
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

Association of Paediatric Chartered Physiotherapists

Newsletter No. 51

May, 1989

“MUSIC”

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EDITORIAL

For nearly three hundred of our members, our Annual Conference at Guildford is still fresh in our minds. The August edition of this Newsletter will be devoted to that conference, with summaries of the excellent lectures we had based on the theme 'Back to Bare Bones'. While we felt the conference was a great success, the National Committee always welcome comments from Members.

This edition is devoted to 'Music', something which we all love and hate - depending on our taste and age! Whether we use music or not in our therapy sessions, we can surely learn of the effects it can have on our patients, based on the knowledge of the good effects it has on us in differing situations. With the vast improvements that now exist in technology, no-one need lack access to both hearing or making music and should be attuned to its potential.

APPRECIATION - ELMA BELL

With very much regret we have had to accept Elma's resignation as P.R.O. for the A.P.C.P.

Elma was elected to the committee as Regional Representative for Scotland and served in this capacity for several years.

In 1986 she became P.R.O. and relinquished her role as regional representative. She has been a steadfast member of the committee and attended many extra meetings in her capacity as PRO.

Elma was responsible for obtaining the A.P.C.P. noticeboard, which has been the centre point of our publicity efforts and we thank her for sending it around the countryside to a variety of functions, and making sure that the notices are accurate.

As a friend, Elma has always been steadfast and reliable. During the past 6 years her contribution to the Committee has been much valued.

She is hopefully remaining on the committee to finish her term of office as elected committee member, but we would like to record our grateful thanks for her work as P.R.O.

The final date for submission of articles for the August Newsletter is
1st July, 1989.

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

MUSIC THERAPY

Sybil Beresford-Peirse, Director of the
Nordoff-Robbins Music Therapy Centre

During the last thirty to forty years Music Therapy has been developing here in England. There are now three training courses for therapists in London, each with their own particular syllabus and direction for the work. It is natural that music can be used in different ways to help both children and adults with special needs, and I will try to convey something of the approach we use at the Nordoff-Robbins Music Therapy Centre, Kentish Town, North London.

This is a Centre to which children come weekly for individual or group music therapy sessions. It also accommodates our one year post-graduate training course for music therapists, validated by the City University, London. Our work is based on the teaching and research of Dr. Paul Nordoff and Dr. Clive Robbins. It was in 1959 that Paul Nordoff, American composer and concert pianist, was invited to Sunfield Children's Home, Clent, to explore the possible use and influence of music with children having a wide range of disabilities, physical, mental and emotional. There he met Clive Robbins, and together they formed a team, working practically in music to meet the varying needs of the children. Out of this practical work they developed a certain direction, based on valid scales of assessment, which we follow. This is not easy to describe in words, without the impact of the music itself.

The language of music consists of rhythm, melody and harmony. We use this language of music to meet the individual child where he is, with his particular needs, and seek through a shared music making to find the lines of development most suited to him. Each child is unique, and with each one we attempt to build bridges of communication and then to support and encourage whatever responses he may make, and through a shared music activity to pursue the goals which emerge. This is a creative approach, the music being improvised for each individual. We find that the response to music does not depend on intelligence, but seems to be innate in human beings.

Working with small groups of multiply handicapped children we have found some of our most unexpected results. These children need the physical support of an adult. The music is specially improvised to stimulate awareness which is seen in their facial expressions, and the gradual lessening of tension in their limbs. We attempt to give them experiences and movements which they cannot take for themselves, working very closely with the physiotherapist and class teacher. Sometimes the physical achievement may be very slight, but the real value lies in the children's increased awareness and pleasure.

Many children with Down's Syndrome react with enthusiasm to music. At first it may be with loud playing on drum and cymbal, emphasising their tendency to dominate the situation in everyday life. Gradually as they learn to listen the situation can change and they are led into a sensitive shared music making, discovering and using another side to this character. Frequently low pitched gruff vocal sounds can become varied as the children are encouraged to sing. Simple play songs and songs about every day happenings can stimulate and help those with speech difficulties. For many children with special needs words are a barrier, but music can form bridges of communication, out of which much can grow and develop.

I have in mind one little girl with severe learning difficulties and no speech when she came into music therapy at the age of five. She was a musical child, frequently imitating and initiating melodic phrases, always perfectly in tune. One day she imitated the word "hullo", with no particular understanding of its meaning. A few weeks later as I was standing with my back to her I heard a very peremptory "Hullo" demanding my attention. Naturally these developments were shared with the parents and school teachers. We all worked together to encourage speech development, and week by week new words were incorporated in the songs.

Recently several girls with Rett Syndrome have come to the centre, and although it is too early to say how much music therapy can help them, the initial work is encouraging. There are real signs of pleasure and co-operation from the children as we begin to involve them in making music. Increasingly they begin to make spontaneous contact with us, after using little grunts and vocal sounds. By helping them to tap on simple instruments such as a tambourine or drum we can encourage the use of their hands, so breaking down the constant hand-wringing which is so characteristic of the Rett child.

In this short article I can only comment briefly on the various needs of the children who come to us. The whole area of autism is one in which music can do much. It is true that some autistic children can be reached through music and drawn out of their isolation to a certain extent. It is not wise to generalise but in our experience music can reach and activate many, and help them towards forming a better relationship with others. When this trust can be established then it can influence the child's life outside the music situation.

Children who have had some experience in individual therapy may well need to be ready to join in a group situation, where the specific needs for growth and integration with others can be encouraged. For a few of our adolescent boys and girls we have just such a group where they are encouraged to share the musical experience together - For the other end of the age range we are meeting the needs of pre-school children in our Parents and Toddlers groups, where the parents can come with their children joining in with games and music designed to help with their special needs.

Above everything this approach in Music Therapy is a creative one both in the improvisation of the music and the insight and understanding on the part of the therapist for the right direction of the work. It is explained fully in the following books by Nordoff & Robbins.

- | | |
|-------------------|---------------------------------|
| Therapy in Music | - Published by Gallancz |
| Music Therapy In | - Published by Magnamusic Baton |
| Special Education | |

ABSTRACT

The next paper updates some earlier work (Wigram and Weekes, 1984) on a combined Music Therapy and Physiotherapy approach to working with patients with severe motor disfunction. The article goes on to explore the physiological effect of sound and reports on a recent investigation into the effects of low frequency sound and music on high muscle tone conditions and Oedema. An account of a further collaborative project between Music Therapy and Physiotherapy is included in this article.

COLLABORATIVE APPROACHES IN TREATING THE PROFOUNDLY HANDICAPPED

MUSIC AND MOVEMENT AND VIBRO ACOUSTIC THERAPY

Tony Wigram - Head III - Music Therapy

Lyn Weekes - Senior I - Physiotherapy

In a paper presented at the World Conference of Music Therapy in Paris, 1983, and later published in the British Journal of Music Therapy (Wigram and Weeks 1985) and the A.P.C.P. newsletter August 1986 the appropriate use of the elements of music in particular rhythm and tempo, was described. A specific scheme of movements was developed over a period of time, each movement having a particular purpose, and the style of the music was designed especially to support and facilitate the movement.

“The relevance and appropriateness of the music used is very important to the effectiveness and success of this particular treatment. Style of music, tempo and timbre in particular, have to be carefully chosen for each movements and even then much depends on how the therapist plays as to whether it is effective. For these movements the music must envelope and support the patient. The relationship formed in the work must be primarily between the patient and the music, the therapist's role being to help the patient to respond to and use particular elements in the music”.

As a result of this, whilst one does not necessarily aim to achieve the full range of movement, the patient co-operates and participates in the movement and begins to anticipate the next movement because of the rhythm of the music. Since this paper many of the younger children have been resettled in the community and the adolescents have become adults.

The scheme of movements has been modified as the adults have become longer, heavier and more difficult to move. It is no longer possible to do pelvic tilting and changes have been made in the order of the movements. A cradling/rocking movement has been introduced to re-establish the relationships between the patient and the therapist before the first movement (spinal rotation). In reviewing developments over the last twenty years in the use of sound technology in treatment techniques, it can now be seen that whereas music gains an intellectual response when listened to, sound also causes a physiological response when sound waves enter the body. The appreciation of music, and the emotional impact of a particular piece may also stimulate a physical reaction - maybe one of elation or depression, sadness or happiness. The components of a sound or combination of sounds, in particular their pitch, volume and timbre will have a significant biological effect on the body. Muscular energy increases or decreases depending on rhythm stimuli and breathing is accelerated or changes its regularity. The impact of sensory stimuli is reduced, fatigue is reduced or delayed, and voluntary activity is increased. In addition, a marked but variable effect on heart rate, blood pressure and the endocrine function is produced, and changes in metabolism and the bio-synthesis of various enzymatic processes may be induced (Benenson, Skille 1987). As sound has

such a significant effect both biologically and physically, investigation has been going on for some time as to how it can be effectively used in a treatment process. There is a considerable body of evidence on the effects of mechanical vibration in reducing muscle tone (Stillman 1970, Carrington, 1980) where a motor within an object or on a base unit will set up a physical vibration that is indiscriminate in terms of frequency. In the late 70's and early 80's, a Norwegian therapist, Olav Skille, initiated some work looking at the effects of low frequency sound on high muscle tone and spasticity. Coupling a low frequency tone between 40 and 80 hertz with a tape of relaxing, unrhythmic music Skille saw very beneficial effects when directing the sound waves into the body of profoundly physically handicapped children (Skille 1982, 1982, 1985). The idea of using a pure sinus tone at a low frequency has been known for thousands of years, and in primitive cultures instruments and sounds were used to treat psychosomatic disorders. (In Shamanistic music, the physical vibrations were often used).

Skille developed equipment which consisted of a vibration unit constructed in the shape of a bed with speakers built into it that patients would lie on, and an audio/stereo unit to produce the sound. He patented it, and located several test units around Norway. The early work with the units concentrated mainly on physical disorders such as high muscle tone, arthritic conditions, back and shoulder pain, and stress induced disorders, but more recently the 'sound bed' has been used in treating pulmonary disorders such as cystic fibrosis, asthma, and emphysema. (Skille 1987). In a manual of Vibro-Acoustics (Skille, 1986), he describes the tones between 40 and 80 hertz that can be used for certain specific physical disorders. The low frequency tones are pulsed by mixing two sounds together, and music is added over the top to increase and improve the effect of relaxation and therapy. The sound waves are felt in the body and generate a vibration within the cell structure of the body. As the frequency is changed, the person will experience the feeling of vibration in parts of their body, depending on the influence of the frequency on different densities of tissue or bone. The effect is pleasurable, and the results to date in Norway and other Scandinavian countries where this has been (diversifying), are very positive.

The authors built and began to use vibroacoustic units at Harperbury Hospital (within the Norwegian patent) in September, 1987. The authors had attended a symposium in Lavanger, Norway, in March of 1987 where several users of the vibroacoustic unit from Norway, Finland and Germany had reported on work with a variety of different client groups, totalling 10,000 hours of use of equipment. Most of the reports given were anecdotal, and contained no evidence of rigorous research. However, most of the reports were reporting positively of the beneficial effects of low frequency sound (Wigram, 1987).

Wigram and Weeks could see particular application for vibroacoustic therapy with clients who had high muscle tone and spasm. The existing programmes they had developed using a combination of music and movement (Wigram and Weeks, 1984) were attempting to find an effective way of treating cerebral palsy clients who had deteriorating problems due to flexor or extensor muscle spasm. It seemed that the value of vibroacoustic therapy would be in reducing muscle tone to the extent where the maximum possible range of motion could be maintained, and the onset

of fixed deformities delayed still further. There was also anecdotal evidence from the work to date in Norway of the effect of low frequency sound in improving circulation. It was, therefore, decided to look closely at another chronic condition in long stay elderly residents, (deteriorating) oedema in the lower limbs.

In approximately 380 treatments, carried out over a period January to December 1988, Wigram and Weekes found comparable results to the work to date in Norway. With one client, there was a specific reduction in muscle spasm in the back, arm, trunk and legs. After the treatment sessions, the patient initiated spontaneous movement and after three treatments her respiration had improved and she was laughing during treatment. Another patient, with very severe spasticity, showed a general reduction in her muscle spasm, and the worried frowning expression on her face disappeared during the sessions. Her shoulders are much more relaxed and her chest movements have increased. Again the patient started spontaneous movements in her arms as a result of the reduction in muscle spasm. She also began vocalising in the sessions, and the extent of her relaxation is that she accommodates to the flat surface that she is lying on and rests her head for long periods of time. She began to flex and extend her legs where previously they were locked in spasm. A third patient also had gross physical deformities, and a worried frown on her face because she was very anxious about being moved. She had been considered for a possible operation to release the soft tissues in her legs which are at present crossed due to her adductor spasm. During the course of the treatment, there has again been a general reduction in the muscle spasm with this patient. She has gross scoliosis and had rapid, distressed breathing, and breathing became easier during the course of treatment. A final example of the client group treated during the course of last year was an Ataxic with typical increased lumbarlordosis and rigidity of her spine, who also has arthritic changes in the spine and knees. She was treated with a pillow under her head and under her knees in an attempt to make her comfortable on the vibro unit. After 10 minutes of vibroacoustic therapy she was smiling, and when she came for a second treatment she was very keen to go on the unit and smiled throughout the session. She was treated in the early morning, and at 6 p.m. in the evening she was still pain free. She coughed during her treatment, loosening secretions in her lungs.

In looking at the effect of low frequency sound on rheumatism and rheumatoid arthritis, we treated a lady who had very painful joints, and whose hands were in splints. It was very difficult to seat her comfortably as she was apprehensive about being lifted onto the vibro unit. We made her as comfortable as we could using several pillows filled with polystyrene beads, and after ten minutes treatment she said she was feeling much more relaxed. After twenty minutes, her shoulders had relaxed and she was able to touch her own nose and was smiling. After three treatments we found it easier to put her back in her chair. We could bend her hips to 90 degrees and she was altogether more comfortable. Incidentally, we found that where we had to support limbs, it was effective to use pillows with polystyrene beads which transmitted vibration rather than pillows filled with foam rubber which did not. As a result of treating residents in the Hospital, the unit evoked interest in staff. One Physiotherapist had a back problem with Sciatic nerve complications and was off work for five months having tried various forms of treatment. She is

now better but left with niggly pains in the Sciatic area. We measured her forward flexion before treatment and after, and we measured straight leg raising, left and right leg before treatment and after. There was a significant improvement in the mobility of her back, and most important of all, she had a substantial reduction in pain. Another member of staff had a history of Sacro-iliac strain. She is frequently required to undertake heavy lifting in the unit and had recently had an acute spell of pain. The sessions she had on the vibro unit gave her considerable relief, and she is now more mobile and pain free. There are other examples of minor problems such as neck strain, headaches, and small back pains that were alleviated with the vibro unit.

Currently, research is in progress to measure the effect of low frequency sound through this unit on subjects with high muscle tone. Measurements are being taken before and after treatment by members of staff who are not present during the course of the treatment, and in half of the twelve sessions the clients will receive music on its own, and in the other half they will receive music and low frequency tone. By means of this single-blind test, we should be able to get an objective measurement which will indicate whether we are obtaining a reduction in muscle tone and an increased range of motion through the influence of low frequency sound as compared purely to a relaxing enjoyable musical effect. The results to date are very promising, and this work will be written up in a subsequent paper.

In conclusion, both the changing aspects of the music and movement programme, and the more recent work looking at the effect of low frequency sound have one theme in common, a desire to find a mode of treatment for people with spasticity, spasm and high muscle tone that is both effective and pleasurable. One should never underestimate the increased motivation in the patient when the treatment is enjoyable, and the efforts to maintain a range of movement at the very least in the face of a gradually worsening condition requires nudging at barriers. All the evidence of the treatment programmes described above shows that they are not only effective, but also illicit the most important response of all from the patients - their co-operation.

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Tony Wigram

Tony Wigram has worked in Special Education, Psychiatry and Long Stay Mental Handicap, and since 1977 has specialised in work with long stay mental handicap patients. A former Chairman of the Association of Professional Music Therapists and Churchill Fellow of 1985; Wigram has lectured extensively in the U.K. and abroad in America, France, Italy, Spain, Norway and Cyprus. he is currently Head III Music Therapist at Harperbury Hospital, and a Post Graduate Research Student at the Royal Holloway and Bedford New College, London University.

Lyn Weekes

Lyn Weekes has a background of experience working with children and adults in mental handicap. Chairman of the East Anglia Region of the Association of Paediatric Chartered Physiotherapists since 1985, and a former Committee Member of the British Society for Music Therapy, she has specialised in work with profoundly handicapped adults, and assessment and diagnostic work with young children. A Senior I Physiotherapist at Harperbury Hospital, Weeks has lectured throughout the U.K. and in France, and is currently involved in research work with Tony Wigram into the effects of low frequency sound.

MUSIC THERAPY - AN ART OR A SCIENCE?

Tony Wigram, Head III Music Therapist, Harperbury Hospital

Music therapy has been growing up over the last twenty years, and is beginning to come to terms with the question posed by this paper. Originally developed in the early part of this century as an interesting diversion in Hospitals, and also to encourage morale and act as an aid to convalescence (Blair 1964), serious developing in its application as a clinical form of therapy began after the war, and have been developing and expanding ever since. Owing to the diversity of the application of music as a therapeutic treatment, definitions of what music therapy is are many and varied. It has been most typically applied in situations where a communication disorder or disability has been the predominant problem and this has resulted in the majority of music therapists working with mentally handicapped or mentally ill people of all ages. The place of music as an art form within a therapeutic process that is more scientifically based is probably quite well defined in a publication 1982 by the Association of Professional Music Therapists in Great Britain: "Music therapy provides a framework in which a mutual relationship is set up between patient and therapist. The growing relationship enables changes to occur, both in the condition of the client and in the form that the therapy takes . . . Problems and handicaps may be emotional, physical, mental or psychological in nature, and by using music creatively in a clinical setting, the therapist seeks to establish an interaction, a shared musical experience leading to the pursuit of therapeutic goals determined by the patient's pathology and personal needs", (A.P.M.T. 1982).

MUSIC THERAPY PRACTISE

As the practise of music therapy developed in America with the establishment of degree courses in American Universities, in Great Britain the work was pioneered by Juliette Alvin (1975) who founded the British Society for Music Therapy in 1959, and subsequently set up the first post graduate training course for music therapists at The Guildhall School of Music in London. As the training courses began to produce qualified practitioners of Music Therapy, the natural outcome was that music therapists began to diversify and specialize their interests. While the American schools began to follow a more behavioural style of work, in Great Britain the most important feature of music therapy practise was clinical improvisation through which the therapist was able to make music with a client and work with that client's musical behaviour and non-musical behaviour. This ethos formed the basis of many different types of work. Work with different types of handicap, and also with autism is well documented by Alvin (1976, 1978), and approaches using specific types of music were also developed by Nordoff and Robbins (1965, 1971, 1977, 1983), whose pioneering work with handicapped children led to the second role in music therapy.

The field of psychiatry, short stay and long stay, was where music therapy had its roots. However, in the last twenty years the approach of the music therapists in psychiatry has become much more focussed and models of psychotherapy and analysis have been more consistently used within music therapy practise (Priestley,

1975, (Odell, 1982). The role of music therapy in working with profoundly physically handicapped clients in collaboration with physiotherapy (Wigram and Weeks 1983), Profoundly Mentally Handicapped Adults (Oldfield 1986), Mentally Handicapped People with Disturbed and Aggressive Behaviour (Wigram 1985) and as a diagnostic medium (Wigram 1988) will give some indication of the present day scope of music therapy in mental handicap. In addition to the considerable amount of work that has been done to date with children who have special needs, sensory handicaps and physical problems (Bunt 1985), the potential of the use of music with neurologically-based disorders is also being explored. Parkinson's disease (Cosgrave 1986) and Huntington's Chorea (Hoskyns 1981) demonstrated the powerful effect of music and its singularly motivating stimulus.

The outcome of this diversity of experience and growing well of knowledge on the effect of the use of music with a variety of different pathologies has been to add a scientific dimension to what essentially began as a therapeutic medium based on an art form. Most music therapists now work in situations where they are relating with increasing confidence to multi-disciplinary teams and to the medical profession. A clear understanding of the pathology, an assessment of the patient's needs, physical, psychological or emotional, and a subsequent system of evaluating the effectiveness of therapy work is channelling music therapists into taking a scientific approach to their work.

TRAINING

The training of music therapists has grown over the last ten years to reflect these much more specific professional skills. Currently, three post-graduate courses in music therapy select in total a maximum of only 35 students from many hundreds of applications each year, and require a high standard of musical skill and personal motivation. The training courses all include a comprehensive section of musical study whereby the student therapist learns to use music in a way that is specific to the purpose of therapy. In addition, there are detailed medical, para-medical and psychological components to the courses and supervised clinical practise undertaken by the students in Health Service, Social Service and Education placements throughout the London area (A.P.M.T. 1982, 1987).

RESEARCH

As the profession has grown, so have the demands for valid evidence that music therapy is an effective and useful form of treatment. The early reports and books that were written were largely anecdotal, and this means of describing music therapy processes and its effect with individual clients has survived in the form of single case studies. The behavioural approach as developed in the United States led to research studies looking at the use of music therapy in controlling difficult behaviour and developing cognitive skills (Steele 1968, Miller et al 1974, Jorgenson 1974). In Britain research has concentrated on attempting to evaluate the outcome of therapy, and the nature of the intervention that has taken place. In addition, work is at present going on to look at the processes involved in music therapy and music therapy interactions. A further area of research is looking at the physical

effect of sound and how it can be influential as a therapeutic treatment for specific physical problems (Wigram 1987). The majority of music therapy research to date is well written up by Bunt and Hoskyns in an article where they review the current standpoint of researches in Britain, and whether it is providing internal and external validity (Bunt and Koskyns 1988). The problems that have arisen in research are reflected in the title of this paper, and music therapists are finding it difficult to apply rigorous research procedures to this artistic medium of therapy.

CONCLUSION

A review of the available literature and the initiatives over the last few years in the research area would clearly demonstrate that music therapists are developing their profession primarily to meet the needs of their patients. Adapting to the situations within which they work, and finding common ground with other professionals such as psychologist, physiotherapists, doctors, educators, and nurses, it is now easier to see how a music therapy programme or intervention is compatible or complimentary to the work of other professionals. On the contrary, the British Society for Music Therapy puts on Conferences, Seminars and Workshops actively seeking to involve members of other professions. In hospitals, joint treatment approaches between music therapists and physiotherapists, music therapists and speech therapists and music therapists and psychologists have been developing for some years. Music is a potent and powerful influence in almost everybody's life. The role of the music therapist is to use that influence and power to meet the emotional, physical or psychological needs of a patient rather than to provide entertainment, musical enjoyment, or improvement of musical skills at a palliative level. The music therapist is a person who works through an artistic medium, but with a scientific framework to their approach which is proving essential in evaluating the benefits and effect of music therapy.

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DISTAL TRANSFER OF THE RECTUS FEMORIS MUSCLE

A procedure to improve foot clearance in the swing phase of gait in children with spastic cerebral palsy (1) (2).

Eva Bower M.C.S.P. Research Fellow, Faculty of Medicine, Southampton University.

One gait cycle starts from the time one heel strikes the ground and continues until the same heel strikes the ground again.

The cycle is usually considered to consist of two phases for each leg a) stance phase which occupies 60% of the cycle and begins with heel strike and ends with toe off of the same leg and b) swing phase which occupies 40% of the cycle and begins with toe off and ends with heel strike of the same leg. However one also needs to consider the transition from swing to stance - terminal swing, and the transition from stance to swing - pre swing.

Two of the important requirements of normal gait are stability in stance and clearance in swing.

To achieve toe clearance in swing the knee normally flexes to about 35 degrees in pre swing and to about 60 degrees to 70 degrees in initial swing.

Gait laboratory analysis usually consists of three areas of instrumental measurement.

1. Kinematic or video motion analysis using 8 to 16 markers fixed onto the child on predetermined anatomical points. The results describe the movements of the body parts in relation to each other during the different phases of the gait cycle.
2. Electromyographic analysis usually measures eight muscles at the same time using surface or intramuscular fine wire electrodes fixed onto the child. It demonstrates when a muscle is active and when the most electrical activity occurs during the different phases of the gait cycle, but it cannot show the amount of force or tension occurring.
3. Kinetics or force plate analysis describes the vertical and horizontal forces generated when the child steps onto the force plate and continues to describe

these forces as he or she progresses through the phases of the gait cycled on the force plate.

The combined information is processed by computer and subsequently displayed for use for clinical decision making. Electromyographic analysis has shown that what appears to be similar movement patterns to the clinical observer are sometimes brought about by differing muscle activity.

Crouch gait with flexion at the hips and knees is often seen in children with cerebral palsy. Hamstring lengthening is often performed but sometimes leaves the child with a stiff legged gait. The rectus femoris muscle originates from the anterior inferior iliac spine and the superior margin of the acetabulum and inserts into the tibial tubercle via the patella. It is a two joint muscle which flexes the hip and extends the knee. During normal walking the rectus femoris muscle assists hip flexion, decelerates the rate of knee flexion in the pre swing and initial swing phases of the gait cycle.

In children with cerebral palsy an overactive spastic rectus femoris may allow insufficient knee flexion in the pre swing and initial swing phases of the gait cycle thus making difficulties with foot clearance.

This could be demonstrated by gait laboratory analysis using percutaneous fine wire dynamic electromyography in order to isolate rectus femoris muscle activity from the vasti muscles, and video motion analysis. If there is continuous rectus femoris activity in swing phase together with difficulty with foot clearance a distal transfer of the rectus femoris muscle is indicated which alters the function of the rectus femoris muscle to one of a hip and knee flexor.

If, however, rectus femoris activity is found only in the stance phase then a proximal release is indicated.

Work is currently going on in the U.S.A. to determine the most advantageous site for attachment of the rectus femoris muscle following distal release to try to overcome any mal rotation present.

Some paediatric physiotherapists feel that the necessity for orthopaedic surgery in cases of cerebral palsy is a sign of defeat and should only be considered as a last resort. Maybe these feelings are the result of some ill thought out mediocre surgery performed in the past. Maybe these feelings are the result of the deterioration found in most children for about six months following orthopaedic surgery. Most children require intensive short term physiotherapy treatment following orthopaedic intervention often in combination with orthotic devices and then longer term management.

I hope that the intervention that I have described has illustrated the possible shape of some things to come. Selectively chosen, thoughtfully timed, skillfully performed orthopaedic surgery in combination with physiotherapy and orthotic management can be a very useful tool in the management of cerebral palsy. Especially so if scientifically instrumented gait analysis is combined with the child's parents', physiotherapist's and orthopaedic surgeon's thoughts during decision taking.

I should like to thank Mr. J. R. Gage M.D. for inviting me to visit the Kinesiology Laboratory, Newington Childrens Hospital Newington Conn. U.S.A. in 1987 and 1988 which has enabled me to observe the gait analysis process in action there.

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KIELDER

Fran Shipman, Senior Physiotherapist

It was probably a chance remark that gave us the idea of taking a small group of children to the Kielder Adventure Centre in the summer of 1987. The children being considered were all in mainstream school and disabled. We decided on six. There were two girls with mild cerebral palsy, a boy with moderate cerebral palsy, a boy with cystic fibrosis and then two severely disabled boys, one with spinal muscular atrophy and one who has mild cerebral palsy with advanced muscular dystrophy. The latter two use electric wheelchairs. The children's age range was 9 - 14 years. Two physiotherapists and one nurse were to accompany the group.

In January we applied for £300 of the estimated £800 needed for the project. We discovered it would be July before we would know if our application had been successful. The thought of having to raise the total amount left us wondering if it should be postponed until the summer of 1988.

At that time James our teenager with cystic fibrosis was extremely ill. He insisted he was going to be well enough for Kielder and was really looking forward to it. He had not been away without his family before. A decision had been made for us.

It was early March by this time. Letters were sent to several local firms, Lions Club and Round Tables. The response was fantastic, some firms sending £100 cheques by return of post! There were wine and cheese parties and raffles. Very soon £700 had been raised with more in the pipeline. A local charity promised a mini-bus, so it was all systems go.

In the weeks immediately prior to going some of the children had quite strong misgivings. The young boy with spinal muscular atrophy had never been toiletted by anybody but his mother in all his nine years. Mother was also very nervous of John's impending adventure. Another extremely shy ten year old girl who had never been away before, repeatedly told her mother she was not going. Despite all this everybody turned up on the morning of departure. One excited, the rest very apprehensive. It did not last long. Matthew and John were soon exchanging electric wheelchair tales and Jason and James decided they would navigate. The two girls remained quiet.

It was a good journey and we eventually arrived at Kielder. Expecting a sign for the Centre we missed it - twice. This produced great hilarity and the idea that perhaps the driver did not really know where we were going.

It was difficult to gauge how the children would cope with all the activities and how much stamina they had. We need not have worried it took no longer than the

first evening to decide they wanted to do them all; and in between spending their time in the pool, they tried canoeing, sailing, absailing, horse riding, orienteering, archery, rifle shooting, table tennis and snooker. The group gelled so well, help was given to each other when needed and they were not quiet anymore. Everybody else at the centre were marvellous. Instructors and guests alike. This, inspite of the fact they were likely to be mown down by speeding electric wheelchairs. The freedom John and Matthew felt could be seen in their faces.

On the final day, we were there for four days, we aimed to leave at approximately 11.00 a.m. What actually happened was many phone calls, just another activity, followed by one final dip in the pool and departure at 4.00 p.m.

The project had been a tremendous success. The children tackled demands on them with more confidence as the days went by. Hopefully the experience would help them realise their potential. We, the staff taking them, learnt a great deal. It certainly gave us more insight into the constant physical demands on parents, and also the problems incurred outside the cloistered areas of physiotherapy departments.

This year the project was repeated with equal success. However, what pleased us most, was that Matthew, severely disabled with muscular dystrophy went to Kielder this year with his parents and two brothers. While he was there he carried out a sponsored wheelchair absail; an activity we steered him away from last year.

“EVERY BODY’S HEALTH MATTERS”

National Physiotherapy Week

The first ever National Physiotherapy week is to be held the week beginning 19 March 1990. The aim of the week is to heighten awareness of the physiotherapy profession and the excellent work it does. We hope to promote as many aspects of physiotherapy as possible, not only to the general public but MPs, policy makers and other health professionals. We want to show that physiotherapy is about the fit and unfit, the well and unwell, the young and the old. That is why the slogan “Every Body’s Health Matters” has been chosen for the week.

The Society will be seeking a number of personalities to be patrons of the week and your group might like to have a patron of your own.

We shall also be approaching radio and TV stations, newspapers and magazines to encourage coverage for the week.

You could perhaps approach magazines that cover your area of work and offer to write an article for the issue that appears that month/week or write something for your local newspaper; Organise an open day, an exhibition or a display in your local shopping centre or conduct group sessions for your particular client group. The list of activities you could do is endless. But now is the time to start planning! If you have any ideas or want to discuss possible events please contact the Public Relations Department.

We will be keeping your group's PRO informed about developments so keep in touch with them. Nearer the time they will be sent a media pack with ideas for activities and how to get media coverage for the week. By the late autumn publicity material will also be available.

But remember the more individual members/groups that get involved the better chance we have of making the week a tremendous success.

Lynn Duxbury
Assistant Public Relations Officer
The Chartered Society of Physiotherapy

ABSTRACTS

Title: Effect of Therapeutic Horseback Riding on Posture in Children with Cerebral Palsy.

Author: Dolores B. Beroti M. S., P. T.

Source: Physical Therapy Vol. 68 No. 10 Oct. 1988.

Cerebral palsy is a chronic disability requiring the child to be involved in therapeutic activity over many years - it is a challenge to sustain the child's interest. Many adjunctive activities have been developed with this in mind such as swimming, dancing and horse back riding.

The purpose of this study was to measure postural changes in Cerebral palsy children after participating in a therapeutic horse riding programme. The results constitute the first objective measure supporting the efficiency of therapeutic horseback riding.

Eleven children with moderate to severe cerebral palsy aged from 2 years to 9½ were selected. Postural assessments were performed by a panel of 3 paediatric physiotherapists using a form designed by the author. This consisted of a visual assessment and scoring of alignment and symmetry of five body areas - namely:-

1. Head and neck
 2. Shoulder and scapula
 3. Trunk
 4. Spine
 5. Pelvis
- Scoring range from 0 - 3

This assessment took place three times - one before a ten week period with no riding programme, one immediately before a ten-week riding programme and the third immediately after the programme finished. Thus the children acted as their own controls.

The riding programme consisted of exercises on horseback and usual activities to promote relaxation of spasticity, improve muscle tone and balance.

Significant improvements in posture balance and weightbearing were recorded after the ten weeks riding programme.

The author feels further studies should be done to isolate additional variables and to examine the effects of therapeutic riding on different disabilities.

Title: The Effects of a Tactile Stimulation/Range - finding programme on the development of very low birth weight infants during initial hospitalization.

Author: Paul J. M. Helders, Bernard P. Cats, Janjaap Van Der Net, Sylvia B. Debast.
Depts. of Paediatric Physiotherapy and Neonatology, University Children's Hospital, Utrecht, The Netherlands.

Source: Child care, health and development 1988 14 341 - 354.

Recent studies have demonstrated that at the gestational age of 12 - 13 weeks the foetus often assumes a hammock like position - at 17 weeks gestational age having begun to explore its environment, the foetus begins to touch its own body. As the pregnancy develops, contact between the intrauterine wall and the foetus increases thus developing specialised cutaneous sensory receptors which at birth are present albeit in a simple form. Sensory input is also provided by the mothers respiration, heart beat and body movements.

This study was carried out on 51 babies with a gestational age at birth of 32 weeks and/or a birth weight of less 1500 grams. They were subjected to a tactile stimulation programme imitating that which occurs during the last stages of pregnancy. All the babies were healthy, in a stable condition, without neurological abnormalities and were sucking well - their development was compared with a control group.

When in supine the babies were nursed in a specially designed hammock, when nursed in a lateral position they were supported and covered by flannelette blankets. These positions were maintained continuously by nursing staff - non moving positioning was chosen to preclude the effects of vestibular stimulation.

Observations were carried out daily by a paediatric physiotherapist prior to feeding. With yes/no score being used on various criteria, for at least two weeks. There was a significant difference between the study and control group, the study group showing better auditive responses, greater variation in hand movements, less hypotonia, fewer brady cardiac and apnoea and improved sucking.

Title: Evaluation of Biofeedback Seat Insert for Improving Active Sitting Posture in Children with Cerebral Palsy.

Authors: Dolores B. Bertoti M. S., PT; Amy L. Gross B. S.

Source: Physical Therapy Vol. 68 No. 7. July 1988.

One of the most common and most limiting motor problems exhibited by children with cerebral palsy is lack of head and/or trunk control. This has obvious implications in all aspects of development, especially motor and social.

Physiotherapy is effective in helping children to benefit functionally by helping to achieve head and trunk control but success is limited of necessity by the comparatively limited time that can be spent with each child by physiotherapists.

It was felt Biofeedback positional aids could be of great benefit in helping to carry over the physiotherapy treatment and prolong the amount of time the child can practise correct postural control. Five children with moderate to severe Cerebral Palsy were used in a study to evaluate the use of a biofeedback positional aid. This was placed against the back of the seating device of each child - taking the form of a contact pressure switch activated by the child when his trunk was extended. This switch, in turn, activated a video-cassette recorder or could be adapted to activate a television or radio.

The results of this evaluation showed the children used this biofeedback insert effectively and thus improved their sitting posture by actively using it. It is felt this insert could prove a useful therapeutic tool.

BOOK REVIEW

EARLY PREDICTION AND PREVENTION OF CHILD ABUSE

K. Browne, C. Davies, P. Stratton (Eds.)
pp 315, polates 12; £9.50 paperback.

The Society for Reproductive and Infant Psychology held a multidisciplinary meeting on the above subject in Leicester recently. Papers given there were published in their journal (1988 volume 6 issue 3) but 22 contributors have gone on to write reviews with comprehensive references for those who want to understand the issues more clearly. There are sections on definition, incidence, methods of prediction, prevention and treatment. A special chapter from Leeds reviews the diagnosis of sexual abuse, illustrated by 12 postage sized plates labelled "anus 1 - 6" and "vulva 1 - 6" in memory of "the year of the bottom".

It is difficult to devise policies for intervention if there is argument about definition and incidence, sensitivity and specificity of prediction, effectiveness and cost-benefit of prevention and treatment but similar problems arise in other aspects of child health, not least developmental medicine and the attempts are justified so long as they are evaluated. Sensitivity (the efficiency of identification of cases) and specificity (efficiency of exclusion of controls) are illustrated by an example which indicates the reason for the place this subject holds on the front page of our newspapers. The best perinatal checklists achieve a sensitivity around 82 per cent and a specificity of 88 per cent. If applied to a population of 10,000 with a diagnosed risk of abuse of 4/1000 33 cases will be identified and 7 missed but nearly 1200 false alarms will be raised. So far as sexual abuse is concerned only the third who suffer physical abuse also will be identified.

Abuse may be active (assault, intimidation, rape) or passive (poor health care, lack of affection, failure to protect) and the latter is harder to define or detect. At

what point should the limit be made on the consequences for children of poverty, recurrent illness, lack of sleep, exposure to hazards, lack of knowledge of child care and excruciating predicaments for families? The answer seems to be when attachment between children and parents has failed to develop or broken down. Stress is not a sufficient explanation for abuse. Aggression escalates when unrealistic expectations lead to interpretation of child behaviour as deliberate defiance threatening the low self-esteem of parents. Methods of identifying this require repeated assessments in ways which society may not accept or fund.

Intervention strategies include enhanced services for high risk families (e.g. by specially trained health visitors) adequate provision of nurseries, family centres and child care, practical and emotional support from local volunteers (e.g. Homestart/Newpin projects) and education of children, especially about sexual abuse and future child care.

We will never have all the answers but this book helps us to ask the right questions in a clinical, social and educational concern which has emerged from public taboo in our lifetime.

Ian McKinlay
Senior Lecturer in Community Child Health
Manchester University

OBITUARIES

Mrs. Elizabeth Ann Mark MCSP

Elizabeth Ann Mark died on 24th December, after living every part of her life to the full. She was a skilled therapist and a loyal supporter of the CSP. A committed member of the local community - she was a serving magistrate and was the focal point of a united and devoted family.

Ann was one of the small group of physiotherapists in Birmingham who recognised the need for a paediatric special interest group. She worked tirelessly and it was largely due to her efforts that the Association of Paediatric Chartered Physiotherapists became established. With great good humour and enthusiasm she assumed the difficult role of Treasurer and guided us towards financial stability. The first National Committee spent many hours struggling with the Constitution, working on codes of good practice and training, and creating a regional structure with effective communicating links, not least by means of the Newsletter. We were fortunate in having some expert advisors to help us, but Ann was always at the core of our discussions and her calm intelligent good sense often kept us on the right path. Early on it was decided that we should have our own logo, and it was Ann and her family who worked on the design.

When her cancer was diagnosed several years ago she vowed that it would interfere with her life as little as possible, and in spite of periods when she felt really ill, it was only during the last few weeks that her activities were severely curtailed. Everyone was delighted to see her and her husband at the 1988 APCP conference

at the University of Warwick, her own territory, which she had helped to organise. It was an inspiration to work with Ann and a privilege to know her and have her as a friend. We had together started to prepare a history of the beginning of APCP, but her illness overtook us. She is very much missed and we offer our sympathy to her husband Freddie, and her son and daughters.

Monya P. Gilbertson

Dr. A. J. Ayres

Dr. A. Jean Ayres, who pioneered work with children with motor perceptual problems, died on 16th December 1988. She devoted her life to researching her theories and developing sensory integration therapy. Dr. Ayres was an O.T. worker in Southern California where she gained therapy esteem for her work which produced the Southern California Sensory Intergation Test (S.C.S.I.T.). Just before she died, she completed a revision of the test called Sensory Integration and Praxis Test (S.I.P.T.). She worked closely with paediatric physios and O.T.s who have continued to develop her work in the U.S.A., Australian, Japan, and Europe. Her major publications were 'Sensory Integration and Learning Disorders (1973)' and 'Sensory Integration and the Child' (1979). We are indebted to her for the contributions she has made in the treatment of the child with learning difficulties.

Jenny French

We are sorry to hear of the death of one of our Scottish members - Mrs. Usher of Peebles.

LETTER TO THE EDITOR

Dear Madam,

I would like to comment on the article in the February 1989 Newsletter on Selective Dorsal Rhizotomy, but first to thank Mrs. Bower for her extremely informative presentation of a novel method of intervention.

My comments are concerned with the criteria for suitability and selection of children for this procedure, and, the results obtained.

The most suitable children are thought to be those at least three years old, with spastic diplegia, good potential for ambulation and strong personal motivation. Selection is made on the evidence of plateauing of functional progress due to increase in spasticity and good underlying muscle strength. The results obtained,

following intensive physiotherapy, three or five times a week for eight to twelve months, are a decrease in spasticity, functional improvement in sitting, half kneeling and gait, but, also, underlying muscle weakness and the persistence of balance problems, primitive motor patterns, abnormal movements and tonic reflexes.

One is forced to ask: of what overall benefit is this procedure, and are the results any different to conventional orthopaedic surgery in cerebral palsy?

This interesting article throws the spotlight once again on the dilemma of cause and effect, (chicken and egg), which bedevils the analysis of problems resulting from cerebral palsy: does Johnny walk on his toes because he has "spastic" posterior tibials, or are these muscles "spastic" because he walks on his toes and has no alternative? Experience with procedures of tendon transfer, or release show the same negative outcomes: muscle weakness and instability, which could be suggesting the tightness or spasticity was of a compensatory nature and due to an underlying balance/coordination defect.

A second important piece of information would be evaluation of the results on a long term basis: forty five patients were evaluated but over what period of time following surgery? Again the lesson learnt from more conventional methods of intervention are that recognisably good results can be seen to deteriorate into near disasters if monitored over a longer period. The problem here, I would suggest, is growth and the constant change in shape and weight of the child's body, together with his inability to perform efficiently.

There must be many paediatric physiotherapists in this country who as a result of clinical experience, would admit to considerable uncertainty and disquiet whenever the question of surgical intervention is suggested in cerebral palsy. A further complication of dorsal rhizotomy may be sensory loss, although this is not thought to be significant. However, current interpretation of the nervous system stresses the dependance on integration of the many varied afferent and efferent components of the body.

Perhaps the time has come to positively question any intervention with these children and to re-think and examine our understanding and interpretation of their fundamental balance and coordination problems.

I would heartily endorse Mrs. Bower's request that she be kept informed of any introduction of this procedure in Great Britain. The very least we are able to do is monitor the affects.

Noreen Hare (Miss)
Superintendent Physiotherapist
PAEDIATRIC PHYSIOTHERAPY SERVICES, NOTTM.

IT JUST NEEDS TIME

It was quite straight forward - or so it seemed - to keep a register of members old and new, subscriptions paid and unpaid. But then I found out!

First, there was the COMPUTER.

Mine was not compatible with that of my predecessor, and it took weeks to change the discs and check that the lists were still correct, but, eventually, all was well. Now I could proceed

Subscriptions were coming in by every post, and I discovered I was expected to be clairvoyant. Who is the lady who has sent me a lonely cheque with no indication as to address, membership number, or whether it is for renewal or new membership? Her name is similar to others on the register . . . A check with the bank reveals she lives in another part of the country, but still uses her old Bank!

Application for membership forms come in for ladies who are already members, so eager to pay, they don't read the form - I have now learnt to check all forms. Pleasant letters arrive enclosing money for renewal of subscriptions, only omitting to mention that the last renewal was years ago. Luckily, the previous Membership Secretary gave me long lists of lapsed members, which only need to be gone through, if by chance the address has changed in the meantime it just needs checking out! Which reminds me of those who renew subscriptions not pointing out that their address has changed since last time - perhaps they are still wondering why their Newsletters went astray.

However, I am sure that you are reading this as one of the 90% who pay with correctly signed cheques and forms giving their membership number - the one in the corner of the membership card - and cause me no headaches at all. Sometimes you are even kind enough to send me stamped addressed envelopes.

In conclusion, APCP has for some time now asked for Bankers Orders to be rescinded, so who are the kind people still paying £1 or £3 and not to be found on any recent lists? We welcome their generosity and would love to send them Membership cards, if they will send the correct amount - £12.50 - but in the meantime, if you have any queries, I will try and help.

More post? Ah well! No knitting for me tonight!

Jeanne Lamond
Membership Secretary

SUMMARY OF NATIONAL COMMITTEE MEETING HELD FRIDAY 20th JANUARY 1989

Terri Fearn was welcomed as the incoming South East Region representative and Kate Richardson attended to assist the London Representative.

Elma Bell is due to retire from the office of Public Relations Officer in March and so there was discussion on who would succeed her in this office.

There was considerable discussion on the ways in which the APCP could participate in and support the organising committee of the World Congress to be held in London in 1991. This resulted in the formation of a sub-committee with a

designated link person to liaise with the organising committee of the CSP. During these discussions it was decided to hold our Annual Conference in 1991 immediately prior to the World Congress and to make it more of an international event. This would be organised by the National Committee with co-opted help and would be held outside London. It was hoped to arrange for visitors from abroad to visit various paediatric specialist treatment centres during their stay for the Congress.

Clinical Interest Conference is to be held in May at Harrogate and provides the opportunity for Committee members of Clinical Interest Groups to get together and discuss various issues. Topics on this year's agenda include -

1. Where should our priorities lie?
2. What skills do physiotherapists possess that other professions or less skilled people do not?
3. Are the skills that we possess reaching the people who most need them?
4. What skills can we share with others?

The committee decided to send one committee member who attended the conference last year and one committee member who would be new to this conference.

The CSP had requested comments on a new DHSS draft document on the welfare of children in hospital. Several committee members agreed to send comments by the end of January.

In the Treasurer's Report it was noted that an increase in money received from subscriptions reflected an increase in new members. The 1988 conference organised by the Birmingham region made a profit of £2,039 and sale of newsletters to non-members produced an increased revenue of £113 last year. Printing and stationery costs were considerably higher the previous year but travel and committee expenses were reduced. This was in part due to the committee's decision not to hold a weekend workshop where specific paediatric physiotherapy issues are examined and discussed. It was also noted that telephone costs were increased this year.

In the Post-Reg. Education Report it was noted that the APCP statement on Conductive Education had been published in "Physiotherapy Practice" in December 1988. Meetings are being held regarding the integration of our validated "Introduction to Paediatrics" course into the Polytechnic for accredited accumulation towards a CNA degree. It was reported that the second post-registration validated course has just been successfully completed at Wolverhampton. Names of the successful participants would be announced at the conference in Guildford.

Penny Robinson drew attention to the press coverage that had been given to a child with cerebral palsy, treated in a UK child development centre who had just achieved independent walking. She stressed the importance of highlighting our own methods and achievements by contacting the local press with appropriate examples of this kind. It is also a good idea to inform Stuart Skye in the PRO Department at the CSP of such publicity for inclusion in the PRO Newsletter.

A reduced number of APCP booklets were sold this year (265) compared with 282 in 1987) - the most popular booklet sold was "The Clumsy Child". Plans were in hand to update this booklet. The committee accepted recommendations to increase postage on the sale of booklets.

The Guidelines for Good Practice in Paediatric Physiotherapy are still in the process of being refined. It is proposed to delay publication until the sub-committee have participated in a CSP workshop for Clinical Interest Groups who are putting together such guidelines. Meanwhile advice will be sought on presentation and layout of the booklet from the Public Relations Department of the CSP.

The National Committee decided to hold a weekend workshop in October to discuss the possibility of standardising assessment forms, methods of documenting treatment given and standardised testing methods.

Finally the committee were delighted to be informed that the APCP has been officially recognised by the Professional Practice Committee of the CSP.

* * * * *

TREASURERS REPORT

Members have asked why the Association does not operate a Direct Debit scheme for the payment of Membership Subscriptions.

I investigated the feasibility of operating such a scheme and reported on it to the National Committee.

The bank produces quite extensive information but is unable to give actual costs for using such a scheme without positive numbers and figures.

The main points to consider are:

1. What are the advantages?
 - a) Cash flow can be controlled with greater certainty (but 3/4 of the subscriptions are already renewed by March of each year).
 - b) Once Members have initiated their participation they do not have to remember to renew membership annually.
2. How much will it cost?
 - a) Initially - forms will have to be produced, approved by the bank and sent to each member (but there should be a permanent address on the form, and it is most unlikely that the bank would accept the C.S.P. as a "care of" address).
 - b) Running costs - entries are recorded on magnetic tape or, occasionally, paper vouchers and are processed. We may need to pay for the Bank's Computer Services. They would give us some idea of costs if we came up with positive numbers. The Bank will also want to monitor us with regard to reaching the required standard of documentation and procedure.
 - c) Processing of Instructions - when Payer's Instruction is received it must be passed to the Bank Branch to which it is addressed. Accurate and up-to-date records will need to be kept. Advance notices will need to be sent to Payers with regard to changes in amounts to be collected.

3. What are the disadvantages?

- a) How many Members will participate? We would need to be quite certain that a large proportion of the Membership would participate in order to justify the costs. There is reason to suspect that just as some members are slow to renew their Membership so some Members would be slow to initiate their participation in the scheme.
- b) Our application may be refused because we do not have a permanent address and Officers change every 2 - 4 years necessitating a resolution being made available to the Bank regarding appointment of Officers.
- c) We would become liable for Indemnity claims and it is suggested that insurance is taken out to cover this, (liability is not limited to amount, it also arises in respect of consequential loss).

The Bank information warns that the Operator of the scheme must be prepared to receive and handle immediately:

- a) Advice of unpaid Direct Debit (from own Bank), regarding Payer's instructions being cancelled, Payer deceased, or Account transferred to another Bank.
- b) Advice of Amendment/Cancellation (from any Bank) for the same reasons as above.
- c) Cancellation of Instruction from Payer.
- d) Indemnity claim (from any Bank).

The National Committee considered this information and decided that the scheme was not altogether suitable for an Association whose Officers change every 2 - 4 years. However the committee would be pleased to give consideration to the views of the Membership via the Regional Representatives.

Jill Brownson
Hon. Treasurer

P. R. O. REPORT

It is with regret that I write my last report as your Honorary P.R.O. It has been a source of deep personal satisfaction to work with the Representatives from the United Kingdom and to establish open, frank communication amongst us. I hope it is true to say that there is a clearer understanding of what we are trying to achieve. The discipline of having a P.R.O./Representatives session before each National Committee meeting has been finally established and it is conducted with formality - within reason. The guidelines have been finalised for adoption at the March meeting prior to the A.P.C.P. Conference. The filing cabinet is ready for hand over and the list of members and overseas members for whom the P.R.O. is responsible is complete. All of these systems will be handed over to the next P.R.O. as soon as the appointment is made.

It is a matter of considerable regret that I have been unable, lately, to project our image on your behalf as positively as I would have wished. On many occasions I longed for the time to consider and to present important issues. One feels that we need a part time/full time P.R.O. doing nothing else but projecting this image. Perhaps some day this suggestion may become a reality.

Finally, I would like to thank every one of you, past and present, with whom I have worked. I will always remember my Honorary P.R.O. days with real pleasure and my friendship with each of you.

Elma J. Bell

BITS OF PAPER

Physiotherapy is wholesome
And thoroughly down to earth
A highly practical career
Of useful noble worth.
A 'jolly-hockey-sticks' approach
Of healthy, hearty, folk
Who scorn all sedentary work
And treat it as a joke.
But wait - there is 'THE OFFICE'
A horror chamber real
Where paper mounts in ugly piles
A sight of NO appeal.

With memos, notes, review reports;
Of paper there's no end;
P.O.M.R. it must be done
And letters I must send.
The phone it rings, I have to read
The Journal and it's contents note,
Keep registers and fill in forms
To try to keep afloat!
And woe betide a physio
Who dares to get it wrong -
The only welcome paper scrap,
Her pay cheque, will not come!

Priorities essential
Somehow I have a hunch
That hidden in this paperwork
I must have lost my lunch.
I ought to eat this paper first
For breakfast, dinner, tea.
Must keep it down at any cost
before it eats up me!
I know - we'll get a shredder
And feed it all this stuff
With unrelenting appetite
I'm sure we've got enough.

I'm drowning in this paper
A prisoner in a cell.
And though my body's A.O.K.
My sanity's not well!!
Now surely there's a reason
To document each move,
For when I'm sued one day in court
My innocence I'll prove.
In all these bits of paper
I'm sure that they will see
Whoever pulled off Johnny's leg
It surely wasn't me!!

So physios unite with me
To fight this battle new.
In typical efficiency
We'll show our colours true.
We'll sort out all this paperwork
Pen-push and not delay
And show the administrative lot
We're just as good as they.
So, looking to the future,
Where our great rewards remain,
When we're allowed one day to see
A PATIENT once again!

Catherine Shore
Senior Physiotherapist
Beaconsfield.

STUDY DAYS/COURSES

Concepts of neural plasticity and the neural control of movement and their relevance to neurological rehabilitation

Date: 11th - 13th May 1989 at Combined Training Institute, University of Wales, Cardiff

Course Organiser: Dr. I. Musa, Cardiff School of Physiotherapy, Combined Training Institute, University Hospital of Wales, Heath Park, Cardiff CF4 4XW.

This course will look at current concepts of neural plasticity and of motor control and discuss their relevance to the rehabilitation of patients suffering from damage to the developing and the mature nervous system. It will include a half day workshop/seminar in which a consideration will be made of the arguments for the effectiveness of conductive education and the Bobath approach, based on the concepts of neural plasticity. It will be of relevance to physiotherapists involved in rehabilitation of either children or adults.

Fee: £50 including coffee and tea but not lunches. Late applicants please contact Course Organisers to see if further places are available.

Counselling

Date: Fri. 19th and Sat. 20th May 1989 at Ulster Hospital, School of Nursing, Dundonald.

The aim is to make us more aware of the wide variety of problems faced by the 'Handicapped Family' and give us an insight on how to deal with these situations.

Application forms are being circulated to APCP members in N. Ireland. Further information can be obtained from: Mrs. Paddy Bailie, 60 Ballymena Road, Doagh, Ballyclare, Co. Antrim.

An Introduction to the Bobath concept: an approach to the treatment of Cerebral Palsy

Date: 20/21/22 June 1989 at the Combined Training Institute, University Hospital of Wales, Heath Park, Cardiff.

Tutors: Gill Stern, Judy Murrey, April Winstock from the Bobath Centre, London.

Fee: To be arranged.

Further details from Mrs. Vivienne Williams, Supt. Paediatric Physiotherapist, Children's Centre, University Hospital of Wales.

Sensory Intergration Therapy

Dates: 6th, 7th and 8th September 1989 at Chesterfield and North Derbyshire Royal Hospital.

Course content: Includes revision of neuroanatomy related to S.I. Case Studies. Inclusion of work with autistic children, the mentally handicapped and an update of work at present being carried out in America.

Pre-course Requirements: Delegates should have attended at least one previous course and have practical knowledge in the use of S.I. methods.

Application Forms: from Mrs. Carol Oldfield, Paediatric Assessment Centre, The Health Centre, Saltergate, Chesterfield, S40 1SX., Please send a large s.a.e. for course programme, details and application forms.

Closing date - 30th June 1989.

Halliwick Method

Dates: September 23rd & 24th 1989 - Part A.

January 20th & 21st 1990 - Part B at Chesnut Lodge School, Widnes, Cheshire.

Course Tutors: Alison Moran and Beverley Denny

A two part course providing an introduction to the Halliwick Method of teaching the disabled to swim.

Places are limited to 14. Closing date July 24th

Apply to Mrs. S. Grant, Supt. Physiotherapist, Halton General Hospital, Shopping City, Runcorn, Cheshire WA7 2DA.

QUALITY OF LIFE

LOUGHBOROUGH 5th, 6th, 7th APRIL, 1990

A.P.C.P. Annual Conference will be organised by the Trent Branch

CARE IN OUR HANDS

World Confereration for Physical Therapy - 11th International Congress

28th July - 2nd August 1991

Remember that it is around this date when, it is hoped, we will be holding our Annual National Conference of 1991.

REGIONAL PROFILES

SCOTLAND

Scotland stretches from Shetland and Orkney in the North, the Borders in the South, to the Outer Hebrides in the West, and Fraserborough/Aberdeen in the East. With a population of five million, approximately 941,130 are children under the age of 14.

There are 15 Health Boards, split into units, each with its own group of hospitals. Three of these Health Boards have main Children's Hospitals, Edinburgh, Glasgow and Aberdeen. Edinburgh and Glasgow provide a regional service for Cardio-thoracic surgery, neonatal surgery, leukaemia/oncology, and other specialities.

Approximately 90 paediatric physiotherapists are employed by the NHS, working mainly in schools and community, with the exception of the three hospitals. The Scottish Council for Spastics also provide a service in their schools, and mobile therapy units.

Scotland is a beautiful country of mountains, lochs and islands, which can give rise to assess problems. On occasions, aircraft have been used to enable the therapist to carry out her duties!

The A.P.C.P. Committee has representatives from most areas of the country, and is very active. Approximately 3 - 4 Study Days are held each year, which are well attended, and stimulate interesting discussions between members.

Ann Harnden

WALES

The A.P.C.P. has been active in Wales since the inaugural meeting 13 years ago. Courses in those early days - on Spina Bifida, with Professor Lawrence and Dr. Ralph Evans, and on Cerebral Palsy with Sophie Levitt - were great successes, and enthusiasm has not waned since.

The A.P.C.P. Annual conference was held in Cardiff in 1984 with the theme of 'The acutely ill child', drawing together many therapists with this common interest. The conference dinner at the Banqueting Hall of Cardiff Castle was legendary, and the conference thoroughly enjoyed by all.

Lectures and study days have continued in a variety of topics:

- Cerebral Palsy - with tutors from the Bobath Centre;
- Seating - with the Research Team from Chailey heritage and their 'Adapta Seat'
- Halliwick courses for swimming
- Lectures from various speakers including - the Clumsy Child; Neonatal Neurology; paediatric neurology conditions; Arthrogryposis.

In 1986 at the Annual Conference in York, Viv Williams (Supt. Physio for Children's Services in South Glamorgan) was elected to the national committee where her interests in the Pre-term baby, Cerebral palsy, Post Registration

Education and Good Practise have contributed to the work of A.P.C.P. She is a co-author of the 'Guidelines for Good Practise' - soon to be published.

Geographically, the Welsh Region is easily defined - but presents enormous difficulties for travelling and administration. Enthusiastic members travel long distances; over mountains - from far and wide - to attend lectures/study days and membership is increasing all the time.

A.P.C.P. meetings provide an opportunity for therapists working in isolation to meet with colleagues for education and information - and act as a forum for discussion on topical issues. We are endeavouring to move the meetings around the region and recently North Wales was the venue for a lecture. The enthusiasm of the people who travelled long distances for an evening meeting confirmed the interest in Paediatrics in Wales.

In preparing this profile, the origins of A.P.C.P. in Wales owes much to the inaugural members who set up the Association and whose original objectives and professionalism paved the way for the development of paediatrics as a multitude of specialities and brought together therapists with common interests. We plan an article for a future newsletter acknowledging the work of the founder members.

Lyn Horrocks

REGIONAL REPORTS

Scotland **Reg. Rep. Ann Harnden, 56 Huntley Court, Langside, Glasgow G41 3DH.**

The Scottish Region held its A.G.M. on 4th March 1989. It was with regret that we heard of the retiral of Mo Grant, Chairperson, and of Adrienne Lyon, Treasurer, who have been unstinting in their enthusiasm and hard work for A.P.C.P. in Scotland. Many thanks are expressed by the current committee.

The A.G.M. was held during a Study Day on 'Aspects of Management of the Multiply Handicapped Child'. This was presented by the team from Falkirk, Physiotherapists, Speech Therapists, Educational Psychologist and Teacher. It was a very interesting day, and was well attended.

Future Study Days include 'Introduction to Bobath' on June 4th, (for information, contact Lynn Campbell, Supt. Physiotherapist, Westerlea School, Scottish Council for Spastics, Edinburgh), and 'Gait Analysis and Orthotic Management' in October.

Wales **Reg. Rep. Lyn Horrocks, 9 Garth Close, Redry, Nr. Caerphilly, Mid Glamorgan CF8 3EN.**

Dr. Sheila Wallace, Consultant Paediatric Neurologist at University Hospital of Wales in Cardiff gave an excellent lecture entitled 'Paediatric Neurological Conditions' at Eveswell Clinic, Newport in February. This meeting was very well attended with physiotherapists, psychologists, health visitors, Portage workers - all brought together by this common interest.

We are endeavouring to move A.P.C.P. meetings around the region of Wales - and in mid-march the Regional Rep. and Treasurer ventured over the mountains to North Wales. Dr. Helen Hughes, Consultant Geneticist at University Hospital of Wales, Cardiff, regularly makes the journey north as she holds clinics in Gwynedd and Clwyd. We had enjoyed her lecture on 'Arthrogryposis' given in Cardiff during last year so much that we asked if she could repeat it for colleagues working in the North. Elaine Owen distributed the information widely, attracting an enthusiastic audience who welcomed the opportunity to get together for general discussion as well as for the lecture. Many thanks to those who travelled long distances to make the evening a success.

N. West

Reg. Rep. Lin Wakely, 2 Ash Bank, Pipers Ash, Chester CH3 7EH

The A.G.M. of the N.W. Region was held on Sat. 4th March at Alder Hey Hospital, Liverpool. It was combined with a very interesting study morning on Epilepsy.

So far, two future study days are being arranged:

1. 17th June - Use of a Video Camera, in Lancaster.
2. 11th November - Muscular Dystrophy - Current Management at Hebden Green School, Winsford.

Our thanks go to Pam Dowell, the retiring Chairman, and Ann Raffle, both retiring from the committee after many years hard work.

N. East

Reg. Rep. Judith Baigent, 16 Valley Bridge Parade, Scarborough, N. Yorks YO11 2PF.

We had a very interesting and informative study day on March 4th at York when Oure Surtees M.C.S.P. spoke to us about Conductive Education and the way the principles have been adapted and are practised at the Percy Hedley School in Newcastle.

We held the A.G.M. during the day at York. Ray Byne has retired from our regional committee after five years and we would like to thank her for all her hard work.

We have as yet no meetings planned for this year because the committee meeting had to be postponed because of adverse weather conditions, but we hope to get together soon to plan future lectures and study days.

W. Midland

Reg. Rep. Mrs. C. Dunn, The Haven, Hartley, Worc. WR6 6PQ.

The A.G.M. was held on Wednesday March 8th at Birmingham Children's Hospital, Ladywood in the William Cant Room. During the business of the evening, three new members were voted onto the Committee to replace those who resigned. The new members are Mrs. M. Moore, Mr. I. Felix and Mrs. R. Merrick. We welcomed them. Those who resigned were Mrs. M. Cledd, Mrs. L. Edwards and Mrs. J. Breeze. Our special thanks go to Mrs. Edwards who has been our Secretary for three years including the period when we

were organising the Conference. She has been a great strength to us all. Following the A.G.M., two of our members spoke of their experiences practising physiotherapy abroad. Mrs. Mason spoke of working in Morocco and Mrs. J. Steel of her experience in Hong Kong. These talks were much enjoyed.

I am glad to say that there seems to be some good ideas for on-going meetings in the coming months. I am optimistic that a good programme is in the offing.

S. West

Reg. Rep. Miss G. Riley, Meadows, Bowerchalke, Salisbury, Wilts SP5 5DB.

About 75 people attended the recent Study Day held at Musgrove Park Hospital, Taunton in March.

The subject - The Clumsy Child - caused much interest and speakers represented the views of educationalists, therapists and parents. Close links between therapists and school personnel were emphasised, therapy treatment should not take part in isolation.

The next Study Day entitled Juvenile Arthritic Conditions will take place in Salisbury on November 11th. Speakers will include two paediatricians plus Mrs. Bobby Jarvis and Mrs. Sheila Lawton from Wexham Park Hospital.

Various other local study days are taking place in the Autumn - these will be publicized in the regional newsletter.

S. East

Reg. Rep. Miss Terri Fearn, 38 Woodlands Close, Peacehaven, E. Sussex BN10 7SF.

By the time this edition comes out in May, we will have held our Spring Study Day on 22nd April, together with our A.G.M. We expect a few changes in Committee - our Chairman, Isobel Johnson is retiring together with Jenny McKinlay who has been both Secretary and Committee member. The Study day was on Clumsy Children and attended by over 70 delegates. The date for your diaries this autumn is Sat. October 7th when the subject will be "The Pre-term Baby". The venue will be Brighton, and more details will be in the August Newsletter.

Trent

Reg. Rep. Mrs. M. Meagher, 9 Oak Road, Thurlston, Derbyshire DE7 3EW.

On Wed. 1st March we had our A.G.M. followed by a buffet at the City Hospital, Nottingham. Fiona Haynes M.C.S.P. gave an extremely interesting talk on her experiences taking a group of children with Cystic Fibrosis to America. It gave rise to lively discussion afterwards as we compared methods used in America and Britain.

There will be an intermediate course on Sensory Intergration Therapy on Sat. 22nd April 1989. Details from Mrs. C. Oldfield, P.A.C. The Health Centre, Saltergate, Chesterfield. This will be a preliminary course for the more advance course to be held from

6-8th Sept. '89. Details again from Mrs. C. Oldfield.

Derby are holding their study day on Sat. 17th June on Visual Handicap in the multiply handicapped child. Details from M. Meagher, Westbrook School, Thoresby Road, Long Eaton, (Tel: 0602 729769 or 0332 574398 (home)). Cost: £15 A.P.C.P. Members: £20 - Non members. Send s.a.e. please.

E. Anglia

Reg. Rep. Mrs. Lyn Weekes, 76 The Cedars, Milton Road, Harpenden, Herts AL5 5LQ.

We finally held our A.G.M. in October during a Study Day held at High Wycombe, Bucks. Mrs. J. Kingswood, Educational Psychologist spoke to us in the morning and Dr. Barbara Kugter, Clinical Psychologist in the afternoon. The meeting was well attended but I have had the following comments from E. A. Members:-

"Can we have meetings on Saturdays. We are so short staffed, I cannot take a day off".

"Please don't hold meetings on Saturdays. I work full time and need weekends for family commitments".

Your committee will endeavour to please everyone by holding week day and Saturday meetings.

I have had a few requests to advertise posts vacant in the region. These were impractical as the newsletter only goes out quarterly. However, if one vacancy coincides with the newsletter (Feb, May, Aug, Nov.) I will gladly include your notice with newsletter mailings. Your committee now consists of:

Chairman - Lyn Weekes.

Secretary - Angela Glyn Davies, Harpenden, Herts.

Treasurer - Chris Burnett, Taplow, Berks.

Comm. Members - Sue Chillingworth, Rayleigh, Essex.

Berryl Dale, High Wycombe, Bucks.

May Goy, Maidenhead, Berks.

Pat Olessam, Kings Lynn, Norfolk.

Jackie Reynolds, Ormsby, St. Michael, Norfolk.

Liz Waugh, Felmersham, Beds.

N. Ireland

Reg. Rep. Mrs. Jenny Saunders, 149 Queensway, Co. Antrim BP27 4QS.

The subject of our March Meeting was "Surgery in C.P.". The speaker, Mr. Kerr Graham, gave a most interesting talk. We plan our spring study week-end for May 19th/20th on counselling and hope this will be well attended. A small group has recently met with Richard Needham, Minister for Health in N.I., to highlight the needs of paediatric physiotherapy province wide. We are about to undertake a survey to collect information on staffing ratios, facilities and post-reg-training. We meet the Minister again in 6 months and hope to put forward a strong enough case to warrant

more funding in this area.

An extra N.I., A.P.C.P. meeting has been arranged for 17th April 1989 in Fleming Fulton School, on Conductive Education. The speaker, Sheila Montgomery M.C.S.P. has recently returned from Hungary where she spent 6 weeks at the Centre in Budapest.

London

Reg. Rep. Vivienne Read, Flat 2, 62 Madeley Road, Ealing London W5 2LU.

Obviously London Region have been very busy so far this year planning the Annual Conference which was held at the University of Surrey, Guildford on 31st March and 1st April. As Chairman of the Conference Committee I would like to thank the following therapists who contributed by their hard work and support to the organisation of the event: Ann Biffin, Karen Burchett, Jaci Church, Di Coggins, Cate Cornwell, Rowenna Hughes, Geraldine Jackson, Kate Lough, Marion Main, Tina Owusu-Ansah, Kate Richardson and Ann Zawada.

However, we are now actively planning several other events for this year. In September there will be a study day on Neonates and some further workshops on Counselling will be arranged. Any suggestions for future topics for study days and evenings welcome.

SNIPPETS

Helping Clumsy Children

Neil Gordon, Ian McKinlay (1988) Churchill Livingstone

The revised and reprinted edition of this book is now available.

The Medical Protection Society would like to have further physiotherapy names on their register. If you are willing to be put forward for this important work, send your name and C.V. to the Secretary of the Association. This is a very responsible role to take up, and should not be embarked upon lightly. If you would like more information, contact our Secretary, or Penny Robinson at the C.S.P.

It is hoped that there will appear in future editions a history of the Association of Padiatric Chartered Physiotherapists. If anyone has memories or details of our beginnings, please send them to the Editor.

From: The Scoliosis Association (UK)
380 - 384 Harrow Road,
London W9 2HU.
Tel: 01 289 - 5652

"Scoliosis - an information booklet" ISBN 0 9513938 0 4

£3.95 plus 30p p&p 44 pages.

This booklet has been written for patients with scoliosis, their families, and others who have contact with children. It emphasises the importance of early diagnosis so that a child's curvature can be monitored and treated if it shows signs of deterioration. There are sections describing the disorder, its possible causes, treatments, school screening and clothing to wear under a brace. Useful addresses, a book list, and a glossary are also included.

For more information, contact Mrs. A. Harrison at the above address during the day.

The Music Advisory Service is available to all disabled people, whatever their age or disability, and to all those involved with them. In addition to answering questions on any aspect of music, both amateur and professional, the aims are to keep in close touch with all other organisations and individuals concerned in music with disabled people: to be aware of new developments: and to encourage people by visiting, giving talks, stimulating training, disseminating information and taking any other appropriate action.

For more information, contact The Music Advisory Service, Disabled Living Foundation, 380 - 384 Harrow Road, London W9 2HU.

This year has shown some exciting new advances in the treatment of brain tumours. There is minimum damage to the surrounding good cells by introducing wires with radioactive isotopes through tubes into the heart of the tumour.

Warm congratulations are due to the Cystic Fibrosis Research Trust as they celebrate their Silver Jubilee throughout the year.

BOBATH REFRESHER COURSE

17th - 21st July 1989 in Salford

This course is aimed at those who have previously attended the Bobath Course in Cerebral Palsy.

It will be conducted by Jenny Bryce, Principal of the Bobath Centre, and will include demonstration and discussions.

Fee - £150 includes coffee and tea, excludes accommodation.

Applications and further details from : Miss P. Janssen, Lecturer, School of Physiotherapy, Salford College of Technology, Fredrick Road, Salford, M6 6PU.
The Tutor is Mrs. Linda Kenny.

In November 1988 edition the article regarding Conductive Education did not mention the work which goes on in Hong Kong. We hope to hear more about that in a future edition.

SOME TIPS ON LIFTING YOUR CHILD

A very helpful diagrammatic leaflet (A3 size) has been produced by Eva Bower to teach parents and carers to lift children more correctly.

It has been designed so that it can be displayed as a poster if required.

If you are interested in having copies, please contact Dragon R. & D. Ltd., 6 Church Row, London NW3 6UT.

10 Copies £ 5.00 (including p & p) 25 copies £25.00 (including p & p)

Larger copies - please ask for details. Cheques payable to Dragon R. & D. Ltd.

Some tips on LIFTING YOUR CHILD

Eva Bower M.C.S.P.

Illustrations by Alison Chapman



- Wear trousers or a wide skirt.
- Wear flat shoes.
- Don't wear jewellery that could scratch your child.
- Place furniture so that you don't have to carry your child far or twist your body.

