ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS

NEWSLETTER

Association of Paediatric Chartered Physiotherapists
Newsletter N. 43 **May 1987**

ABUSE OF THE CHILD

CONTENTS

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EDITORIAL

As a result of the court case concerning a mentally handicapped young lady and the desirability of surgical intervention in the form of sterilisation, the minds of the public has been focussed on the abuse of childrens rights. There have been many views quoted in the media from people in all walks of life with an opinion to air, not least being that of Sir Brian Rix, secretary general of Mencap who said "this is a completely retrograde step." At the other end of the spectrum a Consultant Gynaecologist said 'that there were cases where such operations were needed for the childs own protection.'

Abuse of childrens rights has also been well aired on the subject of test tube babies and surrogate motherhood. The increasing success rate of the in-vitro fertilization techniques and the freezer storage of sperm must raise questions of morality, and the advisability of experimentation with human embryos.

With increasing media coverage expressing many diverse views, people are made ever more aware of the continuing infringement of childrens rights, leading to healthy discussion and sympathetic support in most areas. However, perhaps it should be remembered that not all parents are wrong, and they have a right to exercise their concern not only for the physical protection of their child, but also on matters which may affect the childs moral welfare, without infringing on his other rights in any way.

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By the time this Newsletter is published the 1987 APCP Conference will have gone, but readers take note:-

The 1988 CONFERENCE will be at Warwick University - April 15/16/17.

Be prepared to book early.

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The last date for submission of material for the AUGUST 1987 Newsletter will be July 4th.

THE PROTECTION OF CHILDREN UNDER THE LAW

by T. Philip Dann

It should always be remembered that much of the general criminal and civil law operates to protect children as well as adults. Examples are the criminal offences of murder, assault, rape, incest and theft; and civil claims for false imprisonment and trespass. What follows, however, is an attempt to summarise the most important rules of law applying specifically to children. These are found partly in statutes (legislation) and partly in the decisions of the courts (case law).

There are numerous criminal offences relating to children. It is an offence for any person over the age of sixteen who has the custody, charge or care of a child under that age to asssault, ill-treat or neglect the child: Children and Young Persons Act 1933, s. l. There are various more specific offences under the same Act: exposing a child under the age of twelve to the risk of burning (s. 11); causing or allowing a child under the age of sixteen to beg (s. 4); and allowing a child between the ages of four and sixteen to reside in a brothel (s. 3).

Most sexual offences relating to children are defined in the Sexual Offences Act 1956. These include unlawful sexual intercourse with a girl under sixteen (ss. 4 and 6); and procuring a girl under twenty-one to have unlawful sexual intercourse in any part of the world (s. 23). The 1956 Act also provides that the consent of a boy or girl under sixteen is no defence to a charge of indecent assault. There is a related provision in the Indecency with Children Act 1960, which makes it an offence to commit an act of gross indecency with or toward a child under fourteen. Also, the Protection of Children Act 1978 creates an offence of taking, distributing or showing indecent photographs of a child under sixteen, or having possession of such photographs for any of these purposes.

Various offences of abduction or child stealing are provided for in the Sexual Offences Act 1956 (ss. 9 and 20) and the Child Abduction Act 1984.

The Children and Young Persons (Harmful Publications) Act 1955 is particularly interesting, because it reflects the suspicion which adults have of comic books. The Act makes it an offence to print, publish or sell books or magazines of a kind likely to fall into the hands of children if the material portrays crimes, acts of violence or incidents of a repulsive or horrible nature in a way that would tend to corrupt a child. However, this only applies to material consisting wholly or mainly of stories told in pictures, with or without text.

A well-known provision is the duty placed on parents by the Education Act 1944 to ensure that children between the ages of five and sixteen receive an efficient full-time education. Failure to perform this duty is a criminal offence, and can also give rise to care proceedings.

The law tries to shield children from all popular vices. It is an offence under s. 7 of the Children and Young Persons Act 1933 to sell tobacco to a person apparently under the age of sixteen: this is one of the few cases where the law refers to the apparent, not actual, age of a child. The Licensing Act 1964 contains various offences in relation to licensed premises, such as to allow a person under fourteen to be in the bar; to employ a person under eighteen in the bar; to sell intoxicating liquor to a person under eighteen; and to allow a person under eighteen to consume intoxicating liquor in a bar. The Betting, Gaming and Lotteries Act 1963 makes it an offence to effect a bettting transaction with a person under eighteen. Chilren have, of course, discovered their own vices: hence the Intoxicating Substances (Supply) Act 1985, which creates the offence of supply to persons under eighteen of certain substances which may cause intoxication if inhaled.

It is right to mention also the Consumer Credit Act 1974. Under s. 50 it is an offence to send to a minor a document inviting him to borrow money or obtain goods or services on credit.

There are detailed and complex provisions restricting and regulating the employment of children. For example, children under thirteen may not in general be employed at all; and there are restrictions on the hours which may be worked by those under school-leaving age: Children and Young Persons Act 1933, s. 18. Special provisions apply to the employment of children in, for example, agriculture, shipping, entertainment and street trading.

Finally, in relation to the criminal law, it should be remembered that most forms of medical or dental treatment will amount to an assault unless the patient consents to the treatment. Under the Family Law Reform Act 1969, s. 8, a minor over the age of sixteen may give the necessary consent. On the other hand, the tatooing of any person under eighteen is an offence unless the tattoo is performed for medical reasons by or under the direction of a medical practitioner: Tattooing of Minors Act 1969, s. 3.

There is a vast body of family law applicable to children, dealing with matters such as custody, adoption, guardianship, care and wardship. There is only space to mention a few provisions which relate specifically to the protection of children. First, an important principle is established by the Guardianship of Minors Act, s. 1. This states that in any proceedings before a court in which the custody or upbringing of a minor is in question, the court shall in deciding that question regard the welfare of the minor as the first and paramount consideration. This means that the rights or interests of parents may have to be overridden.

Secondly, the courts have various powers to grant injunctions restraining a person from assaulting or molesting a child living in the same household. One parent may apply for an order against the other, or against a person with whom he or she is living as husband and wife. The spouse or cohabitee may also be ordered to leave the matrimonial home.

Thirdly, local authorities have a duty to bring before the juvenile court a child who, although he may have a parent or guardian, is in need of care and control: Children and Young Persons Act 1969, s. 2. In certain circumstances, a local authority has a duty to receive a child into its care: Child Care Act 1980, s. 87.

Finally, mention should be made of two general principles of civil law which operate for the protection of children. The first is that children under eighteen have a only limited capacity to enter into binding contracts. The second is tht, although children can in general own property, if they own land there must be adult trustees.

LIMITED RIGHTS FOR THE UNBORN

by Terence Shaw

Which role, if any, should the law play in seeking to protect the unborn child from injury caused by the mother who, despite warnings, smokes, takes drugs or drinks to excess during pregnancy?

This legal hornet's nest has been stirred by the unprecedented foetal-abuse prosecution in California of a woman whose use of amphetamines during pregnancy is alleged to have contributed to the death of her son. Prospects of a similar prosecution being brought in Britain have been canvassed, particularly in the light of the recent House of Lords appeal as to whether the effect on the foetus of a mother's heroin addiction could be taken in to account by a local authority seeking a care order under the 1969 Children and Young Persons Act.

Although it seems to some lawyers a far fetched consequence, others have suggested that if a mother's abuse of the child in her womb can be a factor in care proceedings, then on similar principles she may be at risk of criminal prosecution. At present the law in England and Wale provides an unborn child with only relatively limited protection against harm caused by the mother. Killing an unborn child cannot be murder, because for murder the child must be shown to have a separate existence from the mother.

To fill this gap, offences of child destruction and attempting to procure abortions not legalised by provisions of the Abortion Act have been introduced.

What, however, if the harm which causes the child to die or be born with gross deformities or brain damage is not deliberate but the result of the mothers gross negligence as might be alleged if she persisted in, say heavy smoking? Such law as there is in this field is based on old decisions of the courts whose validity in modern times is far from clear. In an 1832 case it was held that where injury to the child was caused by the mother's gross negligence which led to the child dying after its birth, the mother could indeed be convicted of manslaughter.

But as Prof. John Smith and Prof. Brian Hogan point out in their leading textbook of the criminal law, the logical step of the mother being guilty of manslaughter where a child dies as a result of gross prenatal neglect, has not been taken. The rule appears to apply only to acts and not omissions by the mother.

Should the child survive, however, but with deformities or brain damage caused by the mother's behaviour during pregnancy, there will be no prospect of suing the mother for compensation under the civil law.

This is the effect of the 1976 Congenital Disabilities (Civil Liability) Act passed by Parliament after the thalidomide tragedy, to make it clear that a child born disabled in England, Wales and Northern Ireland as a result of ante-natal injury could sue for damages. But the Act specifically excluded actions against the mother except where the injury is caused by the mother's negligent driving which would normally be covered by compulsory third party insurance. It still allows a drugs firm, sued by the child for alleged ante-natal injuries, to claim in its defence that the real cause of the injury was the mothers smoking, drinking or drug abuse, or that this should reduce any damages it might be ordered to pay the child.

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'THE CHILD'S RIGHT TO GRIEVE'

Dr. Michael Shooter, Consultant in Child and Adolescent Psychiatry

Working with the dying and bereaved can be as painful for the carer as those in their care. Not surprisingly, anyone setting out to help is likely to be faced with a wave of referrrals from those as yet unsure of their own skills or unready to suffer the experience themselves. To avoid going under, the helper reaches for rafts of 'normality' and 'abnormality' to hang onto amongst the chaos. Soon there emerges the image of an 'expert' with a free-floating body of expertise - and when the temptation to go into print becomes too great, the process is complete!

I have never believed in such expertise in an area as subjective as bereavement. Any knowledge I have is culled from my own experiences as a person, parent and professional and from that of my clients and colleagues. What I have to say remains, at heart, only an opinion unbolstered by the usual mass of references. The psychology bookshelves groan under the weight of books about death - death is a growth industry! But they too, it seems to me, are opinions rather than scientific fact and should be read as such. The readers of this article, I hope, may find something that gels with their own experiences; they will almost certainly find things with which to disagree. In the last resort, what matters is what seems 'right' to the individual helper and those they are struggling to help. It is a matter of beliefs - and nowhere are they more controversial than in the world of children.

Why the title? Haven't things changed as far as children are concerned? By the 1940's writers were already outlining the child's concept of death in an age where death was a commonplace in their life, most people died at home and children and adults mourned together around the body - wasn't that what front rooms were for? Practical thinkers like Bowlby sparked a revolution in paediatric practice founded on the recognition that children go through the same stages of grieving as adults. Operations were to be avoided, if possible, or parents brought in to share the experience with their children rather than suffer the greater trauma of separation - a 'bereavement' in itself. Oncology wards have encouraged children to talk openly about what is happening to them; siblings are being included in family upset. When my own children's grandfather was admitted to an intensive care unit, the staff allowed them free rein to visit him there, explained X-rays and charts to them and made them feel part of his 'care'. When the time came to turn off his life-support machine, we assembled them first and stood around him while he died and until the last of us, family and staff together, had said our goodbyes. Death, on some wards, is truly a 'family affair'.

In truth, however, the tide seems to run the other way and these are islands of good practice standing out against it. Death is 'satanized' in the modern world and the body tucked away behind the hospital screens. Feelings are flattened by the technology of it and repressed; while television sets scream death daily at them, our children are more and more divorced from the reality of it. There are few accounts of teachers talking about death with children in the classroom though there cannot be a term pass without an opportunity to share the grief over a relative or pet.

It is a short step from the natural desire of adults to 'protect' children from suffering to the assumption that young children cannot or should not 'grieve' in the adult sense, and some psychologists have corroborated this. I have seen it suggested that children cannot make a clear enough distinction between past, present and future; that they cannot sustain one emotion for long enough; that they do not understand the permanence of death; that they cannot retain memories of a lost one or are not sufficiently attached to mourn the loss - in short, that children lack the emotional and cognitive capacity to grieve. The advice to parents is to shelter the children from something they cannot properly grasp, keep a stiff upper lip in front of them or send them away from it all, really or metaphorically, until the dust settles.

It is personally disconcerting to feel that people may not share your beliefs, but it is all the more worrying professionally when the empirical evidence from your work with children and families suggests that children are being denied, by misplaced care, their natural need to experience and express their grief. For feelings repressed do not go away. They are bottled up and leak out later or explode under pressure from similar separation experiences that stir them up. The extreme anxieties of some school refusers I have seen have been rooted in earlier, 'badly' handled bereavements to which they belong. The experiences of adult and child unshared cannot be tested against each other. I have known a daughter and her mother, for example, stuck with separate halves of their dead father and husband; the daughter unable to draw more than half his face - the 'smiley half' - and unable to understand her mother's angry memories of their marital battles. Both of them were unable to 'bury' half a person and unable to share their halves to make a whole. I have known family members retiring separately to an attic room to cry alone for fear of upsetting each other - divided by grief unspoken and comfortless that leaves the child, dying or bereaved, to face it alone, filling in the gaps in its knowledge with fantasies that may be far more frightening than the facts.

How might we help? We start, it seems to me, with the realisation that our 'protection' of children is really a projection of our need to protect ourselves - and that begins with us, as professionals involved with the dying and bereaved children in our care. Such a child invokes an intensity of emotion that can seem endless and chaotic - like going 'mad' or being drawn into the dying process itself - and against which we seek to batten down all the emotional hatches for fear of being carried away in the flood. Helping the bereaved arouses the anxieties about our own mortality that we all carry within us, or challenges us as parents ourselves about the potential loss of our own children. It may awaken memories of actual bereavements in our own lives; a therapist may even be bereaved, as I have been myself, during the course of therapy.

The death of a 'client' can seem like failure to those trained in looking for cure and the grief of a child is hardest of all to bear, the 'guilt' most difficult to assuage. And so we build up defences by maintaining a professional distance from each other and by tailoring what we say to our perception of our clients' 'strengths'. That, with grown adults let alone children, usually means little at all. The model is followed by the families themselves. On wards where doctors and nurses do not share their own feelings with each other or their clients, husbands and wives do not communicate openly together or with their children. A distraught father rushed his son to see me with 'a morbid fascination with death' when his son asked him, a year after the grandmother's death, if the worms would have eaten her up. The father himself had had his own questions flattened by staff at the time of his mother's death and was unable now to alllow his son the space to resolve his own feelings in turn.

As professionals, we need actively to encourage the involvement of children in the grieving process. This means that they need talking to in language that they can understand and not the metaphorical allusions to 'grandfather going on a long sleep' that may be less painful for a parent to say, but which merely makes the concrete-minded child frightened of going to sleep in case they don't wake up too! It means asking the children whether they would like to take part in the ritual vehicles of grieving - being present at the bedside, seeing the body after death, going to the funeral - and honouring the commitment when they unexpectedly say yes. It means adults openly expressing their fears in front of their children so that children have 'permission' to cry too. It may mean carving out space for children to begin to grieve themselves long after their parents have 'put all that behind them' and would rather their children do so too - the teenager in a wheelchair with spina bifida or tied to a dialysis machine, who begins to appreciate for the first time the different future in store for her and needs to grieve the loss.

In all that, we need to be aware of points in the grief-cycle that may be particularly difficult for children and the emotions with which they are most likely to get 'stuck'. Little children live in a 'magical' world in which small distinction is made between thinking something hard and it actually happening; in which, if it does happen, it is as if the child has caused it and in which 'punishment' will surely follow. Children jealous of the attention given to a chronically ill sibling or who are rival to the parent of the same sex for the mother's or father's love will often wish them 'dead'. If their wish comes true, they may feel crippling guilt which the distraught family may unwittingly confirm. 'Look what you've done now' said the frantic mother of a four year old client of mine who sat noisily on the bed of her sick brother the only time she was allowed to visit him in hospital and saw him relapse, suddenly, quite coincidentally but tragically at that very moment.

To help effectively, we need to use the whole gamut of counselling skills - from those always listed at the very bottom of the textbook hierarchies, like 'listening', which seems to me an enormous skill not found in the general population any more, to those supposedly more advanced; like 'disclosure of one's own experiences', that are called on the very first time you sit with a client! We need to remember, too, that far more harm is done to clients by holding off for fear of the extra 'damage' we might do than by trying something new. Work with children often demands more active than purely verbal techniques. I have 'got through' to the repressed grief of children by re-enacting with them the hospital death of their father, this time allowing them to visit me, playing father, and say to me/him all the things they had wanted to say but were prevented from saying because mother and staff together thought he was too mutilated for them to see him. We need always to remember that there is a shape to our relationship with clients that involves building up enough, unhurried trust in ourselves to be able to work through their grief with them in such a way and which must allow sufficient time to separate out at the end without compounding their original bereavement.

Above all, we must build into our service a continuing outlet for our own 'grief' as helpers and mutual support with that grief lest we repress our clients in the attempt to protect ourselves. In order to help adults or children we need to get close to them and our own feelings will inevitably be churned up in the process. We can no more split ourselves off from the experience than our clients can and we, too, will need help with our pain. Some groups do that routinely and openly in their day-to-day relationships; others recognise their ability to duck the issues and organise specific support-group sessions in which to address them. In South Glamorgan, we have run multidisciplinary, experiential workshops to share our feelings and experiences.

It seems to me that the value of all these opportunities lies not in any long-standing reduction of anxieties but in a recognition that our work will always be painful and that we will always be challenged, often excruciatingly, in our beliefs. At the last workshop I led, a participant demanded to know what right I had to suggest that a dying eight year old be encouraged to talk about his death rather than kept in a happier 'ignorance' of it. Her tearfulness drove arrows of doubt into my carefully 'thought-out' world. I began to backtrack and it was left to my colleagues to point out that such a child would almost certainly know what was happening to him and that to pretend otherwise was to isolate him in his grief.

All of us, being human, will defend against what we believe is right when putting it into practice is as painful as working with the child who is dying or bereaved. The child has a right to grieve. We must be careful to allow him to do so.

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THE RIGHTS OF THE CLIENT

Professionals as Proactive, Reactive and Interactive.

by Paula Halliday, Headteacher, Lancastrian School.

It was the end of a module on sex education. The fifth years had had many opportunities to explore sexual functions, feelings and responsibility, and as a way of sweeping up the ends had been asked to write down any questions that had been left unanswered, on paper, and put them in "the hat" for discussion at the final session. The questions were all unsigned and the young people's anonymity was protected by a post box system.

At the session, many questions posed were merely checking out understanding of facts, but two stood out as being different. The first asked, "Why are people so ignorant to the disabled?" Whilst the second questioned "Can disabled people have sex with able bodied people?" Both questions shared starkly the perception of this group of young people that 'the disabled' are a separate subset of society. The first question assigned the problem in relationships with the able bodied subset, whilst the second described the problem as one where the barriers could not be breached. In both cases the focus of control for change was placed well out of reach of the individuals asking the questions.

But sexuality is only one aspect of human relationships, so why the concern? It is perhaps, best explained in terms of the self-awareness of those young people - a self awareness that although it paralells the true perception that in terms of physical functions they were different, was one which equated difference with being less valuable. An examination of where such perceptions come from may be a useful exercise for those working with disabled people.

Self awareness is learned. What is learned may also be taught. Self awareness depends on two sets of factors. One set of factors lies within the person, and dictates how they perceive the world. The other set lies outside and comes from society's response. Neither set is independent. How we perceive and respond to the world can have a casual effect on how it responds to us and vice-versa. There are, however, components of both sets which do not interact. As professionals we help young people sort out their perceptions of the world, to make sense of it and to make physical and emotional forays into it. In this way we help the young person to perceive the world as a comfortable, or as a threatening place. We sometimes forget, however, that regardless of our motives, we act as agents of society and teach young people about themselves, by our response to them. As professionals or parents we are part of society. We share society's responsibility in the formation of young disabled people's self concept. Sometimes because of our involvement we have a greater input than others. I propose to look at three aspects of self concept which we may directly influence.

Firstly, we have involvement with developing the aspect of self concept called 'body image'. We are all stuck in a body. Few of us are happy with the one that we have. The shape, the size is always wrong, and we spend fortunes forcing ourselves nearer to some mythical, acceptable norm. Young disabled people also get messages about this norm, and know they can never achieve it. We work hard to help them reach optimal function. We help them to make decisions about movement of the whole and of parts. We teach them some of the implications of movement or non-movement in a constantly changing mobility environment. We may even teach them about the messages sent by body posture, or body movement in that complicated communication system called body-language. We fulfil our job role by increasing function and fighting deformity. We hope we are aware of our own and other people's reactions to the disabled, but what of the responsibility for honestly addressing the issues of being in a disabled body and all that says about me to others and to myself? Is that outside our job remit?

Sensuality is another aspect of self concept wich we can address. The body is an enormous sense receptor. We use it to help make sense of our whole world, whether by sight, hearing or tactile inputs. We work with our young people by helping them make sense of, and responding to, a constantly changing environment. We enable them to explore this environment by extending their boundaries of movement. We help them sort out or compensate for disorders of sensation. We work really hard to increase competence as a sensing individual.... except for sometimes when for all the right reasons we surround them with hardware, and erect barriers between them and the sensory world. We can all point to youngsters who have had limited learning about textures or size because time for playing on the floor could not be fitted in around treatment and education time, or to the youngster who has to learn about security through holding mother's hand because we have (rightly) insisted that she uses her hands to self propel in her wheelchair.

The third area that I wish to examine is the aspect of self-concept known as the locus of control. This is perhaps the one we can most easily unconsciously or consciously effect without having to compromise professional decisions. Locus of control starts to be established as a baby learns that it is a separate entity from its parents. It learns it is an actor as well as being acted upon. As the able bodied child grows the ability to be an actor increases and the necessity to be acted upon decreases. By young adulthood the able bodied person becomes a fairly autonomous being. Not so the person with a physical disability. For them the emotional boundaries are blurred by the necessity to have others involved in aspects of care which able bodied youngsters keep private. As professionals we are often called upon to manage young adult bodies, part of which may be non-sensing. We can choose to treat these bodies merely as mechanisms or hardware and protect ourselves, or we can involve the whole person we are treating by including them at least by communicating the treatment. If we treat the body as one component of the person and involve the whole person in the treatment, we increase their ability to act on and interact with us. This can feel quite threatening to us, and cause us to have to examine our own attitudes, competences and even prejudices. If we truly value our patients as people, and see our relationship with them as reactive as well as proactive we will be teaching them something about their rights over their own bodies.

This acknowledgment of the rights of the young disabled person over their own bodies is crucial. As professionals we can so easily ignore those rights, either to protect ourselves from involvment or because we see ourselves as having the monopoly in the decision making process about the mechanisms we treat. We have no mandate for this. The therapeutic relationship must be reciprocal. How can we ensure this? The most important way, perhaps is to acknowledge to young people that their bodies are disabled, but not in a negative way. So often we hide behind platitudes like "after a while you don't notice they are disabled". This is not true!! All we teach is that one aspect of that persons life is taboo or not to be treated with honesty. Alongside this we must set and maintain appropriate expectations for performance and progress and share these with the young person. We must support and encourage self-determination and independence even when it leads to questioning of our own input. We must provide a variety of experiences and appropriate discipline to inculcate self discipline. Most of all we must be aware of needs - we must be consistenct and supportive without being cossetting. We should not be in a power relationship over young people. This removes their rights. We must acknowledge we are working for young people not "by doing to them" but by working alongside them to enable them to grow in confidence as well as competence.

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ALTERNATIVE THERAPIES

Hardly a day passes but the press or media feature some new form of 'Therapy' which promises new hope for severely handicapped children, and understandably, many parents in desperation, wish to try out these new methods. This is their right if they so wish.

Many paediatric physiotherapists in consequences are wondering what their position is, should a parent wish to take a child for alternative therapy, whilst in the middle of 'routine treatment'. It is hoped that the following guidelines will clear up any doubts.

1. You are legally obliged by the NHS to treat a child referred to you.
2. Should you discover that the child is receiving other forms of 'Therapy' about which you have no information - FIND OUT ABOUT IT -
3. If, having found out about the alternative therapy you still have concern about the childs welfare, discuss this in depth with the parents, explaining your reasons.
4. Inform you Superintendant and the Health Authority, in writing, that you are unhappy about the childs welfare, so that in case of accident they are aware of what has happened.
5. Do make clear to parents that if they wish to have a break in treatment, but then come back to you, then you will accept them for the sake of the child's treatment.
6. Make an effort to be well informed about alternative methods of treatment, in order that you can discuss them knowledgably with parents, they are naturally seeking 'the best' for their child.

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POST REGISTRATION EDUCATION REPORT

The Abuse of the Physiotherapist.

P. M. Eckersley, Advisor, Post Registration Education APCP

Physiotherapy is a stressful profession. Recent surveys have shown low morale, demotivation and high stress levels amongst physiotherapists. As a profession we are - notorious? - for feeling guilty about keeping patients waiting, insisting on squeezing in an extra child into already overburdened case loads and feeling that if we are not "with the patient" we are not working. This is abuse of the physiotherapist.

If we are to fulfil the needs of the physiotherapy service and the rights of our patients, then the physiotherapist in turn must have rights which are respected.

* The right to feel competent and secure in professional skills.
* The right to have professional skills acknowledged.
* The right to develop competency in practice.
* The right to recharge batteries.
* The right to be told 'you are doing too much'.

The answers to the following questions would make helpful and interesting reading.

1. What "exposure" to paediatric physiotherapy did you have before entering the speciality?
2. If you have just entered paediatrics what sort of In Service Training programme are you involved in?
3. How frequently do you have staff meetings, discussion meetings or continuing education meetings?
4. How often do you take annual leave/pay for yourself to attend a study day, course or SIG meeting?
5. When did you last fit in an extra patient visit on the way home?
6. When did you last prepare a report or plan a treatment session after work/at home?
7. Have you ever attended a clinic appointment with a child on your day off or made "just one phone call" from home?
8. How often do you work through your lunch time to feed a child, or run a sports session, or write up notes, or attend a case conference, or, ... or....

   And if you do, does anyone notice, or do you ever tell them?

Please let me know any answers or comments on the above. I would be grateful to know the region you work in and the District if possible. These are only preliminary queries to see if a formal survey would be useful. Names and Districts would be in strictest confidence.

Thank you.

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THE 1981 EDUCATION ACT - A QUARTERLY UPDATE

P. M. Eckersley BA MCSP. Advisor, Post Reg Education APCP

The subject of 'The Abuse of Childrens Rights' is particularly apt for this update. During the last month, the parents of a nine year old boy have withdrawn their case on the speech therapy provision for their son which is due to be taken to the Court of Appeal. The case was to have challenged a High Court ruling that the provision of speech therapy as detailed in a childs statement was not legally binding on education authorities.

Oxfordshire Health Authority have now agreed to finance five speech therapy sessions weekly for the child but a spokesman for the authority stated that this was not setting a precedent.

In discussing the case in an article in Therapy (2nd April 1987) Diana Oxley, District Speech Therapist commented on the "unpalatable decisions" which would now result. Do we provide therapy for statemented patients leaving many more than ever with further diluted therapy? And should we simply allow waiting lists to build up, knowing that, without therapy, many disorders will be further compounded by the passage of time?

The case highlights the problems for speech therapy provision. The problems faced by physiotherapists are identical. Two lessons in particular can be learned from the case:

1) A therapist assessed a child and gave her professional advice that daily speech therapy was required. All of us who are aware of the shortage of speech therapists will realise that this must have been done in the knowledge that its provision was unlikely. However by stating the provision required the child's needs were not abused, and in the event, and after much publicity, those needs were fulfilled, and the therapists opinions justified.
2) In increasing the provision to this one child without increasing funding or staffing levels the assumption must be that services will be withdrawn or reduced for other children.

There seems no answer to the dilemma. If we do NOT state true needs for physiotherapy involvment, then we abuse the child. If we can only provide adequate services for 'statemented' children then equally we abuse other children.

But there is some light at the end of the tunnel. Many groups are 'taking up the cause'. Later in her article Diana Oxley states that "our energies should be directed towards passing information to our paymaster - the government."

In answer to a question in Parliament on the slow progress in meeting the aims of the Act (Dec. 2 1986) the Under Secretary of State for Education and Science replied that review of provision was being made and the implications of a research project at the Institue of Education, London University was being studied.

A working party of the National Council for Special Education, has prepared an extensive document for the House of Commons Education Committee in which it states:-

"Many formal statements reflect provision in an authority rather than the needs of the child (6.4) Central and local government should either acknowledge this failure and abandon the principle publicly, or make resources available to extend and improve provision in line with the advice given in childrens statements". (para 6.5)

Almost like British Rail we "may" be getting there! But ONLY if we keep on-and-on stating the true needs of the children we visit. I would be pleased to receive any information from physiotherapists on the way they write - or are told to write - the needs of the child and the required physiotherapy involvement.

* *

BOOK REVIEW

CONTINENCE AND INCONTINENCE

Psychological approaches to development and treatment.

By Paul S. Smith and Linda J. Smith.

Published by Croom Helm. January 1987
Price £22.50 hbk

Written by two psychologists who have obviously gone to great trouble to draw together a vast amount of information on the subject of Continence and Incontinence, this book starts with a fascinating potted history of the subject going back to 1596 and continuing to the present day. It then continues with chapters on the function of micturition, developmental skills of continence, maturation and learning, nocuturnal eneurisis, enconparesis, and loss of continence associated with dementia. Whilst much of the work is academic, there is a practical chaper on training guidelines, setting out clearly the various stages and sequences of training for children with incontinence problems of urine and/or faeces. Correctly used this chapter could be of invaluable assistance to trainers, but one does wonder if the authors have ever experienced the practicalities of carrying out such programmes themselves. Nevertheless the scale of the problem in many areas is clearly highlighted, and all information and suggestions can only be welcomed, for what is a difficult condition with which to deal.

The 26 pages of references must provide adequate proof that this is a subject worthy of further study and as such, this book will be an asset to the bookshelf.

PUBLICATIONS

Play at Home for Under Fives.
£1.30 inc. p. & p. Cheques and postal orders should be made payable to: Langbaugh PPA Publications. Orders to: Rosemary Nicholls, 106 Wilton Bank Saltburn, Cleveland TS12 1NU Tel. 0287 23225.

The Willow Street Kids. Play Safe. Stay Safe.
- Book aimed at helping parents to teach their children how to protect themselves from danger.
Price £1.75. Published by Piccolo.

Braille for Infants pack.
£14.95 from RNIB 224 Great Portland Street, London W1N 6AA.

The Hearing Impaired Child in the Ordinary School.
A. Webster and J. Ellwood.
£8.95 Beckenham-Croom Helm.

Families of Handicapped Persons.
J. J. Gallagher, P. Veitze Baltimore, P. H. Brooks.
£3.75 Available from: Quest Meridian 145a Croydon Road, Beckenham, Kent.

Marks Wheelchair Adventures.
Camilla Jessel.
£4.95 Methuan.

Knitting and Crochet with One Hand.
Mary Konior.
£3 Philip and Tacey Ltd., North Way, Andover, Hants SP10 5BA.

Spectators access Guide for Disabled People. (2nd Ed.)
Compiled by Peter Lawton.
£2 from RADAR, 25 Mortimer Street, London W1N 8AB.

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ARTICLES OF INTEREST

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

January 1987

7
Bowdler D Deliczny L
Educating Sarah: a study in integration. (spina bifida)
Br J. Spec Educ 1986 Dec; 13(4): 159-60

12
Reynolds J M. et al
Living with chronic renal failure.
Child Care Health Dev 1986 Nov-Dec; 12(6): 401-7

14
Lough L K Nielson D H
Ambulation of children with myelomeningocele: parapodium versus parapodium with Orlau swivel modification.
Dev Med Child Neurol 1986 Aug; 28(4): 489-97

15
Watt J. et al
A prospective study of inhibitive casting as an adjunct to physiotherapy for cerebral-palsied children.
Dev Med Child Nerol 1986 Aug; 28(4): 480-8.

32
Scull SA et al
Physical and occupational therapy for children with rheumatic diseases.
Pediatr Clin North Am 1986 Oct; 33(5): 1053-77

33
Spencer CH et al
The child with arthritis in the school setting.
Pediatr Clin North Am 1986 Oct; 33(5): 1251-64

February 1987

10
Morroni K Hickman L
Early childhood intervention (position paper).
Am J Occup Ther 1986 Dec; 40(12): 833-4

11
Morroni K Hickman L
Roles and functions of occupational therapy in early childhood intervention.
Am J Occup Ther 1986 Dec; 40(12): 835-8

13
Shaw G
Vehicular transport safety for the child with disabilities.
Am J Occup Ther 1987 Jan; 41(1): 35-42.

29
Cullen CA
Contoured components on adaptive seating devices.
Clin Manage Phys Ther 1986 Sep-Oct; 6(5): 12-3.

45
Walls-Rosenstein DL
Camp celebrate: a therapeutic weekend camping program for pediatric burn patients.
J Burn Care Rehabil 1986 Sep-Oct; 7(5): 434-6.

48
Balfour I et al
Pediatric cardiac rehabilitation: physiologic benefits.
J Med Assoc Ga 1986 Sep; 75(9): 560-2.

March 1987

16
McDonnell T et al
Hypoxaemia during chest physiotherapy in patients with cystic fibrosis.
Ir J Med Sci 1986 Oct; 155(10): 345-8.

19
Hillman MR
Interfacing the BBC microcomputer for use with profoundly handicapped children.
J Med Eng Technol 1986 Jul-Aug; 10(4): 196-8.

22
Karshmer AI et al
An inexpensive and portable talking-tactile terminal for the visually handicapped.
J Med Syst 1986 Jun; 10(3): 229-44.

26
Brubaker CE
Wheelchair prescription: an analysis of factors that affect mobility and performance.
J Rehabil Res Dev 1986 Oct; 23(4): 19-26.

27
Engel P Seeliger K
Technological and physiological characteristics of a newly developed hand-lever drive system for wheelchairs.
J Rehabil Res Dev 1986 Oct; 23(4): 37-40.

ABSTRACTS

TITLE Study of Normal Baby Movements.

AUTHORS T. Weggerman, J. K. Brown, G. E. Fulford, R. A. Mins. Dept. of Paediatric Neurology, Royal Hospital for Sick Children Edinburgh, Scotland.

The authors describe an observation study in which twenty five normal newborn babies aged betwwen 3-6 days had their movements recorded by various means which included - clinical observation in a controlled environment and cine photography. Of particular interest was the general posture of these babies. Their movements and their ability to change position.

There have been recent studies to suggest that immobility in utero can lead to neonatal positional abnormalities - also recently there has been increasing awareness of secondary postural deformities which may occur in neurologically abnormal children with limited mobility in the neonatal period. It was considered to be of practical important to look at normal healthy babies and observe them closely. A few basic patterns of movement can be quantified - some of the points on the summary are:-

Neonates are more active in supine than in prone, but are only able to change the trunk position by accidental rolling. In prone the baby is not able to change his trunk position at all. Most babies show a side of preference for their head position - usually to the right - this being present more frequently in supine than in prone.

It would appear that the position in which an infant is nursed and how often this is changed influences the amount and type of movement the young baby can make. It is thought if a baby is persistently nursed in supine, this could predispose to assymetrical postures and possible postural deformities. This would be particularly so in neonates and wherever the neonatal stage of development is prolonged, as in a brain damaged infant.

SOURCE Child Care Health Department. Vol: 13 - No. 1. Jan./Feb. 1987.

* *

TITLE	Care by Parents of their Children in Hospital.
AUTHORS	C. P. Q. Sainsbury, O. P. Gray, J. Cleary, M. M. Davies, P. H. Rowlandson. .Depts:- of Child Health, University of Wales, College of Medicine, Cardiff and Institute of Health Care Studies, Swansea.
SOURCE	Archives of Disease in Childhood. Vol: 61 - No. 6. June 1986.

Many sick children can be cared for totally by their parents in hospital with appropriate supervision - by those who are resident and those who stay for the greater part of the day.

A 'case by parent' option was introduced into a general paediatric ward. 32 families entering the scheme were studied, all the patients being under 3 years of age - 23 of them being under the age of 1 year. Medical management was continued in the usual way, but the care was evaluated in three ways:-

Medical information relating to diagnosis, management, and family structure were recorded, parents completed a questionnaire recording what they had done, the difficulties encountered and what they felt about their role. Comparable questionnaires were completed by the designated nurse at discharge of each patient concerning abilities of parents, difficulties encountered and how they felt about their role. The scheme proved successful - the parents gained in confidence and skill, managing all the simple nursing procedures and learning more complex techniques such as naso-gastric feeding and parental feeding. Success was greater in the longer admissions, parents having more time to learn and develop their skills. The scheme made heavy demands on the nursing staff - the time invested by them in teaching parents was wasted if the child was discharged within a short time.

However, considerable interest was shown by nursing staff - the parents were grateful for the opportunity of caring for their own children, were pleased to be kept occupied and gained confidence in their ability for managing their childs illness in the future. The children involved appeared happier, both eating and sleeping better during their admission.

* *

STUDY TOUR ON SENSORY INTEGRATION THERAPY

DATE	June 15-26 1987.
ORGANISED BY	Netherland Centre for Sensory Integration and Professional Development Programs of Minnesota USA.
SPEAKERS	Dr. Bert Touren, Mrs. A. Lint (Physiotherapist), Dr. Njiokiktijrn (Paediatric Nerologist), Patricia Detter (Occupational Therapist), Susan Stryuzewski (Occupational Therapist), Pat Wilbarger (Occupational Therapist).

VENUE 15-19 June, Amsterdam. 22 June, Hamburg - visit to Inge Flmigs Institute for Child Development. 26 June, London - Post Grad, Med. Centre. University of London.

PRICES One day F1.120. Half Day F1.70. A week F1 550.

This study tour is designed to help therapists apply sensory Integrative Theory to the treatment of children with sensory Integrative Dysfunction. There will be workshops for participants to problem solve and plan treatment for the children videoed during the sessions. The organisers recommend that participants have previously attended a sensory integration course, or practice sensory integration.

Further Information from:- NeoCentre v. Sensorische Integratie, Jan Nieuwenhuijzensir 1, 2013 ZA Haarlem, Holland or phone Holland 00931 23 32 37 30.

* *

FORTHCOMING COURSES

June 10-11 Splinting and Seating for Handicapped Children.
Mrs. B. Hindley, Higher Clerical Officer, Rehabilitation Unit, Withington Hospital, Nell Lane, Manchester M20 8LR. Price on application. Tel. 061 447 3409.

June 11 Screening Procedures in Childhood.
Enquiries: The Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield WF1 4OG. West Yorks. Tel. 0924 375217 Ext. 2510/2263.

June 16 Possum 'Teach In'
Pinderfields General Hospital. Address as above.

June 25 Visual Handicap.
Disabled Living foundation, 380-384 Harrow Road, London W9 2HU. Tel. 01 289 6111. Price £25

July 5-15 Music in Action.
(For physically disabled between 14 and 40).
SHARE Centre, Co. Fermanagh, N. Ireland. Details: Dr. Michael Swallow, 15 Deramore Drive, Belfast BT9 5JQ. Tel. 0232 669042. Price £1.50

July 6-8 The Brain and Movement: Its Development, Maturation, Response to Injury and Rehabilitative Physiotherapy.
Chester College of Higher Education. Details: Miss J. A. Bentley, Supt. Physiotherapist, Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry, Salop SY10 7AG. Price £80. Closing Date June 22nd.

October 8 **Respiratory Problems of Children in the Community.**
Mrs. B. Hindley, Higher Clerical Officer, Rehabilitation Unit, Withington Hospital, Machester. Tel. 061 447 3409.

November 26 **Cerebral Palsy in Children + Supporting Exhibition.**
The Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield, West Yorks. WF1 4DG. Tel. 0924 375217 Ext. 2510/2263/

February 1988 **Current Legislation - The Therapist and the Child.**

March 3 **Reading and Writing Disorders in Children and Adults.**

Both these 1988 courses - applications and details from: Mrs. B. Hindley, Rehabilitation Unit, Withington Hospital, Manchester. Tel. 061 447 3409.

* *

TOYS

The following items are all available from Rompa, P.O. Box 5, Wheatbridge Road, Chesterfield, Derbyshire, S40 2AE. Tel. 0246 211777.

Balls in a Bowl

A large, lightweight and translucent bowl and three balls with spinning discs. Stimulates and helps to master spatial concepts through filling and dumping activities. Good for floor and water play.
Price £10.00

Red Rings

Flexible red rings with a blue ball in the centre which contains a bell to emit pleasant sounds. Encourages a variety of activities.
Price £4.00

Rings and Rollers

Beads spiral, helter skelter, inside see-through cylinders while coloured stacking rings fit with cylinders to build towers. Encourages eye-hand co-ordination, handling and muscle skills.
Price £10.00

Leybourne Butterfly

This is a suspended action toy made for children and adults who spend long periods sitting or lying. Movement for the butterfly is simply produced by any movement of the easy grip handle. Size 47cm across.
Price £17.60 (item eligible for VAT relief)

Bobbing Man Mobile

Just pull the wooden beads to make his arms move up and down. The beads are colour matched to his hands.
Price £16.50

Mobile Mirror Chimeabout

A roundabout with hanging strips of mirror and coloured acrylic. A bell is on the end of each strip. Good for the partially sighted.
Price £26.25

Activity Frame

Easily assembled, very sturdy and adjustable support frame is the basis of a versatile activity system that can be adapted to suit many needs. It is supplied complete with the large framed safe acrylic mirror which can be tilted and locked in any position. The reverse side of the mirror makes a useful wooden work top when locked in a horizontal position. This mirror/worktop is also adjustable in height making it adaptable for people of all ages to use in a standing, sitting, or laying on the floor position. The frame is also wide enough to be used over most hospital and single size beds.

The removable angled top bar will hold up to five hanging mobiles and the mirror can be adjusted to reflect these. The upper part of the frame will accept the specially designed series of activity boards which can easily be interchanged and adjusted for height.

The frame is constructed from steel tubes with a black, epoxy finish and an extra tough plastic joint system. Overall size: 112cm wide × 170cm high (to top of angle bar).
Price £137.95

Frame Music Activity Board

A well made activity centre with good quality musical sounds. Made to fit the Activity Frame but can be used separately. Size 112 × 46cm.
Price £90.90

Frame Touch and Spin Electronic Board

This robust and easy to use board is designed for profoundly handicapped people to use, but all children will be delighted by the sounds and lights. A symphony of sound can be created with a very light touch of the eight coloured panels. The large coloured lights are activated by pressing them lightly or by spinning the large disc which will create exciting flashing effects. Made to fit the Activity Frame but can be used seperately. Battery operated (not supplied). Size 99 × 50cm.
Price £266.25

Inset Puzzles

Simple large inset wooden puzzles with 6 pieces showing two basic shapes, complete with dice for simple game. Puzzle pieces have 1-6 feely dots to match dice.

Fish, Size 35 × 17cm. Price £14.00
Butterfly, Size 21 × 24cm. Price £15.50

Children of the World

A series of jigsaws showing children from many parts of the world. The puzzles have between 5 and 16 pieces. Colour prints are securely glued to 4mm plywood which is fixed to 3mm hardboard base. Size 28 × 23cm.

Hispanic Boy (Face). Price £3.50
Black Girl (Face). Price £3.50
White Boy (Face). Price £3.50
Asian Boy (Face). Price £3.50

Pencil Grips

A simple aid to better pencil control and handwriting.

Standard size - pack of 10 - Price £2.60
Jumbo size - pack of 10 - Price £3.20

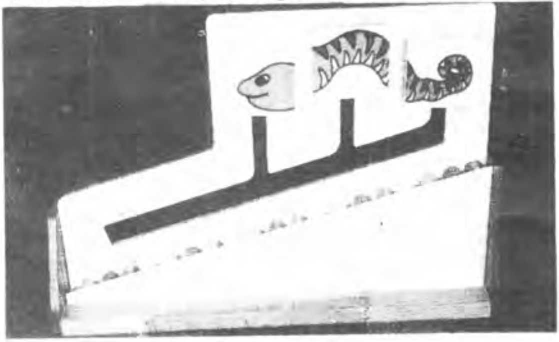
Table Top Scissors

This is a self opening pair of scissors fixed to a polished hardwood base and is operated by pressing the plastic covered handle.
Price £16.10

Spring Balls

A most basic toy providing exciting colour and movement for the least physically able. The brightly coloured wooden balls will wobble in all directions when pushed or, for the stronger user, when the base is shaken. A very solid and safe piece of equipment, size 36.5 × 11.5 × 16.5cm high (14½ × 4½ × 6½in).
Price £18.95. Available from Nottingham Rehab, 17 Ludlow Hill Road, Melton Road, West Bridgford, Nottingham, NG2 6HD.

This cheerful sequencing toy from Toys for the Handicapped will teach children to put things in the right order. Slot in the pieces in the correct sequence and you will get a smiling snake. Four pictures are included, made of solid wood and painted in bright colours. £47.50 mail order from Toys for the Handicapped, 76 Barracks Road, Stourport-on-Severn, Worcs.



PROPOSALS FOR MAJOR OVERHAUL OF CHILD CARE LAW

The DHSS issued the following press release in January 1987:

Norman Fowler, Secretary of State for Social Services, today published proposals for a major overhaul of child care law. These include measures to improve safeguards where young children are being looked after by child minders or in other day care facilities.

In response to a Parliamentary Question from Tom Sackville M.P. (Bolton West), Mr. Fowler said:

"The welfare and protection of children is a matter of great concern to all of us, and it is important that the law reflects that concern. I am pleased to publish today our proposals for a major overhaul of child care law and also to propose measures to improve the safeguards where young children are being looked after by child minders or in other day care facilities."

"Our proposals take account of the recommendations of the working party on child care law and the many comments received on them as well as the views of those who commented on arrangements for children under five. They will offer a better service for families and protection of children at risk of harm."

"The Government remains committed to introducing legislation as soon as Parliamentary time can be found."

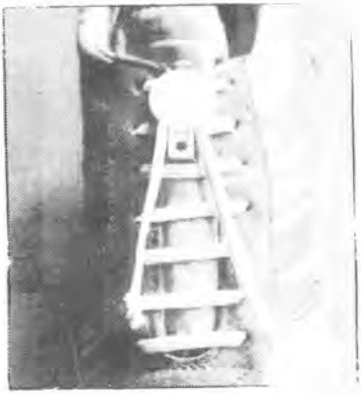
The Paper's proposals are wide ranging. Key points include:-

* a postive statement of the role of local authorities in promoting the care and upbringing of children within their families which will generally be in the child's interest;
* for children looked after under voluntary arrangements an emphasis on partnership between parents and local authorities in caring for their child;
* the local authorities' responsibilities for planning their care to extend to all such children including those who are handicapped;
* clearer and greater emphasis on the local authorities' parental responsibilities for children committed to their care by court order;
* rationalisation of the twenty or more legal provisions by which a child can be committed to the care of a local authority;
* a new and simplified list of legal grounds on which a court order committing a child to local authority care can be made;
* the new grounds should cover cases where substantial harm is likely in future as well as cases where harm has already occurred;
* local authorities should no longer be able to take parental rights over a child in their care without reference to a court;
* changes to court procedures to ensure a fairer and more expeditious means for the court to determine what is best for the child;
* full involvements of parents in court proceedings and more involvement of relatives, friends and foster parents who may also be allowed to provide a suitable alternative home;
* extending the court's present power to hear cases where access to a child in care is denied to cover cases where there is dispute over the reasonableness of the access granted;
* introduction of clear rights of appeal from decisions in magistrates courts for local authorities and parents, in addition to existing appeal rights for the child;
* recasting of the law governing private and voluntary facilities for children leading to improved arrangements for facilities for under fives and a more rational approach to facilities for older children.

EQUIPMENT

Lace-N-Lock

Lace-N-Lock is a simple way to secure shoe laces, that can be used with one hand. Available in 8 colours from The Lace-N-Lock Co. Downalong, Bushey Heath, Herts. £2.50 inc. p & p.



Wheelchair Battery Fuel Gauge

Enjoy the freedom of your wheelchair with confidence knowing the state of charge of your battery at all times - no more fear of being stranded! Increase your battery life by avoiding the harmful effects of both over-discharge and too frequent charging.

The Curtis 900W wheelchair battery fuel gauge is suitable for all 24 volt outdoor electric wheelchairs, scooters and mobility aids, and is easily fitted to new or existing chairs. Price £49.50 + VAT.

Available from Curtis Instruments (UK) Ltd., 51 Grafton Street, Northampton, NN1 2NT. (Tel: 0604 - 29755).

Writestart

These triangular pencils help young children develop a good grip. They are a comfortable shape and size, and encourage correct finger position. 12 pencils - LD 330 - Price £1.99, 144 Pencils - LD 331 - Price £21.50. Available from Learning Development Aids, Duke Street, Wisbech, Cambs. Tel: 0945 63441.

TRANSPORTER TRICYCLE

Can be used to transport a person around the building or just to give an enjoyable outside experience. The passenger seat is moulded in weatherproof polyurethane foam and shaped to give support and to prevent the passenger slipping out. Can be used with a safety harness. The foot is hinged so that it can be lifted out of the way allowing the seat to be positioned close behind the person to be seated. State colour required. Size 200cm long × 70cm wide.

With rear facing passenger seat. Price £265.00
With front facing passenger seat. Price £700.00
Supplied by ROMPA.

SNOEZELEN

Snoezelen is a Dutch word meaning an activity which has been developed in Holland over the past few years as a specific occupation/experience for handicapped people. Snoezelen is a development which through artificial means provides multi-sensory experiences that can be controlled and are available on demand.

"in everyday life the senses are addressed in a complex way. 'Snoezelen' enables handicapped people to concentrate on one experience at a time, e.g. touch." The perception of sounds, shadows, light effects and scents, and the touching of various shapes are experiences in themselves."

Rompa will be pleased to discuss 'Snoezelen' with you and help you plan a room suitable for your needs. Rompa, P.O. Box 5, Wheatbridge Road, Chesterfield, Derbyshire. Tel. 0246 211777.

SNUG SEAT

The Ortho-Med Snug Seat is designed to be flexible in need and application. A modular system of pads enables adaption to the shape of the child, and the seat can easily transfer from home to car to baby buggy. Available from Ortho-Med, 5 Loaning Road, Edinburgh, EH7 6JE. Tel. 031-652-1603.

ASTHMA WHISTLE

A cheap and simple device for estimating lung function in asthmatic children should enable self-monitoring of the disease to be greatly extended.

The peak flow whistle, made from cardboard, performs similarly to the Wright peak flow meter, says a team of researchers from the Children's Hospital, Sheffield.

One of the team, deputy superintendent physiotherapist, Olga Bannister, who specialises in treating asthma, showed more than 100 children how to use the whistle. The children were instructed to blow into a peak flow meter and then through the cheaper device - a cylinder with graduated holes along its side. The results were comparable. Sucking the whistle was also found to be useful in instructing children how to use inhalers.

Home monitoring is important because a drop in peak flow value could indicate a need for medical advice or hospital admission.

CONTROLLER CHAIRS

A new range of armchairs for disabled children and adults which will blend with other furnishings and yet provide adjustable angle for back and seat, to provide correct amount of hip flexion, and a comprehensive range of cushions to solve any difficulties you may have. Covered in a choice of colours and materials, all covers removable. Optional extras include footrest and cushion and wheels.

Further details and demonstration: The SPA Collection, Stowaway.
Furniture and Design Company Ltd, 29 Midland Road, Bedford, MK40 1PL.

DOUBLE BACKED FEEDING CHAIR

A bright idea from Anne Slater, Allowah Babies Hospital, 8 Perry St. Dundas.

A double backed chair is used in every nursery at Allowah to ensure the comfort of the feeder and to ensure the children are fed upright with their heads correctly aligned.

It can be used for small babies and for children up to approx. five years of age.

It is particularly good for children who extend when fed and also works well for floppy children.

Assembly. Two C319 Hospital issue chairs (George H. Murphy Ltd) were used. The back of one chair was removed at the seat junction and welded to the other chair as illustrated. (Note (L) or (R) side depending on feeder hand dominance).

THE 'CHRISTINA-GORDON' HARNESS AND FRAME FOR USE WITH AN ELECTRIC HOIST

1. Simple to use - front fitting, simple assembly, leaves the back and buttocks clear for treatment.

2. No requirement or lift to roll the patient into the harness.

3. Eliminates back strain for nursing staff. Patient supported in a normal upright sitting position. Prop-up is not required when transferring into a chair.

4. Eliminates need for manual head or neck support during lift.

5. Quick release connectors to facilitate simple use.

For further information contact:
Christine Hollick, Top of the Hill, Shantock Lane, Bovingdon, Hertfordshire, HP3 ONG. Tel. (0442) 832264.

HAVE YOU HEARD????

The Department of Health is insisting on full information from manufacturers of new safer whooping cough vaccines before clinical trials can take place. They feel full information is essential for a vaccine intended for children, as previous vaccines have been implicated in causing brain damage.

* Experimental work using coloured lenses has been having some success with certain types of dyslexia.

* A 25 year old British cyclist raised £10,000 for the Save the Children Fund, by cycling 12,000 miles from London to Sydney using a sail on his bicycle to help him on his way.

* Some disturbing research reported in 'Mother' magazine suggests that taking tiny babies swimming can be dangerous. Some babies in California have suffered a form of brain damaged caused by swallowing a lot of water whilst swimming. As yet there are no cases in this country.

* Children in over 3½ million families are brought up in homes where the income is below the poverty level. (Report by National Childrens Home).

* The lending library of recorded books for those with a visual handicap, also has over 500 childrens books on tape for all ages from four upwards. Cassettes are lent free to anyone unable to read printed books. Details: Susan Wright, Childrens Library, Calibre, Aylesbury, Bucks HP20 1HU.

* Patterns for Living is a new Open University course produced with Mencap, for anyone closely involved with people with Mental Handicap. Information from: Jennifer Rock, Dept. of Health and Social Welfare, The Open University, Walton Hall, Milton Keynes. Tel. 0908 653743.

* The Royal Horticultural Society's garden at Wisley in Surrey, has facilities and routes laid out for people in wheelchairs. The Garden also has a number of wheelchairs available on loan. The Garden is open all year round.

* The Dept. of Transport's Mobility Roadshow is to be held at the Transport and Road Research Laboratory, Crowthorne, Bucks from June 12-14 inclusive. Entry free. Visitors will be able to try out a range of adapted cars, and look at many mobility aids.

* Autochair is now the only British car roof wheelchair hoist. For details of nearest agent contact: Autochair, Mobility Techniques Ltd., Bagshaw Hill, Bakewell, Derbyshire DE4 1DL.

* The suicide rate among children and young people has risen by 24% in the past decade. One wonders whether there is any one underlying cause for this, or is it a combination of factors?

* *

POINTS TO PONDER

The reprint of the 1981 Education Act - guidelines for Physiotherapists and other paediatric professionals is now available at the very modest charge of 75p for APCP members and £1 for non-members. Send money and orders to Mrs. Catherine Miller, P. R. Dept., Chartered Society of Physiotherapy, 14 Bedford Row, London.

Newsletters will be charged at a cost of £2 per copy to non-members in future.

Subscriptions to APCP, for retired members will be half the full sum due.

Mrs. J. K. Williams, Senior Paediatric Physiotherapist, Wythenshawe Hospital, Southmoor Road, Manchester 23, would be pleased to hear from any other paediatric physiotherapists dealing with the special problems of the physically abused child, immediately post trauma, and during the immediate post rehabilitation period. Perhaps a Study day could be arranged - she has many slides and videos available.

Patterns for Living - is the new Open Univeristy Course produced with MENCAP for people who are closely involved working with mental handicap. It covers issues such as social skills, work and leisure through case studies. Information - contact: Jennifer Rook, Dept. of Health and Social Welfare, The Open University, Walton Hall, Milton Keynes. Tel. 0908 653743.

If you are interested in becoming part of a scheme to put people in touch who have the same disease so they may talk together for moral and practical support, contact: Share-a-Care, National Register for Rare Diseases, 8 Cornmarket, Faringdon, Oxon - enclosing a stamped addressed envelope.

Mr. Norman Fowler, Secretary of State for Social Services, and Mr. John Major, Minister for Social Security, will transfer control of the limbless service from Civil Servants to a specialist management board. These changes follow a government-appointed inquirey, which last year produced a report pointing to 'widespread deficiencies' in the present system.

The McColl report said that half the limbs were delivered late and the DHSS had proved incapable of controlling 'the costs, prices or profits of the companies'.

Mr. Lewis Carter-Jones, Labour MP for Eccles, said he hoped the new board would contain people with the necessary management skills 'together with the type of person who has lost a limb or is paralysed and knows what it is all about.'

Some of you will have noted that in the February Newsletter, the Annual Subscription was quoted as being £7.50 when in fact (good news!) it is only £7. The treasurer assures those who have overpaid that the extra 50p will be deducted from next years subscription.

REGIONAL REPORTS

West Midlands **Reg. Rep. Mrs. C. Dunn, The Haven, Knightwick Road, Martley, Worcs.**

The meeting put on for us by 'Sense in the Midlands' on 5th November 1986 was very successful and attended by over 60 multidisciplinary participants.

An evening talk is planned for February when Dr. A. Adcock, Senior Clinical Medical Officer with Bromsgrove and Redditch Health Authority, will speak on Child Abuse. The venue will be the Scott Atkinson Centre, Redditch, Worcs.

The A.G.M. is arranged for April 2nd at the Post Graduate Centre, Birmingham Childrens Hospital, at 7 p.m.

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

On March 3rd we combined our A.G.M. with an evening lecture on the 'Visually Impaired Child in relation to Physiotherapy Management.' The speaker was Dr. Patricia Sonkson, Paediatrician at the Wolfson Centre, her talk was very informative and well illustrated. Afterwards there was Cheese and wine buffet and the event was attended by about 40 members.

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

Our A.G.M. was held on March 3rd in Leeds. We are sorry that so few people were unable to attend. Our thanks to Sue Morton and Frances Russell who retired after serving for three years as Treasurer and Chairman. Following this we had an informal talk with the Conference Committee about the arrangements for the Annual Conference to be held in York. We shall be holding an evening meeting on June 23rd at the Clarendon Wing of the Leeds General Infirmay, when Dr. Jane Wynne a Consultant Community Paediatrician will talk on 'Child Abuse.'

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

A Study Day entitled 'Education - Integration or Not' was held March 21st at Dorset County Hospital, Dorchester. It was attended by about 50 people - a third being representatives from Education. Much discussion was elicited about the pros and cons of special schools and placements in mainstream schools. It was obvious that the day was not long enough to plumb the depths of this important subject. The A.G.M. was held on this day - at which Regional matters were discussed. Changes in management are now making themselves felt throughout the Region - some top posts are being frozen, and paediatric physiotherapists are finding themselves without professional managers. It was interesting to hear of the increasing amount of regular localised meetings of paediatric physiotherapists throughout the Region, and the benefit being gained from these.

Wales **Reg. Rep. Miss V. S. Williams, 5 Larch Grove, Lisvane, Cardiff.**

On February 24th 1987 a lecture on 'Living Language' was given by Denny Rees, Senior Speech Therapist at Eveswell Clinic, Newport. This was followed by refreshments at the A.G.M. and an enjoyable evening was had by all.

A mixed disability/training week-end and squad training was held at R.A.F. St. Athan on March 28/29. The Reg. Rep. had an opportunity to talk about physiotherapy in Sport and Sport Injuries, and to stress the importance of seeking advice from chartered physiotherapists in the case of injury, even for the youngest athlete. The week-end was so successful that further week-ends are planned throughtout Wales, and anyone wishing to be included is invited to write to Marilyn Godfrey, Development Officer, Sport for the Disabled in Wales, Sports Council for Wales, Nationals Sports Centre, Sophie Gardens, Cardiff.

Future Courses.

May 19,20,21.

An introductory Bobath Course with Gill Stern and Judy Murray, Tutors from the Bobath Centre, will be held at the Combined Training Institute.

June 6th 1987.

A joint meeting with the Association of Physiotherapists in Respiratory Care, will be held at Cardiff Royal Infirmary, the subject will be 'Paediatric Chests.' For further information contact: Vivienne Williams, Childrens Centre, University Hospital of Wales, Heath Park, Cardiff.
Tel. 755944 Ext. 3585.

North West **Reg. Rep. Miss L. Wakley, 2 Ash Bank, Pipers Ash, Chester CH3 7EH.**

A very interesting study day on 'The Visually Handicapped Child' was combined with the A.G.M. on March 7th at Arrowe Park Hospital, Birkenhead. A request for suggestions for course subjects produced some interesting ideas, and the committee is meeting in April to discuss and plan the programmes for the coming year. The committee wish to thank Mrs. Katherine Jones for all her hard work over the past years, as our Regional Representative.

East Anglia **Reg. Rep. Mrs. Lyn Weekes, 37 The Cedars, Milton Rd, Harpeneden, Herts.**

Our first A.G.M. was held on March 3rd at Wexham Park Hospital, Slough, Bucks., and the steering committee was elected en bloc. It was combined with a most interesting Study Day on the Lower Limb. Our thanks to the families who brought their children to the afternoon session. The next meeting is a Study Day on "The Hand" at Watford General Hospital on June 19th. Full details on the application form which will be enclosed with this Newsletter.

STOP PRESS

At a recent International Child Health Conference held in Edinburgh, the Director of the Adras Peto Institute in Budapest - Dr. Hari - explained the philosophy behind the treatment techniques which are presently so much in the news. She said that each child was taught that personality had priority over handicap, and they were encouraged to adopt a positive attitude towards achieving a normal life.

Mr. Andrew Sutton an Education Psychologist closely associated with the Birmingham project felt it was more an educational project with methods of exercise that teachers could carry out.

In response to a number of questions about whether the Institute is too selective in the children whom it treats, Mr. Sutton admitted that there were some severely handicapped children who would not benefit from the treatment, but argued it would be wrong to let them undergo treatment when this was known.

This is in direct contrast to this country where all children have an opportunity for treatment whatever the level of disability.

COPY OF LETTER TO B.B.C. TELEVISION

9th April 1987

Dear Sirs,

As a regular viewer of Newsnight, I felt obliged to write to you. I am a Chartered Physiotherapist and have worked with handicapped children for the past 20 years. I attended the Dr. Maria Hari lecture at the Edinburgh Child Health Conference and your programme on Monday had been so edited that it came over as biased and ill-informed.

At the Edinburgh Conference, Dr. Hari's answer to the question whether the multi handicapped child (i.e. someone both mentally and physically handicapped) was treated? - her answer was NO - her explanation was that there are only 400 places at the Institute. The children prior to attending the Institute will have been seen regularly at Mother and Baby Clinics by Conductors who will then send to the Institute those children they think will benefit. It is therefore obvious, that although Dr. Hari sees all children sent to the Institute, there is still a selection as to who gets there in the first place. However, if they have been accepted and they do not show progress at the end of two years in the Institute, they have to leave - for what we did not find out. From all the films we have seen the Institute accepts mild hemiplegias and diplegias. In our area, due to early therapy (i.e. from 6 months onwards) by the time children with this level of handicap reach school age they are usually accepted into the Normal Education System. The majority of children in Special Schools have severe handicaps, our aim is to help these children overcome their handicap and reach their potential.

Ten years ago a lecture by Esther Cotton convinced me of the logic of the Peto Philosophy but, there are many methods of treatment - children here are treated individually and in groups. The professionals do get together and work out relevant programmes for ALL the children and not a selected few. They are encouraged to take part in riding, swimming, dancing etc.

It appears that in Hungary one needs to be a walker to succeed in the Education System, thankfully in this Country neither a wheelchair nor physical handicap need bar one from academic achievement.

Other points made in Edinburgh were that the Institute does not treat the blind, that they are just as selective over the Spina Bifida children as over the Cerebral Palsy child.

Andrew Sutton says he does not know whether his Conductive Education project will be successful and it will take up to 20 years before they do know.

In the meantime, I suggest both Andrew Sutton and the B.B.C. investigate more deeply what is happening in the Country. This type of television undermines the confidence of parents who are doing their best for their child. Without knowing all the facts they feel guilty and let down that their child is being deprived of the wonderful method of treatment.

The film "Stand up for Joe" and Newsnight 6th April, 1987 implies that if all handicapped children received Conductive Education they would reach the level shown on T.V. There was no mention of selection and it gave false hope to hundreds of parents.

The Chartered Physiotherapists in Liverpool, and I am sure the rest of the Country are awaiting your reply to this letter.

Yours sincerely,

It is hoped to publish the B.B.C.'s reply to this letter in due course.