - age 6 months on - with pelvic support and/or shoulder protraction, choice of long or flexed sitting adjustable seat depth etc. It has great therapeutic value and is aesthetically pleasing.

The Tippa Chair

Brightly coloured chair with bolster seat, highly adjustable. With or without head support, shoulder protraction etc. good sized tray. 2 years up.

The Preston Kneeling Frame

A kneeling frame to encourage pelvic stability, adjustable in height and depth so that the childs ankles are flexed at 90 degrees, pelvic and thoracic straps to maintain positioning.

Both chairs and kneeling frame new on the market from:—

R. Taylor & Son (Orthopaedic Ltd.) Compton Works, Woodwards Road, Pleck, Walsall WS2 9RN.

The Trans-Sit Seat

A simple device for carrying or transferring a disabled child or adult. Two sizes. Made of strong washable synthetic fabric with padded seat for extra comfort. Folds flat for storage or packing. Fitted with strong canvas waist belt for use at all times. The seat can take over 17 stones under normal transit conditions. £28.16 (Large) £27.50 (Small).

Details from Ellis, Son & Paramore ltd., Spring Street Works, Sheffield S3 8PB. Tel, 0742 738921.

Wheelchair Anti-roll Device (WARD)

The wheelchair anti-roll device is available for £30 from the Old Post Office, Minera, Wrexham, Clwyd. It is easy to fit and needs only one screw. Please state what kind of wheelchair you have and allow 6 - 8 weeks for delivery.

BOOK REVIEWS

PROFOUND RETARDATION AND MULTIPLE IMPAIRMENT

By James Hogg and Judy Sebba

Volume 1:	Development and Learning	£14.95
Volume 2:	Education and Therapy	£14.95

Published by Croom Helm Ltd. 1986.

Working with the Profoundly Handicapped has always been a very complex task, and Volume 1 of this book presents an immense amount of background material and theory, aimed at understanding the problems associated with this group of people.

The frequency with which visual, auditory and multiple impairment occurs, and the combination of physical and profound retardation, are thoroughly discussed, together with developmental assessment and a suggested framework of intervention. Acknowledgement of the difficulties in identifying levels of intellectual function is made, together with the need for an interdisciplinary approach.

In Volume 2 methods of teaching and communication skills, possible methods of establishing a curriculum with use of resources, practical ways of attempting to establish communication and some aspects of the physiotherapy involved are all thoroughly explored.

The myriad references given at the end of each chapter, not only indicate the wide sources from which the information given has been drawn together, but also highlights sources of further reading on a subject which has only been more deeply investigated in recent years. The book will be welcome to newcomers in the field as a valuable source of information, particularly from the psychological standpoint.

THE OTHER SIDE OF PROFOUND HANDICAP

By Pat Brudenell. RMN RDTh. AIST Cert. Ed.

Published by MacMillan in the New Approaches to Care Series. 1986.

This very straightforward and easy to read book is realistic about working with the profoundly handicapped, and it is obvious that the author has had practical experience of the problems involved. Many interesting case histories are given and practical solutions are suggested together with numerous ideas for various forms of creative work.

Reference is made to the isolation felt by many staff working in special units and hospitals, and the need for strong back-up support is emphasised, together with the need for multidisciplinary teamwork, although very little mention is made of physiotherapy input. There are four useful appendices for (1) Interesting reading, (2) Useful addresses, (3) Profound Retardation Project, (4) Reading for Historical Background.

I would recommend this book for anyone working with the profoundly handicapped for its honest approach and thoughtfulness.

CHILDREN WITH NEUROLOGICAL DISORDERS

Edited by Neil Gordon and Ian McKinlay

Volume 1 Neurologically Handicapped Children, Treatment & Management.
Volume 2 Neurologically Sick Children, Treatment & Management.
Published by Blackwells Scientific Publications 1986. £19.50 each.

These companion volumes make fascinating reading, the straightforward style of the many eminent contributors focusing the attention without difficulty on the subjects discussed. Edited by two well known consultant paediatric neurologists the information given is clear, and well presented.

In Volume 1 the many facets of chronic paediatric disorders are thoroughly discussed together with chapters on genetic counselling, rehabilitation engineering, remedial teaching and aids to vision, so that problems and possible solutions are both presented. In this format the many sources of care now available and the increasing range of 'treatment tools' is very apparent.

Volume 2 which deals with more acute disorders is written in a rather more technical style, perhaps with the medical rather than the allied professions in mind. However it is still most interesting reading, giving a wealth of information on modern methods and diagnosis and the difficult field of neurosurgery. The appendix chapter on neuroradiology is particularly interesting.

Throughout both volumes the obvious concern for the parents and wider families of these children, that they should thoroughly understand the problems and possible solutions, shines like a beacon. The gap between families and the professions is shown as being considerably diminished by the joint efforts for the welfare of the sick child.

The text is clear and enhanced by many photographs, diagrams and plates, so that as well as fascinating reading this is an excellent source of reference.

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PUBLICATIONS

"WHAT TOY". The only authorative consumer guide to toys and play. Published by PLAY MATTERS and CT. Publications is now available through leading newsagents and contains information on over 600 toys recommended by Play Matters/NTLA for their play value - £1.50.

Deron's new catalogue of switches and microelectronic equipment for severely handicapped people. This is a must, for anyone dealing with the problems of handicap, giving a wide range of devices from teaching aids to environmental controls.

Available from: Deron, Unit 8 Foundry Lane, Byker, Newcastle-upon-Tyne.
Tel. 091 - 276 0660.

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VIDEOS

'Say NO to Strangers.
Home Office video. 15 mins. long.
Distributed by CFL Vision, Chalfont Grove, Gerrards Cross, Bucks, SL9 8TN.
Hire Charge - Free.

Kids can say NO
20 mins.
Distributed by: Albany Video Distributors, The Albany, Douglas Way, London.
Hire Charge - £8. Purchase £36.

Sounds Like a Rainbow to me!
VHS Colour 20 mins.
Drama with profoundly handicapped children.
Available from: Liz Hare, Open Gate, 29 Gladstone Terrace, Bulk Road,
Lancaster, LA1 1DW. Tel. 0524 39552.
Price - £20 inclusive of booklet.

* *

EXTRACTS

TITLE — Classroom performance and social factors of children with birth weights of 1.250 grms or less - follow up to 5 to 6 years of age.

AUTHORS — Betty Low Eilers, MD. Nirmala S. Desai MBBS, Melissa A. Wilson RN MSN, M. Douglas Cunningham MD.

From the Division of Neonatology, Dept. of Paediatrics, University of Kentucky College of Medicine, Lexington

Taken from: Paediatrics Vol. 77. No. 2 February 1986.

33 L.B.W. Children, all below 1250 grms. admitted to the neonatal intensive care unit of University of Kentucky Medical Centre during the period July 1974 - July 1978 were followed up and compared with their peers or school aged siblings to gain some idea of their educational performance. 91% (30) were in mainstream education, 47% (14) of these needing extra tuition to maintain their grades -9.1% (3) were receiving special education and were in classes for children with major handicaps. The 16 who were in mainstream school and requiring no remedial help tended to be from families in a high social-economic bracket, and likely to have received more suitable stimulation throughout their early life. The authors feel encouraged by these results, and speculate there could be a need for early intervention to increase the parenting skills of the young mothers of these children, as early suitable stimulation seems to be of such benefit.

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TITLE Noisy Toys = A possible source of sensorineural hearing loss.

AUTHORS Alf Axelssson MD & Thomas Jesson.
Dept. of Audiology, Sahlgrenska Hospital, University of Goteberg, Goteberg, Sweden.

Taken from: Paediatrics Vol. 75 No. 4 October 1985.

In recent investigations it was demonstrated 2/3rd of hearing losses in a group of 1000 children could be related to exposure to gunfire and noisy leisure time activities. The sensitivity to noise in humans at a young age is completely unknown, but there is circumstantial data to indicate it could be greater than that of adults. Sound levels from certain toys have shown values that exceed damage risk criteria set for adults - in particular toy weapons. Many toys produced for older children produce sounds intended to simulate the noisy real objects on which they are based, thus enhancing their attractiveness.

It is questioned that some commonly used squeaky toys have the same effect on young children - seven of these were analysed and sound levels at a distance of 10 cms were 78 - 108 dB. The noise in all cases consisted of pure tones which could be even more harmful, than the sound level suggests. Hence the authors conclude there is a clear risk of noise induced hearing loss if these toys are constantly used close to the ear of the child.

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Diane Oliver, Senior Physiotherapist at Stanley School, Pensby Road, Thingwall, Wirral has been kind enough to send us a treatment note of interest.

Lorraine, aged six with cerebral palsy and mentally handicapped, had severe bilateral shortening of her achilles tendons. She was treated on a Flowtron machine to induce relaxation and stretch her achilles tendons. The results were dramatic. During treatment, her feet could be over corrected without apparent discomfort, she was also more generally relaxed, thus making her treatment more beneficial.

HAVE YOU HEARD ? ? ? ? ? ?

Maubri Fashions Unit 13b, Springfield Industrial Estate, Fursley, Leeds, West Yorkshire, LS28 5LY - make washable lined capes in choice of lengths and fastenings for children and adults, also made to measure clothing.

Christianna - also make clothes to order for any size or disability - White Cottages Lodge, Wrexham, Clwyd. Tel. 0978 752534.

The Pill Mill price £5.95 from most chemists - has 28 compartments to help organise a pill taking regime.

Orthokinetics operate a buy-back system and sell reconditioned models of wheelchairs - Orthokinetics UK Ltd Gaffney House, 190, Commercial Road, Totton, Southampton SO4 322.

Jig Saw Library - being started by Doreen Sewell, "Cheluki" 772, Foundry Lane, Leeds LS14 6BN. Information contact this address.

Boots have asked Everest & Jennings to design and develop an exclusive range of wheelchairs to appeal to the majority of users and meet their needs. Further information from: Boots Head Office, Nottingham.

Post Adoption Centre, Gregory House, 48 Mecklenburgh Square, London WC1N 2NU. Tel. 01 833 3214/5. Can be phoned or visited to discuss any problems that may be associated with adoption.

T.A.M.B.,A. Twins and Multiple Births Association, - exists to give support to parents of twins, triplets or more. Information: The Secretary, Katy Gow, 20 Redcar Close, Lillington, Lemmington Spa, Warwickshire CV32 7SU.

Sunday April 17th wil be observed as National Cystic Fibrosis Sunday when it is hoped special prayers will be offered in churches for all sufferers, parents and care staff. This is the beginning of the National CF Week 18 - 26 April.

Caravan Holidays for Cystic Fibrosis Families - Information - Cystic Fibrosis Research Trust, Alexandra House, 5 Blyth Road, Bromley, Kent BR1 3RS. Tel. 01 464 7211.

The RNIB have holiday hotels where the staff understand the problems of the visually handicapped. Contact RNIB, 224, Great Portland Street, London W1N 6AA.

Expectant mothers who want their children to grow up contented should sing to them during pregnancy, the vibrations of the mothers song are felt by the unborn foetus and give it a sense of harmony with the world it is about to enter. Sir Yehudi Menuhin speaking at the inaugural meeting in London of the British Society for Pre-natal Psychology in Medicine.

Kidscape '86, 82, Brook St., London W1Y 1YG is a campaign providing practical ways for children to keep safe from dangers and particularly sexual assault, with the help of parents teachers and others.

The Childrens Foot Health Register, lists footwear retailers who have pledged to carry adequate stocks of childrens shoes in four width fittings and to provide trained staff to measure the childs feet and carefully fit shoes at the time of sale. The Register is revised annually. Information from: N. R. Wilkins, Administrator, Childrens Foot Health Register, 84 - 88 Great Eastern St., London EC2A 3ED.

The London Dial-a-Ride Users Association came into being recently. It replaces the Federation of London Dial-a-Rides, and hopes to provide an opportunity for users to get together and press for improvements in the quality and quantity of the services and will offer advice to DaR users. London Dial-a-Ride Users Association, St. Margerets, 25 Leighton Road, London NW5 2QD. Tel. 01 482 2325.

Under new powers which came into force in July, local authorities are now empowered to make police checks on their paid staff and volunteers, who apply to work with children and adults in the households of those who care for children as foster parents and child minders. It is proposed to make similar checking arrangements for staff and volunteers in the NHS and for those working in independent schools.

Government agencies in Japan are funding research on robots that will care for the handicapped. Kobe University has developed a talking physiotherapist! Placed on a patients bed it moves its arms according to a micro computer programme to help paralysed people to move their limbs. It has the ability to mimic the human physiotherapist and talk in soothing terms! Could we be in danger of being replaced soon?!

The Holiday Care Service has recently set up a service called Holiday Helpers to try and find suitable helpers for people who cannot go on holiday on their own. The Holiday Care service cannot however pay any part of the cost of the holiday and the costs of the helper have to be met. For further details: Tim Smith, Holiday Helpers, 2 Old Bank Chambers, Station Road, Horley, Surrey RH6 9HW. Tel. 0293 775137.

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HELP NEEDED

Lyn Horrocks, a Senior Physiotherapist in Wales is currently studying for the Certificate of Management Studies Course and is requesting information.

The topic of her research project for the course is the feasibility of producing a teaching video, and accompanying leaflets giving information about the work of the Childrens Centre at the University Hospital of Wales. This is a multidisciplinary centre for the assessment and treatment of young children with special needs. Numerous professionals visit the centre and consideration is being given to the need

to improve communications and information. Any therapists who have been involved in producing similar videos or information leaflets and could offer help and advice or feedback please contact:

Lyn Horrocks, The Childrens Centre, University Hospital of Wales, Cardiff. Tel. 0222 755944 Ext. 3585.

FORTHCOMING COURSES

February	**5**	**Paediatric Physiotherapy - Handling the Handicapped Child.**
February	**12**	**Child and Adult Muscle Disease.** Details for both courses: Mrs. B. Hindley, Higher Clerical Officer, Rehabilitation Unit, Withington Hospital, Nell Lane, Manchester M20 8LR. Tel. 061 447 3409. Price on application.
March	**2 - 5**	**Ankle Foot Orthoses for the Management of the CP Child.** Details: Prof. J. Hughes, Director, Nat. Centre for Training and Education in Prosthetics, University of Strathclyde, Curran Building, 131 St. James Rd., Glasgow. price £160. NHS Free.
March	**6**	**The New Chailey Adjustable Postural Support Seat.** Venue: Preston. Details and application forms: Mrs. Gay Hall, Head Occ. Therapist, The Willows CDC, Peddars Lane, Ashton, Preston. Price £7.50. See Course programme.
March	**6**	**Physical Therapy (including PNF) for Neurological Patients.** Littlewood Hall, Leeds General Infirmary. Details: Jill Smith, Acting Head Speech Therapy Services, St. Mary's Hospital, Leeds 12. Price £12.
March	**12 - 13**	**Neurosciences Course for Therapists.** Details: Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield WF1 4DG. Price £30.
March	**13**	**Paediatric Chest Conditions.** Details: Mrs. B. Carter, Course Secretary, Demonstration Centre, Area 'A' Wythenshawe Hospital, Manchester M23 9LT. Price on application.
March	**13/15**	**The Hand as a Guide to Learning.** Castle Priory College, Thames St., Wallingford, Oxford. Tuition £47. Residence £42. Non residence £15.
March	**16/20**	**Micro-Technology and Special Educational Needs.** Castle Priory, Thames St., Wallingford, Oxford. Tuition £70. Residence £84. Non residence £30.
March	**16/22**	**Introduction to Paediatrics in the Community.** Venue: Child Development Unit, Rowan House, Grange Road South, Hyde, Cheshire SK14 5NY. Tel. 061 366 5705. Applications: Mrs. Linda Whitaker, Supt. Community Physiotherapist at the above address. Outside places limited to 10.

March	**18**	**Management of Motor Neurone Disease.** Details: Secretary, Demonstration Centre, Mary Marlborough Lodge, Nuffield Demonstration Centre, Headington, Oxford OX3 7LD. Price £20. Closing date February 13.
March	**20**	**Younger Disabled Unit Conference.** Littlewood Hall, Leeds General Infirmary, Leeds. Details: Mrs. J. Packter, Rheumatism & Rehabilitation Research Unit, 36 Clarendon Rd., Leeds LS2 9PJ. Tel. 0532 441199. Ext. 278. Closing date March 13. Price on application.
March	**21/22**	**Swimming for Disabled (Halliwick Method) Part A.** Venue: Ashleigh Centre - Blackburn. Details: Mrs. B. Duncan MCSP, Lancasterian School, Elizabeth Slinger Road, Manchester M20 8XA. Cost £20 including tea/coffee but not lunch.
April	**13 - 14**	**Perceptual and Cognitive Rehabilitation.** Details: The Co-ordinator, Demonstration/Aids Centre, Rookwood Hospital, Llandaff, Cardiff, CE5 2YN. Price £34. Closing date March 2nd.
June	**3 - 5**	**Child Abuse and Neglect.** Castle Priory College. Details on request.
June	**5 - 7**	**Listening and Responding.** Castle Priory College. Tuition £48. Residence £44. Non residence £16.
July	**20 - 24**	**Blissymbolics Communication System.** Castle Priory College. Tuition £125 (incl. Materials) Residence £88. Non residence £32.

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Course Programme for 'The New Chailey Adjustable Postural Support Seat' Provisionally called 'The Chailey Adaptaseat'

10.00	Introduction. Moulded Seating and its disadvantages. The Orthogonal Moulded Seats. Padded Inserts. The Chailey Adaptaseat.
10.25	Assessment procedures. Levels of Sitting Ability. Prescription Criteria.
11.00	Coffee and try a ramped cushion!
11.30	Design philosophy of the Adaptseat.
11.40	Discussion of the clinical trials.
1.00	Lunch

2.00	Demonstration of the Chailey Adaptaseat.
2.30	Assessment and Fitting of the Chailey Adaptaseat.
3.00	Logistics of Supply.
3.30	Tea and departure.

Presented by: Roy Nelham Technical Director.
Catey Mulcahy, Research Occupational Therapist.
Terry Pountney, Research Physiotherapist.
Geoff Billington.

The Chailey Adaptaseat will be available from Everest & Jennings Ltd. from March 1987 and this Study Day will introduce participants to the design and application of the Adaptaseat. The day will be of interest to all those who have involvement in the provision of adaptive seating, or who treat children and adolescents who have special seating needs.

50 places only.

ARTICLES OF INTEREST

Copies of the following articles can be ordered from: Mr. M. Saunders Asst. Librarian, National Demonstration Centre, Pinderfields General Hospital, Wakefield, W. Yorks. WF1 4DG. Please quote the bulletin date, 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.

November 1986

6
Fitch KD et al
The effect of running training on exercise-induced asthma.
Ann Allergy 1986 Aug; 57 (2) : 90 - 4.

16
Smart S Richards D
The use of touch sensitive screens in rehabilitation therapy.
Br J Occup Ther 1986 Oct; 49 (10) : 335 - 8.

28
Glynn MK et al
Management of the upper-limb-deficient child with a powered prosthetic device.
Clin Orthop 1986 Aug; 209 : 202 - 5.

32
Rodger S
Parents as therapists: a responsible alternative or abrogation of responsibility?
Except Child (Queensland) 1986 Mar; 33 (1) : 17 - 27.

36

Cirillo S Sorrentino AM

Handicap and rehabilitation: two types of information upsetting family organization.

Fam Process 1986 Jun; 25 (2) : 283 - 92.

December 1986

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Mulcahy CM

An approach to the assessment of sitting ability for the prescription of seating.

Br J Occup Ther 1986 Nov; 49 (11) : 367 - 8.

15

Paik SS Barton J

Equipment review: made-to-measure walking aid.

Br J Occup Ther 1986 Nov; 49 (11) : 361.

17

Brooks PL Frost BJ

The development and evaluation of a tactile vocoder for the profoundly deaf.

Can J Public Health 1986 May - Jun; 77 (Suppl. 1) : 108 - 13.

38

Madison LS et al

Changes in stuttering in relation to children's locus of control.

J Genet Psychol 1986 Jun; 147 (2) : 233 - 40.

47

Bertoti DB

Effect of short leg casting on ambulation in children with cerebral palsy.

Phys Ther 1986 Oct; 66 (10) : 1522 - 29.

49

Nwaobi OM

Electric goniometer for positioning children with cerebral palsy: suggestion from the field.

Phys Ther 1986 Oct; 66 (10) : 1540 - 1.

53

Drago CJ

Design considerations for construction of a mouthstick prosthesis.

Quintessence Dent Technol 1986 Jul-Aug; 10 (7) : 451 - 3.

REGIONAL REPORTS

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

The Liverpool Childrens Hospital at Myrtle Street, organised a 'Hemiplegia Day' with Colin Stevens in November. The day was very well attended and enjoyed by many APCP members and their friends, and provided another good opportunity for APCP propoganda.

The Regions Annual General Meeting is to be held at Arrow Park Hospital, Birkenhead on March 7th 1987. The meeting will be included in a Study Day on the Visually Handicapped Child. Information and application forms may be obtained from our Chairman: Pam Dowell, Dorrin Park School, Wheelstone, Liverpool.

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

A very successful Study Day entitled 'Cerebral Palsy' was organised by the Southampton District Paediatric Physiotherapy Service on November 15 1986. Speakers were Professor McLellan, Mrs. Esther Cotton, Miss Sophie Levitt and Mr. David Scrutton.

Over 120 people attended and much lively discussion was elicited. Ten Paediatric Superintendent Physiotherapists met in early November to discuss the needs of the Region, and the programme for the next two years. Two Regional study days are to be planned per year, interspersed with smaller work shops planned on a more local basis so members can discuss techniques and problems in more informal settings. The Spring regional Study Day is to be held in Dorchester on March 21st 1987, and will be entitled "Education - the effect on the 1981 Education Act. It is hoped there will be a representative from Education.

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

A successful and well attended Day Course on Hydrotherapy was held in early November. A good balanced programme was set by Bridget Davies, who demonstrated individual treatments by the Bad Ragaz method, and Colin Stevens who showed us group stimulation using the Halliwick method.

At our evening meeting at the end of November, Mr. MacFaul gave a very interesting lecture on Epilepsy. We are hoping to have our AGM at an evening meeting in March.

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

The Annual General Meeting - Members only - will be held in the Physiotherapy Dept. Royal Hospital for Sick Children, Yorkhill, Glasgow on March 28th 1987 at 11.15 a.m. followed by a Buffet lunch with wine price £3. Tickets from Miss M. Grant, Supt.

Physiotherapist, Royal Hospital for Sick Children, Sciennes Road, Edinburgh EH9 1LF by the 14th March. Nominations for the Scottish committee to Miss M. Grant. There are vacancies in RHSC Yorkhill, West Scotland, Fife, Tayside, Dumfrieshire and the Borders.

At 2 p.m. there will be a lecture on "The Contemporary Management of the Paralysed Child" by Mrs. E. Condie, MCSP National Centre for Training and Education in Prosthetics and Orthotics, University of Strathclyde.

Wales

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

We held a study day in November which was attended by parents, teachers, care-workers and therapists. The aim of this meeting was to learn about the 'Play to Grow' scheme and explore the idea of starting the scheme locally.

So successful was this study day that the first 'Play to Grow' session was held in early December.

"Lets Play to Grow' was initiated in America, in 1976, sponsored by the Joseph P. Kennedy Jnr. Foundation. Last summer Chris Maloney from the Gloucester Leisure Centre, and Dilys Price, Senior Lecturer in dance and movement came across the scheme whilst visiting the Special Olympics in America. Dilys Price, who was responsible for bringing Special Olympics to this country and Chris Maloney, felt the 'Play to Grow' idea was something that could be tried in this country. Chris started the first group in Great Britain, which meets regularly during school holidays, at the Gloucester Leisure Centre.

The idea is to provide a venue where families of children with special needs can meet - play together and have fun. The sessions last about two hours and include a programme of activities for children of all ages and abilities. Twenty families of young children with special needs, and many friends came to the inaugural meeting of Cardiff's 'Lets Play to Grow' on Saturday December 6th, in the Dance/Drama Studio, a large, warm attractive room, arranged by Dilys Price. The topical theme for the day was "The Snowman' which we incorporated in games, stories and creative dance. We made snowflakes and enjoyed a sing-song and a visit from Father Christmas. Everybody joined in with festive spirit, and proclaimed the afternoon a great success. We all look forward to arranging a similar session in the Spring.

Anybody interested in this scheme, is welcome to contact:

Lyn Horrocks or Viv Williams at the Childrens Centre, University Hospital of Wales, Heath Park Cardiff. Tel. 0222/755944 ext. 2241 3585 or 2470.

East Anglia **Reg. Rep. Mrs. Lyn Weekes, 37, The Cedars, Milton Road, Harpenden, Herts. AL5 5LQ.**

Our next meeting is a Study Day on the 'Lower Limb', to be held on March 3rd at Wexham Park Hospital, Slough, Bucks. Mr. Swann will be speaking about surgery of the lower limbs, and Mr. Florence on lower limb orthoses. There will be a Trade Exhibition during the day, and an AGM for APCP members.

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

The AGM will take place on Tuesday March 3rd at The Hospital for Sick Children. Great Ormond St. The Programme will be: 6.30 p.m. AGM 7.00 p.m. The Visually Impaired Child-Patrica Senkson. 8.00-9.00 p.m. Cheese & Wine Buffet.

We do hope as many people as possible will be able to attend as the evening should prove to be not only informative but also an opportunity to chat to fellow APCP members. Details of this event will be in Physiotherapy, and the London Branch February Newsletter. Future study evenings and days are being arranged for May, June and September.

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The Membership Secretary and Treasurer would like to remind members that the ANNUAL SUBSCRIPTION OF £7.50 was due on JANUARY 1st. If you have overlooked this important fact, will you please hurry up and shake the moths out of your cheque books! At the same time notify any change of name or address since last you paid. Thank you.

* *

CHILDRENS CONSCIENCE CODE

NEVER

go with anyone - even someone you know - without asking Mum or Dad first.

NEVER

take anything - even sweets - from a stranger.

NEVER

get into a car or a van with a stranger.

NEVER

play anywhere out of sight, especially on your own.

NEVER

play outside after dark

Always go home by the same route - don't wander off

Always tell your teacher or parent if a stranger tries to talk to you

* From a leaflet prepared by the Central Office of Information for the Home Office.