
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

WATER-WORKS

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

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you haven't paid your subs!**

EDITORIAL

Vivienne S. Williams, Nat. Committee Member & Edit. Board.

At this moment in time, physiotherapists are feeling very uncertain about the future of the Health Service and how services will evolve. It is very easy to bury one's head in the sand and wait for things to happen. Whoever does this will get all they deserve.

It is more important than ever that we work to improve the quality of our service and how it can be adapted to the changes in the N.H.S. or better still, can we influence the changes in the N.H.S.? Unless we become very active and sure of what we are doing and how we are doing it, we will fail.

HOW CAN WE IMPROVE OUR SERVICE?

The committee work very hard on your behalf and spend many hours of their own time in consultation with the C.S.P. and other bodies, drawing up guidelines.

e.g. 1981 Education Act, Guidelines of Good Practise for Paediatric Physiotherapists (about to be published). There is the work of the sub-committees and Editorial Board without which this Newsletter would not be published. Each year we have an annual conference and many study days all over the country. Articles have to be written and books reviewed.

Did you know that A.P.C.P. are organising a special conference in Cardiff in 1991 as part of the World Conference? (see page 31).

Did you know that some members of A.P.C.P. from children's services in South Glamorgan have an active part in arranging an eight week Bobath course in Cardiff in 1990?

Did you know that a member of the National committee in addition to writing a text book on cerebral palsy has also organised a successful paediatric past-registration course for the second time?

Many more exciting things are happening, too numerous to mention here. If you want to know more get to know your regional representative, write to your committee, offer your services - remember - everyone has something unique to offer. The sad thing is people are seldom aware of it or too shy to offer.

Make your mind up now!
DO SOMETHING POSITIVE TODAY!

THE HALLIWICK SWIMMING METHOD

J. C. Ness and E. J. Bell, Scottish Council for Spastics

The Halliwick method of teaching swimming was designed for use with the Disabled. The originator of the method was James McMillan, MBE, who is a qualified engineer. While working at the Halliwick School in London, he observed the problems encountered by the disabled person attempting to learn to swim. Thus, in 1949, he applied his knowledge of Hydrodynamics and the scientific understanding of the behaviour of the human body in water to devising a carefully constructed approach to

teaching swimming, which would overcome problems previously encountered.

The Halliwick Method stresses ABILITY in water, as opposed to DISABILITY on land, and the aim is to teach safety and competence in water. No artificial flotation aids are used, but rather the more flexible, subtle support of an instructor, who will provide only minimum assistance in order that the swimmer is able to learn to appreciate the upthrust of water and also to find and maintain his own balance in the water.

The Hydrodynamical Principles involved in the Halliwick Method must be clearly understood by anyone using it, in order that maximum benefit can be obtained. The main principles to be considered are the efforts of relative density; pressure in water; metacentric forces; impedance factors; flow and turbulence, in all its aspect. Unless the Physiotherapist has a good grasp of the essentials on which Halliwick is based, the maximum potential benefits of Hydrotherapy will be lost. The Therapist must be able to anticipate probable reactions in the water and also be able to harness the behaviour of water to the swimmer's advantage. Water is only critical of shape and density and the potential swimmers must be taught how to either utilize or counteract the dynamic effects of water as it pertains to themselves.

The Halliwick Swimming Method possesses four phases, which are

1. Mental adjustment
2. Balance restoration
3. Movement inhibition
4. Movement facilitation

Within this framework are ten graduated stages, which make up

“The Ten Point Programme”

Once this programme has been worked through successfully, the swimmer should be completely safe and at home in the water; he might be termed “water-free”.

THE TEN POINT PROGRAMME

1 MENTAL ADJUSTMENT

Both mental and physical aspects are present here. A swimmer who is totally adjusted to being in water will have total mastery of breath control, in all its stages, balance and relaxation. Work in the pool is initially done in the vertical, only gradually graduating to working in the horizontal, supine position. Halliwick insists on swimming on the back, as any potential breathing problems are there by eliminated.

2 DISENGAGEMENT

This stage, too, is concerned with physical and mental aspects. Both MENTAL ADJUSTMENT and DISENGAGEMENT are long-term aims. Disengagement is the process by which the swimmer gradually frees himself from the need to have any support from his instructor. Initially, this would be voluntary dropping of eye contact and it culminates in the swimmer's total independence in the water. It must be remembered that a person in water loses all points of reference relating to body position and movement, so that he must re-learn patterns of movement that have been familiar on land. Consequently, these two stages can take a long time to be mastered.

- 3 **VERTICAL ROTATION**
This rotation occurs around the transverse axis of the body and is initially a case of head control, as the position of the head determines the position of the body in water. This is the reason why the head is never held by anyone using the Halliwick Method. Vertical rotation enables the swimmer to move easily between vertical and horizontal positions.
- 4 **LATERAL ROTATION**
The head will also initiate this rotation around the longitudinal axis of the spine and can be achieved in both vertical and horizontal planes. The swimmer will have to learn to control unwanted rotation, brought about by the asymmetrical shape of the body, before he progresses to inducing a roll himself. Both these rotations will finally be controlled through 30 degrees.
- 5 **COMBINED ROTATION**
A combination of the two previous rotations, combined rotation is not necessarily taught after the others. Mastery of this point means that the swimmer has complete control of his position in the water, so that he can always achieve a safe breathing position.
- 6 **UPTHRUST**
The swimmer attains an understanding of the buoyant force of water. He requires an advanced level of breath control at this stage, as he must be able to exhale, while submerged, against the pressure of water.
- 7 **BALANCE IS STILLNESS**
An ability to balance oneself, despite the inevitable turbulence present in a pool, is taught at this stage of the Programme. Initially, this is worked at the vertical, followed by the more difficult skill while in the horizontal.
- 8 **TURBULENT GLIDING**
At this level of the Programme, the swimmer is learning how to control his shape and maintain his balance while being towed through the water by his instructor, who utilizes turbulence to achieve this movement.
- 9 **SIMPLE PROGRESSION**
Once the swimmer is confident enough to allow himself to be towed through the water, it is possible to progress to asking him to move himself through the water by making small, sculling movements with his hands.
- 10 **BASIC MOVEMENT**
True swimming is established while working on the tenth, and final, point of the Halliwick Programme. Exactly how the swimmer propels himself through the water must obviously depend on his own particular abilities. The stroke is likely to be a backstroke, however, as this is what will have been worked on throughout the Programme.

The importance of good handling cannot be emphasised enough and the Physiotherapist must ensure that the highest standard is maintained. This includes lifting and handling on land and the holds in the water that are specific to the Halliwick Method. There are specific holds that enable the instructor to adopt different positions in relation to the swimmer, while giving the minimum support called for. It is preferred that entry to the water is from the poolside and there is a range of entries that can be taught in which the swimmer gradually takes a greater responsibility for his own entry. Swimmers are also taught to exit the pool over the side where possible.

The Halliwick Method of teaching swimming is best taught in a group situation. Various formations are regularly used and the teaching of the Programme is achieved through the use of games and group activities. There are innumerable advantages to be had in working in a group, although programme planning for a group must be carefully planned, incorporating both group and individual aims. Many of the games involve singing, encouraging participation by all concerned.

Although the Halliwick Method of teaching swimming was originally intended to be used to teach recreational swimming, it has been transferred, extremely successfully, to the therapeutic field, in which it can be used either in the group or individual situation. The Method can be used with any age group, from babies to adults. There are many ways in which the Physiotherapist may ally her work on land to work in the water. The most important must be the use of the head to control position and initiate movement and the emphasis on rotation.

Communication, social skills and educational concepts are all inevitably incorporated into the Halliwick Programme. Additionally, the resulting confidence and rise in self-esteem that arise as the Ten Point Programme is worked through cannot be under-estimated.

The relationship that will build up between swimmer and instructor is extremely valuable. The exception to this would be in cases where babies are taken into the water, in which case they should be with one of their parents. A minimum age of one year old is recommended; certainly the vaccinations must be complete. Great care must be taken when the children are so young, regarding duration of the pool session, familiarisation, routine and an awareness of the development stage of the child.

The Halliwick Method of teaching swimming can be used with any type of client group, which is one of its greatest advantages.

The Association of Swimming Therapy (A. S. T.) was founded by Mr McMillan in 1952 in order to promote Halliwick, and is the parent body to this day. There have been a number of publications dealing with the Halliwick Method, and it is gone into in greater detail in the forthcoming Eckersley publication "The Elements of Paediatric Physiotherapy", published by Churchill Livingstone.

PARENT AND CHILD WATER AWARENESS

Carol A. Hicks, A. S. A. Staff Tutor

Once you and your baby have settled into a regular routine you will be wanting to socialise and get out and about. What can you do together? One interesting, fairly new and exciting way to enhance your weekly routine is to introduce your baby to a Water Awareness Programme whilst at the same time exercising yourself and getting that former figure back.

What is Parent/Child Water Awareness? It is a gradual and harmonious introduction of Parent and child to the enjoyment of water activities. Together you can learn water confidence whilst maintaining respect for an environment which can prove a hazard. Everyone needs to learn to swim – we are an island here in Great Britain surrounded by water and within our island there are many streams, canals, lakes, ponds and pools so we need to learn how to survive in a water environment.

What benefits will going along to your local pool with your baby have? Firstly baby will be able to strengthen and mobilise his/her limbs – as with support of the water movement is easier and because of the pressure of the water on the limbs they will work a little harder than on land. Because of the exercise the cardio vascular system works more efficiently and is especially of benefit to babies born with respiratory problems e. g. asthma. It has also been found that due to exercising baby's sleep pattern improves and if trouble with feeding appetite improves. Generally health improves and baby is able to cope with minor illnesses more efficiently.

Mentally, because you are introducing baby to another learning environment, they are stimulated.

For, you, the parent you are physically able to exercise and especially the mother who wishes to rid herself of those extra pounds. Psychologically you are able to socialise with your baby, meet other parents with their children. Other members of your family need not be left out as swimming can be enjoyed by all ages and it is comparatively cheap.

How do you go about participating in this activity? It can either be done as a member of the public in your local pool or more ideally join a class. These are advertised in the foyer of your pool or leisure centre and maybe in your local newspaper. What should you be looking for?

Firstly you will need to know if the pool environment is suitable for taking a small baby to. Is there a special small teaching pool? This is the most ideal as the water here will be shallow 1 metre (3ft.) throughout or graduated 1/2 metre (1ft 6") – 1 metre (3ft.) – comfortable enough for you as a parent to stand or maybe kneel whilst feeling safe and secure holding baby. The water temperature is vitally important as baby's heating mechanism is not very efficient, they lose body heat quickly and do not have a shiver reflex for you to observe they are getting cold. The water temperature should be 30 C (86F) – 31 C (88 F) and the air temperature 2 degrees above water temperature.

Changing facilities need to be suitable for you and the baby. Is there somewhere to put your push chair? Are changing mats, playpens to place baby in once toddling, bins for soiled nappies, non-slip mats on the floors, low level toilets for the newly potty trained toddler, if not take the potty with you, supplied. Is it far from the changing room to pool-side? Hopefully it is only a short distance. Remember to take large bath towel to wrap baby in for the walk from and to the changing rooms to the pool.

Also find out when is the quietest time at the pool as babies and young toddlers are

often upset or distracted by a lot of noise and activity.

When is the best time to start taking your baby to the pool? The earlier the better, as they are used to the feel of fluid around their bodies having been in this environment in the womb. Babies naturally move arms and legs when put into water and, therefore, usually love being immersed. On health grounds it is advisable to wait until around 4/5 months old before baby should start being taken to the pool, as tiny ones have very little natural immunity to disease. Hopefully they will be having immunisations, especially polio – the only water born disease – and allow 3/4 weeks for the vaccine to be absorbed into the body. Psychologically it is ideal to introduce your baby to the big bath at home with parents before going to the pool.

Once you start going swimming try to go regularly – toddlers learn more from frequent short visits than a longer visit infrequently.

What do you need to take with you for baby? A well fitting costume or close fitted towelling pants. It is preferable to wear something in case they pass a stool. Urine is no problem as it is sterile. Do not put plastic pants or a nappy on as they become water logged and cause baby to sink. A large bath towel will be needed to keep baby warm from changing room to pool and also to dry baby with. Remember to dry all those little creases well and do make certain all water is out of the ears. Lay baby on your lap first turn on one side, then the other and let water drain out, then just dab with piece of cotton wool, do not use cotton bud as this will push water into the ear canal. Baby's favourite bath toy is also a good idea to take with you. Don't forget the usual powders and creams and maybe a bottle or drink if you are not feeding baby yourself.

You may also like to try one of the many buoyancy aids available on the market but nothing can substitute for mum or dad's manual support. Buoyancy aids allow a child to experience freedom of movement but do not put them on very tiny babies they need the warmth and support of the parent. Aids also tend to make a child swim vertically instead of horizontally and also children can become reliant on them. Arm Bands are the best buoyancy aid to use. Inexpensive and easy to fit. Make certain that you buy the type which have safety valves, so that if the stopper comes undone they do not deflate. Also double cylinder bands are preferable so that if one cylinder gets a puncture the other will still support the child. Rubber Rings are not a good idea as they can tip easily. Aqua Packs – inflatable packs which strap on a child's back – once immersed in water tend to ride up around the neck due to the pressure of the water. Poly-Otter Suits are ideal but expensive as they need to fit snugly and have to be changed as the child grows. Floats are very useful as a child gets a little older and can be used from about the age of one right through their swimming life.

On your first pool visit it might be a good idea to just have a look. Find out about the pool, let baby sense the smells and sounds, enabling him/her to get used to the atmosphere.

When should you not take baby swimming. If baby is even slightly unwell better to miss your pool visit. Colds, temperature, nose, chest ear or eye infection stay at home. Stomach upsets which cause either diarrhoea or sickness would mean no swimming. Athletes foot or verrucas with older children may mean wearing a rubber sock and definitely a visit to the chiropodist. Any contagious disease – chickenpox, measles, etc. of course means stay at home. Eczema, asthma or epilepsy check with your doctor before starting pool visits.

If you as a parent do not swim do not worry as the pool you have chosen will have shallow water but try not to pass your fear onto your baby. Maybe enroll yourself onto

the local Learn to Swim Programme for Adults.

If you decide to join a Parent and Child Water Awareness Class check the lessons out. Visit the class before you enroll, see how it is run. Make certain there are no activities taking place which encourages throwing in, holding under, pushing under or too many submerging activities. You may say 'Surely this does not happen' but I can assure you I have seen these very things taking place and causing much distress to parents and babies as well as making the babies physically sick and later on causing ear problems. These practices are NOT acceptable repeat NOT acceptable and will definitely not make your baby swim more quickly and will only frighten him/her. Ask if the teacher is qualified with either an A. S. A. or S. T. A. Swimming Teachers Qualification. The A. S. A. also have a qualification for Teachers of Parent/Child Water Awareness Classes. If you cannot find a class and wish to find out either where one is in your District or maybe you might like to start one up in your community just write to:

The Amateur Swimming Association
Harold Fern House
Derby Square
Loughborough
Leicestershire LE11 0AL

THE ROW MOORE WILDERNESS TREK – a tale of a canoe journey in the Boundary Waters told by Flok de Rijke

"Why travel all the way to America to make a canoeing trip if you can do the same practically from your own doorstep at less than a quarter of the cost?" was a question frequently put to us when we made our plans known.

'WE' were a party of thirteen people with varying abilities determined to make such a journey.

Our goal was to explore an area within a vast wilderness north of Lake Superior, stretching far into Canada. A canoeist's paradise of thousands of square miles of forest, interlaced by thousands of lakes, calm and turbulent rivers and accessible only by foot and canoe.

We called our expedition the 'Ron Moore Wilderness Trek' in memory of Ron Moore who was an inspired leading authority on canoeing for disabled people in Britain. Ron studied and worked in these Boundary Waters when he was awarded a Churchill Fellowship. He returned profoundly moved by the experience of bringing people together in groups of mixed abilities and great diversity of age and background.

His untimely death in 1986 prevented him from returning to the area with a group from the United Kingdom. It seemed right that a group of his close friends should take up the challenge.

We were interested to learn more about the philosophy and the techniques of minimal impact camping and looked forward to be introduced to the style of leadership of our American colleagues. Our American contact was a non profit making organisation with a longstanding reputation of introducing people with disabilities to outdoor life in tune with nature in wild remote places. Intergration within the group is more important to them than sole concentration on improvement of physical skills.

At regular training weekends in England, teamwork and communication between members was much encouraged. We had to use every minute of these meetings to put in ideas for publicity and fundraising, to share medical information about each other and to train in canoeing.

This is not the time to go into details of fundraising, but for those who wish to embark on similar adventures, let me just say that fundraising is the most demanding part of the entire expedition! It is also a most heart warming experience when one is on the receiving end of so much help and support from so many.

One member of the group with a paralytic scoliosis was advised to withdraw from the expedition about two months before our departure. She was due to have a spinal fusion and had to remain lying horizontally as much as possible. Our healthy budget enabled us to buy three aeroplane seats for her, so that she could travel in relative comfort. We were truly gratified to have a budget that allowed for such extras.

The expedition entered the BBC/RGS Competition, Mike Burke Award, and won one of the awards to make our own short video of the Trek, for transmission in the autumn of 1989 on BBC2.

The canoe journey took place in the White Otter Lake region of Ontario, Canada.

For three weeks we would travel as an independant group without contact with the outside world.

We carried all our food supplies and a comprehensive medical kit, including snake-bite kit. In case of emergency, we would have to paddle out of our area to raise the alarm. It would take an estimated two days for an emergency service to reach us. We were fortunate in only needing first aid on a few occasions.

The circular route took us across lakes, down rivers, along portages that had been used by indians, fur trappers and traders. Daily distances varied between five to ten kilometres, depending on how the many and often long portages slowed us down. Paddling was best in the morning and the coolness of the evenings. The temperatures above 100 necessitates long midday stops for sleeping and swimming, reading and writing, and of course eating and drinking. To glide through still gleaming water in the stillness of night guided by the moonbeams is a magic experience. Arriving at an unknown campsite in the dark can be somewhat daunting. The group really showed tremendous teamwork at those times, working efficiently and quickly unloading the boats and setting up camp.

The delegated duties were all to do with food. We were in four teams and rotated duties over a two day period:

1. Wood gathering and keeping the fire fed.
2. Cooking and serving.
3. Washing up. Packing food away, animal proof!
4. Time off.

All the other necessary camping work such as putting up tents, digging the latrine, care, personal and for each other, was undertaken voluntarily.

Our guides had an unobtrusive style. They ensured that they spent time with each member of the team. They were facilitators rather than leaders, enabling us to enhance our awareness, reflect and internalise our experiences and through their example develop our commitment to such care for each other and the environment.

They made us aware that we were guests in the habitat of the natural residents (flora and fauna) and respect was shown in everything they did.

Group discussions were held in daylight by preference, so that the members with profound hearing loss could participate fully.

We had three deliberate opportunities to express our perceptions as the Trek progressed:

At the beginning we openly shared our hopes for the outcome of this journey and we tried to be honest about our needs, physical, emotional and spiritual.

Halfway through the Trek we reviewed our thoughts and could enjoy our developing closeness.

At the final discussion we explored how to build on our experiences on return to Britain.

As time went on we progressed with tuning in to our 'New World'.

Living on simple, wholesome food, drinking crystal clear water straight from the deep waters in the lakes, listening to the sound of water rushing, leaves rustling and the haunting calls of the northern divers, made our senses both relax and newly aware. A deep sense of contentment had come over us.

Almost a year after the Trek we held a reunion, mainly to discuss to which causes we could donate our surplus funds.

It was very encouraging to see new assertiveness in members of the group and to hear of the commitments they had taken on to stimulate other persons with disabilities to break down personal barriers.

CARDIFF WATER BABIES

**Lyn Horrocks, Senior Physiotherapist, Children's Centre,
University Hospital of Wales, Cardiff**

Swimming club for parents and young children.

The club has been going for nine years - many of the children who had their first experience of fun in the water with us, are now excellent swimmers and active members of Halliwick and other clubs in the area.

The club, run on Mondays April - October at 5.00 - 6.00 p.m. at the hydrotherapy pool at University Hospital of Wales, offers an opportunity to teach handling in the water to families with young children with special needs. All conditions are included, the only proviso being that the children have had medical permission. The informal atmosphere encourages mothers and fathers to join in group activities and have fun with their children in the water. The club becomes a parent support group, gives support to new families and helps build up confidence.

We recently organised a parents training day - Have a Splashing Day! - in which eight families came together for a structured day. We talked together about basic Halliwick principles of water



happiness, water safety and swimming. Therapists and physiotherapy helpers organised a creche for the children, so that we could have a session with all parents in the water having great fun practising 'bicycles', 'kangaroos', 'eggs for breakfast', etc. After lunch altogether, we all went in the water for a lovely splashing time! We managed to include blowing bubbles and poached eggs, 'bicycle and submarine' races, snakes and trains, and 'the little one said roll over'.

The whole day was so successful that we shall be arranging another one in the spring. During the winter we are arranging an evening meeting for parents and therapists to get together socially. This will be organised by the parents and will include slides, videos and photos and an opportunity to discuss a programme of activities for next year. We are inviting Dinah Cadogan, MBE, who introduced Halliwick clubs to South Wales, to meet families whose children will be progressing to Halliwick and ordinary swimming clubs in the area.

* * * * *

Swimming and the Asthmatic Child

Pam Roquette, Community Physiotherapist, Salisbury Health District

Why swim

It has long been an accepted fact that swimming provides the best form of exercise for the asthmatic child. The reason for this is related to the warmth and humidity of the air in a swimming pool. Exercise induced asthma is thought to be caused by the necessity to warm and humidify large quantities of air due to hyperventilation. Experiments during which the subject breathed fully humidified air at body temperature could prevent an asthma attack during exercise. It was found that the water content was a more important variable than the temperature. The swimming pool provides the best environment to enable the child to perform exercise with the least stress and so build up their exercise tolerance.

Swimming itself is an excellent form of exercise for general development but in particular for chest muscles and breathing control. It is an activity which can be carefully monitored so that tolerance levels can be extended gradually.

Why a Special Group?

The asthmatic child is often rather shy and introspective, they lack self confidence when taking part in physical activity and have a reluctance to participate in exercise. Many asthmatic children find that they cannot keep up with their peer group at normal swimming lessons, considerable pressure is put on them and they often give up rather than fall behind.

The Club Session

Our club session always starts with a warm up, this gets the children used to the temperature and the water environment. We start by sitting on the side thinking about posture, shoulder and upper chest relaxation and diaphragmatic breathing. Each non-swimmer has a helper allocated to them who supervises their activities at all times. Children are accepted at the club as young as 3 years old and some will stay up to the age of 11 or 12, although many will have moved on to ordinary swimming clubs before that time. It is important that the temperature of the water is no lower than 8 degree F.

Emphasis is put on fun and enjoyment so encouraging water confidence. The first

fifteen minutes are spent on group activities before the children are split up into smaller groups according to their swimming ability. The warm up period is spent on games, each game having a teaching point, either breath control, maintaining a vertical position, using the head to move the body from the prone to supine position or horizontal rolling. Correct breathing is emphasised all the time and more strenuous games are interspersed with the quieter ones.

Once in their smaller groups time is spent on teaching correct strokes, this is very important, each stroke has its own breathing pattern and a competent stroke saves energy and improves stamina and endurance. A child is not encouraged to swim distances until he has mastered one stroke reasonably well after which he can gain badges for each increased distance.

We use star system, each small achievement being rewarded by a star e.g. face in the water, blowing bubbles etc. This gives the children an incentive and the helpers a guide to each child's progress. We also use the Swimming Teachers Association badges progressing up to the Bronze Personal Survival.

The session always finishes with ball games and for the more advanced swimmers a mini basketball or water polo game.

Swimming provides tremendous scope for fun and enjoyment once initial fear has been overcome and water confidence is achieved. It is also a sport at which asthmatics can excel and even compete at top class level.

AQUATOTS

Jenny McKinlay, Sutton Community Physiotherapist

Taken from a similar group found in the Bromley area, Aquatots in Sutton was originally formed as a community activity, but problems existed over pool access, and so it takes place at Queen Mary's Hospital pool, Carshalton. That pool is very large and consists of two parts – a 3 feet deep section some 10 feet x 20 feet and a larger part which, like a beach, gradually slopes to 1 and a half feet deep.



The Aims of Aquatots are as follows:

1. To provide a further support service for parents and children with special needs.
2. To bring parents and babies together in a fairly unstructured environment but with the benefit of professional assistance.
3. To encourage movement and activity in children who are floppy.
4. To promote relaxation in babies with spasticity.
5. To encourage general activity in warm water as a pre-swimming exercise.

Parents are encouraged to come into the pool with their children, but, should they not wish to do so, a therapist is available to take the child, advise about handling and demonstrate ways in which they should work with the child.

Aquatots has only been running for a year, and in that time, a great variety of conditions have been seen from the severely multiply handicapped, the cerebral palsied, developmentally delayed and many different 'syndromes'.

Babies must have had two triple immunisations before entry into the pool. Referrals come from the doctors, health visitors, physiotherapists, and any member of the multidisciplinary team, but medical permission is always sought before entry is permitted.

Our pool is allocated a two hour session once per week for Aquatots, and parents are encouraged to spread their time of arrival so that changing facilities are not overcrowded, and the pool itself is not overloaded.

In this way, the sessions are run on a one-to-one basis rather than group activities, but it is hoped that a more structured arrangement will evolve in future, particularly as slightly older children become involved. Currently those attending are under 2 and a half years of age.

Varying methods of management occur in the pool from working towards independant floating without any aids, to being independantly mobile by use of both arm bands and rings in out-of-depth water. The latter is particularly rewarding for the Downs children when they achieve self-propulsion.

For some of the cerebral palsied children, it is doubtful if the water helps relaxation because of anxiety and the noise disturbance in the pool, but patience and the passage of time often alleviate this problem, and much enjoyment can be noted.

As yet it is difficult to evaluate the effectiveness of Aquatots on all our patients, but there is a unanimous expression on the part of the mothers that it is an invaluable part of the weekly programme of care for their children.

* * * * *

FURTHER READING

HYDROTHERAPY IN PRACTICE

B. C. Davis and R. A. Harrison

1988 192 pages illus paperback £12.95 0 443 03026

Churchill Livingstone

'This book is a welcome addition to the all-too-sparse literature on hydrotherapy'
Physiotherapy

- * Will provide help and stimulation to physiotherapists involved in designing new hydrotherapy departments.
- * Through treatment of techniques and physical principles of pool exercises

HYDROTHERAPY IN PAEDIATRICS

M. Reid Campion

1985 248 pages paperback 0 433 06392 0 Heinemann Physiotherapy

A practical book, providing the physiotherapist with instruction and ideas for activity in water, both therapeutically and recreationally, when working with the disabled. The author has had extensive experience of hydrotherapy techniques, and has long been associated with the Hallwick method of swimming with the disabled.

The contents cover the basic physics of liquids, many activities and games, specific disabilities and their treatment using water, and water activities for the young child. The importance of assessment and recording of treatment are stressed.

SWIMMING FOR THE DISABLED

Association of Swimming Therapy.

ISBN 0 7136 2624 0 Adam and Clarks Black

Pleasure and exercise are both important aspects of swimming as far as disabled people are concerned, and neither of these is neglected in this useful book, but special emphasis is given to the joy that disabled experience when water sets them free from the constraints of dry land.

A. T. Skinner, A. M. Thompson (1983)

"Duffields exercise in water". 3rd Edition, Bailliers Tindall

TEACH YOUR CHILD TO SWIM

S. Merideth with Carol Hicks and J. Stephens

Illus Paperback and hardback ISBN 0 7460 0199 1 Usborne Parents' Guide Usborne Publishing.

Every concerned parent wants their child to swim - for safety, for fun and for fitness. 'Teach your Child to Swim' is a practical, easy-to-use guide which shows how to help a child learn. Written in close collaboration with leading baby and child swimming experts from one of Britain's top national sports centres, the emphasis throughout is on making early water experiences fun and anxiety-free and on allowing children to build up their confidence gradually and proceed at their own pace.

The book contains masses of ideas for enjoyable introductory activities for babies and children of all ages. Once the child is afloat, ways of teaching the major strokes and water skills, including diving, are described in detailed step-by-step pictures and clear, concise text. There are also sections on games to play in the water on swimming at the seaside and on water safety.

The Ron Moore Wilderness Trek

Limited copies of a more comprehensive report are available.

Please send s.a.e. to:

Ms. L. F. M. de Rijke-Winter
Acting Superintendent Physiotherapist
Trengeath School,
Hartley Road,
Plymouth,
Devon PL3 5LP



PHYSIOTHERAPY RESEARCH PROJECT INTO THE INTEGRATION OF CHILDREN WITH PHYSICAL DISABILITIES INTO "ORDINARY" SCHOOLS.

The aims of this project were:

- To improve communication between health and education professionals, eg teachers, school nurses, physiotherapists, doctors etc.
- To find out the needs of teachers and care assistants in relation to children with physical disabilities.
- To find out the views of the parents of the children with physical disabilities in "ordinary" schools.
- To find out the views of the parents of the classmates of the children with physical disabilities.
- To produce teaching material in the form of videos, pamphlets and inservice training for use in the future.
- To produce recommendations for the Health Authority and the Local Education Authority.

Method

Questionnaires were sent to 57 headteachers, 70 teachers with children with physical disabilities in their class, 150 other teachers at random, 12 care assistants, 61 parents of children with physical disabilities, and 60 parents of other children. The average reply rate for these groups was 65%. Answers were categorised and entered onto a database.

Results

The majority of teachers and headteachers "strongly agreed" or "agreed" with the concept of integration, although a significant number of teachers "strongly disagreed." An overwhelming majority of parents of the able bodied children thought that children with physical disabilities should be educated in "ordinary" schools, and 79% of these parents thought integration had a positive effect on their own child.

The teachers saw the effects of integration on themselves as being increased responsibility (30%), more time taken in preparing lessons (42%) and increased awareness (21%). Only one teacher commented that it would be worthwhile. Other concerns included insurance cover, the impending National Curriculum, and the possibility of being "dumped with other people's responsibilities."

Teachers and headteachers were willing to accept most disabilities into their classes, particularly if extra help was given where needed. They were however unwilling to accept incontinent children into the schools, even with the proviso of unlimited resources. Only 5% of headteachers would accept a child back to school with a leg in plaster of paris with the current levels of resources. The provision of unlimited resources increased acceptance levels of such a child almost twentyfold.

The majority of the teachers in this survey had not had inservice training on the subject of integrating physical disabilities (89%). Only 15% **did not** want any training, but 75% of those who had not had training **did** want some. A large number of teachers did not know how to cope with an asthma attack or a diabetic coma, or an epileptic fit.

The role of the care assistant was very unclear. Duties ranged from helping the children with physical disabilities to do tasks requiring manual dexterity, assisting the whole class so as not to segregate that child, assist with non-teaching duties, and to help around the class. They all agreed that the care assistant should not do the "brainwork" for the child.

Teachers and headteachers were asked whether they were aware of the professionals provided by the NHS for a child with physical disabilities in the school. 86% of teachers and 70% of headteachers were not aware of such professionals as physiotherapists, occupational therapists, speech therapists etc.

A common bone of contention for the teachers was the lack of information they were given. All the headteachers said that information about a child's special needs should not be held in confidence by themselves, but the teachers felt that relevant information was not filtering down to themselves.

There seemed to be no fixed rules for the giving of medication during school hours. The parents and school secretary were often the administrators of drugs, but the first aider was the most common choice.

In order to meet some of the teachers' requirements for inservice training, an open access system was set up for a 2 month trial period. Teachers and headteachers were given the opportunity to contact the physiotherapist and to ask for advice, discussions, lectures etc. It was thought that this would fulfil the recommendations of the Warnock Report and also the needs of those teachers who wanted inservice training at a convenient time for them, and on relevant topics. Unfortunately only 2 schools took up the offer.

The following recommendation have been made to Surrey County Council:

Inservice training is required for teachers on the subject of physical disabilities, health problems, and how to cope in an emergency.

Training is also needed for the care assistants who generally have no formal training, but who can play a vital role in integration.

Care assistants need clear job descriptions, and a investigation into their rates of pay.

There needs to be better communication between home, hospital and school.

The role of the school nurse needs to be expanded to include the task of liaising with all involved with integration.

Other children in the class should have lessons on disabilities if such a child is to join the class.

Teachers need to know where they stand legally if a child with physical disabilities has an accident in the class, and whether they are responsible for the actions of the care assistant.

School medical records, special needs register and reports file all need updating.

Schools should be preparing for future intakes of children with physical disabilities, rather than waiting for problems to arise.

Guidelines are required to assist the schools in the task of integration. These include guidelines for the administration of drugs, the handling of confidential information, insurance cover, and evacuation of wheelchair bound students in the event of a fire.

This is only a brief resume of the research project and its results, further information can be obtained from:

Sue Danks
Chartered Physiotherapist
Physiotherapy Department
Epsom District Hospital
Dorking Road
Epsom
Surrey
KT18 7EG

The Full Research Project can be obtained for £5

SUMMARY OF THE NATIONAL COMMITTEE MEETING HELD ON FRIDAY 7th JULY 1989 AT THE C.S.P.

At this meeting Caroline Dunn was elected as PRO, replacing Elma Bell. It was reported that the accounts from conference 1989 were not yet finalised and that Jill Brownson was to undertake the updating of conference guidelines for future committees.

The CSP has asked for one nomination from each clinical interest group to be put forward for random selection onto the professional practice committee. Mary Clegg, Sandra Holt and Viv Williams were all nominated and Sandra Holt was chosen to represent us, by random selection.

The CSP have invited the Chairman and Secretary to attend the first annual clinical interest group officers meeting in September at Bedford Row. Chris and Maggie look forward to attending.

The committee had a letter from the Conductive Education Association regarding an article in the Sunday Times on 11.6.89 which highlighted a new clause to the Children's Bill (tabled by Robert Kee Tory MP for Salisbury on 13.6.89). This would give local Education Authorities new powers to send children with cerebral palsy and spina bifida to the Peto Institute in Hungary. The Association urged APCP members to write to their MP's and to their local Education Authorities expressing concern that funding for services to handicapped children should be spent in this way.

Penny Butler, Senior Physiotherapist from the Orthopaedic Hospital in Oswestry, attended the Committee meeting for a short while to present her search project to the committee. This is to develop and evaluate equipment to augment the physiotherapy management of children with cerebral palsy. Penny asked the committee to consider endorsing the work of her project and also contributing to the funding. This was referred to the Post Registration Education Committee to consider the project in depth and then report back to the committee.

The committee agreed that Honoraria of £100 per year be paid to Chairman, Post Reg. Education spokesman, PRO, Secretary, Treasurer, Newsletter Editor and Membership Secretary. There was discussion on the difficulties which have arisen from the subscription differences where new members pay £7 per year for the first year and renewing members pay £12.50. It was agreed to make this an agenda item for the next meeting.

The criteria for Honorary Membership was now complete, together with the proposal form and up to date list of 13 Honorary Members. This was approved by the committee.

104 booklets had been sold at conference in Guildford, an increase from sales at previous conferences. The committee are at present looking into the possibility of updating the booklet "The Clumsy Child".

Concern was expressed that the Spastic Society leaflet on cerebral palsy was given out to parents in some areas by health visitors but without explanation. This had resulted in some parents being upset. The committee decided that Maggie should contact the Secretary of the Health Visitor's Association to discuss this matter.

Viv Read announced that her three years as London Regional Rep had finished and she was handing over to Karen Burchett. The committee expressed grateful thanks to Viv for all her hard work on the committee and especially her part in organising this year's annual conference.

The committee heard that the arrangements for the 1991 WCPT Conference were well under way. APCP members will be required to have supper at the Barbican on one evening to meet with other international paediatric physiotherapy colleagues, it has been decided that "Centres of Excellence" would be imported into the Barbican to display their work. There is a call for papers – if enough paediatric papers are received there will be a paediatric session. It was suggested that our APCP Annual Conference be held at St. David's Hall, Cardiff, on 2–4th August and would be a unique conference – open to other disciplines and possibly for one session to the public.

A vacancy on the Editorial Board is to be filled by Lyn Weekes, representative for East Anglia.

The 1989 Annual Report of A.P.C.P. can be found on
page 37 of the August Newsletter.

POST REGISTRATION EDUCATION REPORT

This has been a particularly busy year in Post Registration Education. Not only has the validated course run again, with Wolverhampton School of Physiotherapy as the venue, but there have also been several other areas of important developments where the A.P.C.P. have participated in discussions. The validated course and its ongoing development remain the top priority. This has run successfully for a second time in Wolverhampton with only small changes from its original form.

It is obvious from the very high standard of the projects done by the students that we have some very dedicated, hard working and talented people among us. The importance to the Association of having a validated course, need hardly be stressed, and the ongoing running of it, teaches those of us involved how the educational requirements must be looked at and updated. Those requirements and developments must be met as the course goes for re-validation, probably in early 1990.

Physiotherapy in paediatrics is a growing skill, much in demand, and Post Registration Courses must be one of the ways forward to acquire, increase and improve our clinical skills and knowledge.

I wish to thank all the people who have taken part, and helped to make the course a success. There are too many to name, but I must mention in particular Jean Richards, Senior Lecturer at Robert James and Agnes Hunt Physiotherapy School, Oswestry

without whom I would have had an impossible task. I also thank the Principal, Marion Tidswell at Oswestry for allowing Jean the time to help us.

Again thanks to Mr. Denham, Principal of Wolverhampton, and his staff for their patience with us tramping about and taking over the photo copier!

Thanks also to the workshop tutors who put in so much work – Noreen Hare, Stuart Bedford, Penny Butler and Maggi Cleake. Thanks must also go to the students for making the course.

We had 22 successes, out of which we have 7 distinctions.

Distinctions

Miss. Christina Amy
Mrs. Susan Baker
Miss. Christine Barber
Mrs. Elizabeth Carey
Miss Jacqueline Stephens
Mrs. Jill Tothill
Miss. Ellen Williams

Passes

Miss. Jenny Carroll
Mrs. Sarah Curtis
Miss. Linda Frost
Mrs. Gill Garner
Mrs. Patricia Kehl
Miss Sharron Losh
Miss. Mary Mathew
Mrs. Elizabeth Monkley
Miss. Mary Osborne
Miss. Faustina Owusu Ansah
Mrs. Ann Peters
Mrs. Julie Price
Mrs. Liz Shanklin
Miss. Alison Spinner
Miss. Shirley Wayman

Last but not least my thanks to my secretary, Sue Caddick who organises me so well and constantly reminds me of things I have not done.

The beginning of 1988 saw the introduction of the Post Registration Master Plan, presented by Angi Titchen, Education Department at the C.S.P. This was discussed at the S.I.G. Conference in June. The theme was standards, quality and assurance. John Huntingdon, then Director of Education posed the question – “what are the specialities” and “how should we group them?” These thoughts were further discussed at a Post Registration Training Meeting held in October at the North London School of Physiotherapy, together with ways in which Post Registration Education could be structured, in relation to C.S.P. Policy.

A busy two day workshop attended by Sandra Holt and myself was held in August at Loughborough by the Education Department of the C.S.P., on the role of the Facilitator in Post Registration Education.

The past year has also seen the first joint discussions of physio's and O.T.'s to

examine the ways in which the professions can work together to serve the needs of particular client groups. This Development Group discussion took place in Bristol last August. The A.P.C.P. was represented by Sandra Holt, Jill Brownson and myself, it was a very busy but extremely thought provoking two days. The outcome of this meeting was published by the C.S.P. in the journal.

I was invited to attend a meeting last September, of the N.H.S.T.A., to discuss the setting up of a multi-professional training course in Community Paediatrics. This is on going and we are due to meet again shortly.

Last month Caroline Dunn and I represented you at a Sub Committee meeting of the Professional Practice Committee to discuss Physical Disability Services and how they might be improved. This is a brief for a sub-committee of the Professional practice Committee.

This Committee as a standing Committee of Council, offers us as a group a liaison to Council.

The 1981 Education Act continues to offer topics for debate, the recent amendment causing some ripples of concern for physiotherapists in paediatrics.

The C.S.P. has just sent out a document suggesting why it might be a retrograde step for therapists to be employed just by Education. This came to the A.P.C.P. for comment before going out.

Finally I would like to thank all members of the Committee for their help, particularly Sandra Holt and to the C.S.P. for their continuing support and encouragement.

MARY CLEGG

BOOK REVIEWS

The Neurologically-Impaired Child: Doman-Delacatto Techniques Reappraised

by Robert A. Cummins

Croom Helm 1988 427pp

Any technique which is promoted for the treatment of childhood disability must be the subject of critical analysis and evaluation, not just once but again and again. This book, written by an Australian academic in a style which is accessible to the professional and the layman alike, sets out the theories and claims of Doman and Delacatto and then exposes them to scientific scrutiny. There is a wide-ranging review of the literature, including publications by proponents of the techniques and by those who seek to evaluate their claims. It is a methodical critique of what he terms "magical thinking" and of the application of selective "scientific" analysis to sustain an ideological position.

The techniques used in the Institutes for the Achievement of Human Potential are clearly shown to be based on flawed and largely discredited theories of neurological organisation and human development. Intervention techniques using a relatively unvaried set of programmes are described for the treatment of neurological disorders at different "levels". There are also programmes for the treatment of language problems, poor reading ability and for arousal from coma. Despite anecdotal tales, as the author shows there is no evidence that the programmes actually bring about

improved mobility, coordination, reading skills, intelligence or arousal from coma. This is despite the inordinate demands which may be placed on children and their families.

So why are some families drawn to such treatments? Cummins offers some convincing reasons. There may be a failure on the part of professionals to meet the needs of parents leading them to seek more comforting and optimistic advice. And this is what the Institutes provide, with what are described as misleading measurements of attainment and public misinformation on the efficacy of their techniques.

This book is essential reading for all those who seek to advise parents who are impelled to look for answers in fringe techniques. It should be recommended reading for the parents themselves.

Carlos de Sousa
Lecturer in Child Health

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Children's Health 1 – 5.

by Dr. D. P. Addy.

The B. M. A. Family Doctor Guides, 107 pages £2.99 Paperback.

This book is one of a series of Family Doctor Guides aimed at Parents, intending to give clear answers to questions and worries concerned with bringing up children.

There are 15 chapter headings; some are useful sections dealing with topics such as immunization, growth, childhood illnesses, milestones, dietary requirements, behaviour and bed-wetting. However the chapter on the Kidneys and Bladder steps away from simple urinary infections and describes techniques such as a Micturating Cystourethrogram and Kidney Failure; topics which are outside the usual experience of raising children. Similarly the description of febrile convulsions is followed by fairly detailed descriptions of epilepsy and drug therapy. I would hope that parents of children with conditions such as epilepsy, renal failure and mal-absorption would have access to more pertinent information from their Paediatrician. The chapter on clumsiness, overactivity and allergy glibly smooths over problems seeming to dismiss overactivity as fashionable and clumsiness a simply a variation on the norm, indeed there may be an element of truth in this but the comments emerge as being antagonistic.

To summarize, this book at £2.99 could have been a very useful handbook for Parents had the author confined it to basics. The format is good, there are some useful diagrams but disappointing photographs. By extending the content, the book seems to have been taken out of the range of the average family into the realm of the avid-reading middle class child rearsers for whom there are plenty of books particularly if they need information on specific conditions.

This book would not be classed as a reference book but might usefully be on sale at Health Centres.

JILL BROWNSON
GradDipPhys MCSP

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ABSTRACTS

- Title:** The Effect on Gait of Lengthening of the Medical Hamstrings in Cerebral Palsy.
Author: J. Thometz, M. D. S. Simon, M. D. and R. Rosenthal, M. D., Boston Massachusetts.
Source: Journal of Bone and Joint Surgery, Vol 71-A No. 3. March 1989.

The importance of gait analysis in the evaluation of the results of surgical intervention in Cerebral palsied children has become clear in recent years but so far is rarely used.

In this study gait analysis was used to gain a more objective assessment of the effect of lengthening the medial hamstrings on the gait of 31 subjects with spastic cerebral palsy. Pre and post operative measurements of velocity, stride length and temporal components of gait – rotation of the pelvis, hips, knees and ankles during gait, and electromyographic activity of both the quadriceps and hamstrings were compared for each patient.

In 28 of the subjects surgery was performed to correct a so-called 'crouch' gait – to correct excessive flexion of the knee during stance and contracture of the hamstrings when examined. In the remaining 3 subjects the aim to correct an internal rotation gait. The 14 subjects had concomitant surgery mainly T. A. lengthenings or releasing structures around the hip joints. 10 patients used walking aids.

The average length of follow up was 24 months. Generally post-operatively, velocity, stride length and cadence did not improve when analysed. However there was marked improvement in the extension of the knee in the stance phase tended to be accompanied by a decrease of flexion resulting in a stiff legged gait. The subjects that had concomitant lengthening of the T. A.s demonstrated greater improvement in all parameters of the gait sequence.

It felt, at the end of this study that gait analysis had been a useful form of evaluation and could be used as a useful selection tool for similar surgery in subjects with cerebral palsy.

- Title:** Early Diagnosis and Secondary Prevention of Duchenne muscular dystrophy.
Author: R. A. Smith, J. R. Sibert, S. J. Wallace, and P. S. Harper.
Institute of Medical Genetics and Dept. of Child Health
University of Wales College of Medicine, Cardiff.
Source: Archives of Disease in Childhood 1989 Vol. 64, pp, 787 –790

Recent advances in the understanding of molecular genetics have highlighted the importance of early diagnosis in that reliable antenatal tests can now be given for pregnancies at high risk – early genetic counselling being able to prevent secondary cases within kindred. The lack of obvious clinical signs in affected young boys leads to a late diagnosis with resultant frustration to parents and delay in effective management.

33 boys aged between 8 months and 6 years were entered into the study, all had a

high creatine kinase activity. Twelve were diagnosed in the asymptomatic phase because of a family history, twelve presented with development delay and nine presented with locomotor problems. A control group of 21 normal boys matched for age were recruited from the Cardiff birth register.

Formal developmental assessments were carried out on both groups of boys using the Griffiths and Reynell scales.

Scores achieved by the boys with Duchenne Muscular Dystrophy were found to be significantly lower than in the control group – the most noticeable discrepancy being in the locomotor and hearing. Although delays in locomotor and language development have been reported in earlier studies, the existence of global developmental delay and the extent of language delay have not been previously recognised.

It is suggested that as a result of this study, the typical pattern of developmental delay could lead to an earlier diagnosis and thus improve the chances of prevention. All boys with unexplained developmental delay especially in locomotor and language abilities could be systematically tested for DMD, the present unsatisfactory delay in diagnosis could be rectified.

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Title: Cerebral Palsy in Two National Cohort Studies.
Author: A. Emond, J. Golding, & C. Peckham.
Dept. of Child Health, University of Bristol and
Institute of Child Health, London.
Source: Archives of Disease in Childhood 1989 – vol 64 pp 848 – 852

It has often been assumed that asphyxia and cerebral trauma at birth would be associated with a high risk of impairment amongst survivors – this hypothesis is now being challenged.

In this study, the prevalence, and risk factors for Cerebral palsy in 2 national studies were examined, both studies being similar in design and structure but taking place twelve years apart. During the intervening twelve years, there were reductions both in the number of still births and neonatal mortalities as obstetric practices changed and became more interventional.

In 1958 the British Perinatal Mortality Survey aimed to study all births in mainland Britain during the week 3 – 9 March – it was estimated 98.5% of all births that week were included in the study. The 1970 British Births Study included all births during week of April 5 – 11, it was thought only 2% of births were omitted. Both studies used similar methods, in that detailed questionnaires were completed by midwives using clinical notes and detailed information from the mothers soon after delivery.

The children were then followed up at ages of 7, 11, and 16 years, details being obtained about medical histories, each child having a clinical examination and the children's teachers asked to assess the children's ability. Notes were taken on each child detailing any impairment, disability or handicap.

Of the children born in 1958 40 of the surviving 1675 developed Cerebral palsy (2.4/1000) and in 1970 41/16, 136 (2.5 / 10000)

9% of the cases from the 1958 study had died by the age of 10 years, in the 1970 study all cases had survived. Only 17 CP children weighing under 1500 grams had survived in 1958 – only one weighing under this weight in 1970 developed Cerebral palsy.

After some discussion, the article concludes that most cases of CP are not associated with perinatal factors. Although there have been pronounced changes in obstetric practice the prevalence of Cerebral palsied children remained the same. Evidence is now suggesting there is an increase of Cerebral palsy amongst survivors with low birth weights since the widespread introduction of neonatal intensive care.

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THE EDITORIAL BOARD

The editorial board's objective is "to provide four times a year a newsletter which will cover all aspects of children's needs with special reference to paediatric physiotherapy."

The board's aim is to keep all A. P. C. P. members up to date with recent trends and advances in treatments, equipment and happenings. It is hoped that new members especially those entering the field of paediatrics are given a greater insight into the world of their chosen speciality.

The board consists of 9 members all of whom are also on the National Committee of A. P. C. P. These are:

| | |
|--------------------------|--------------|
| Jenny Mckinlay, - Editor | Gill Riley |
| Michele Lee | Viv Williams |
| Maggie Diffey | Mary Clegg |
| Caroline Dunn | |
| Noreen Hare | |

The Editorial Board meets twice a year to discuss the theme and articles for each edition. Each member is given specific responsibilities for approaching authors or writing articles themselves. The themes for the newsletters are discussed 18 months in advance to ensure there is enough material and time to write the articles for each edition.

The editorial board feels it is of utmost importance that it meets the needs of its readers. If any reader has any suggestions for future themes or articles please let us know!

* * * * *

STUDY DAYS/COURSES

West Midlands

Downs Syndrome Day

held at William Cant Room, Post Grtad. Centre, B. C. H.
4th November, Saturday. Time 9.00 - 4.00

Cost - £13.50 APCP Members; £15.00 Non Members
(incls. lunch)

Speakers - Doctor, Teacher, Portage Worker, Social Worker
(re adoption)

Application and cheques to : Hazel Wotherspoon, MCSP
34 Westminster Rd., Selly Oak, Birmingham

Respiratory Day

at Post Grad Centre, Dudley Road Hospital
Sat. 20th January, 9.00 – 4.00

Leg Lengthening: Pre and Post Operative Management

Wed. 15th November, Sheffield Children's Hospital

Topics covered: Physiotherapy

Pre operative assessment

Nursing care

Post operative management

Operative Techniques

Social and Psychological Support

The Sheffield Results

£25 to include tea, coffee and lunch.

Following this one day course there will be a 3 day conference for orthopaedic surgeons on all aspects of bone lengthening.

If any delegate would like to attend the lectures they are welcome to do so. However, only surgeons will be participating in the practical workshops. Exact details and times of these lectures will be known at a later date. Lunch on these days will not be provided.

For further information and application forms please write enclosing a SAE to : Mrs. Maria Burton, MCSP, Physiotherapy Dept, The Children's Hospital, Western Bank, Sheffield S10 2TH.

Trent Region

New Ways of Helping The Clumsy Child – Seminar: Paper and discussion

Mon 27th November at Ash Field School, Leicester
(with kind permission of Mrs. Hinchliffe)

Tutors: Leicester Paediatric O. T. Team

Tea served at 3.45 p.m. Meeting to begin at 4.15

Sensory Intergration and Test Procedure Tutor: Jenny French BA MCSP

Dates – 5th & 6th Jan. 1990 9.00 – 4.00

Fee: £25 APCP Members: £27.50 Non Members

Venue – Doncaster Royal Infirmary

Details and application forms from Mrs. Sue

Tallents, Supt. Physio, Childrens Hospital,

Doncaster Royal Infirmary, Armthorpe Rd.,

Doncaster Tel: 36666

HAVE YOU HEARD?

* A recently compiled resource list – “Children: Seating and Play Equipment” (price £1.00) is available from the Disabled Living Foundation Library, 380 – 384 Harrow Rd., London W9 2HU Tel: 01. 289. 6111

*** A comparative evaluation of the Hip Guidance Orthosis (HGO) and the Reciprocating Gait orthosis (RGO)**

32 pages, £10 (Free to the NHS) ISBN 0261 - 0736

This is an excellent book, it is of use to anyone who is working with the Hip Guidance Orthosis and Reciprocating Gait Orthosis Copies are obtainable from:

In England: DSS, NHS Procurement Directorate, Room 423, 14 Russell Square, London WC18 5EP Tel: 01 636 6811 Extn. 3179

In Wales: The Welsh Office, Health Management Systems, Personnel Division, Cathays Park, Cardiff CF1 3NQ Tel: 0222 823641

In Scotland: Miss K. Glancy, SHHD, Room 54H, St. Andrew's House, Edinburgh EH1 3DE Tel: 931 55 8400

In Northern Ireland: DSS, General Services Branch, Works Unit, Stoney Road, Dundonald, Belfast BT1 0US Tel: 023 18 4535 Extn. 2411
Vivienne S. Williams MCSP

EUROPEAN ACADEMY OF CHILDHOOD DISABILITY

At a time when the business world is looking to its influence in Europe ready for 1992, it is particularly pleasing to see the inauguration of the European Academy of Childhood Disabilities.

The Academy's first meeting took place in Oxford at St. Catherine's College from 21st to 23rd September. For two and a half full days of intense programme, we were presented with a high standard of papers from many disciplines within the paediatric field, and greatly enjoyed meeting with doctors and therapists from other countries.

This was a 'trial run', seeking to test opinion regarding the continuation of the Academy, modelled on the American Academy of Cerebral Palsy and Developmental Medicine. Those directly associated with this new organisation, and responsible for its planning, were the Committee of the Medical Education and Information Unit (MEIU) of The Spastics Society, based at the Newcomen Centre in Guy's Hospital. Our thanks go to that group for providing such a well run meeting in a very pleasant setting.

The primary purpose of the Academy is to run an annual meeting of a high scientific standard which contains the presentation of original work, teaching sessions which may be basic or advanced and guest lectures. It is hoped that it will be used for the exchange of ideas between disciplines and various professional groups concerned with disability.

If you wish more details about the E. A. C. D., and would like to become a member, please contact the Administrative Secretary, Ms Olivia Plunkett at the Medical Education and Information Unit of the Spastic Society, Newcomen Centre, Guy's Hospital, St. Thomas Street, London SE1 9RT.

Is this not an ideal opportunity for us to forge links with our European Physiotherapists?
Jenny McKinlay, Editor

Пожалуйста

No, this is not new physiotherapy terminology, but a welcoming Russian word.

As you will have seen in our Journal, and in this Newsletter, there is being organised a visit to Russia next March, (17th – 25th) to see aspects of Paediatric Physiotherapy in Leningrad and Moscow.

It is an ideal opportunity to visit another country and glean information about different treatment methods, and learn about the standard of medical training given. There will also be time for some sightseeing tours and to meet informally with Soviets to exchange experiences and views.

The cost of the trip is £499 inclusive.

There are still places available, and applications should be made directly to the organising group:— Interchange, Interchange House, 27 Stafford Road, Croydon, Surrey CRO 4NG. For those who have expressed interest but not yet confirmed their booking, please would they do so now so that final arrangements can go ahead. (Please quote reference CSP/P when applying.)

This is an excellent opportunity – not to be missed.

LETTERS TO THE EDITOR

Dear Madam,

I write about a matter which concerns us and would be pleased to know if other areas experience the same problem.

It is to do with the provision of trikes.

At one of our meetings of paediatric physios in the area, we compiled a letter, which we all signed, to the Medical Director at Exeter DSA. I enclose that letter together with the response we received from the Medical Director, and wonder if other areas may have felt the same and written accordingly to their Medical Directors.

Dawn Clabond

Child Development Centre, Scott Hospital, Plymouth

Letter to Disablement Services Authority

“All the paediatric physiotherapists in Plymouth meet on a regular basis and at our most recent meeting the subject of tricycle provision was discussed. We understand that tricycles will only be available to those children who have no other means of independent mobility. We feel that this is a decision that will detrimentally affect the life qualities of many children.

Examples of this are:—

1. Those who can walk very short distances but need a tricycle to participate in playground activities.
2. Participating in extra curricular activities such as the Ten Tors, Duke of Edinburgh, etc.

3. Participating in normal family life, i. e. going to the shops etc.

We also feel that the psychological aspects of enjoying a normal activity within the community as well as the personal satisfaction of self propulsion cannot be ignored.

As a group we strongly recommend that this change of policy be reconsidered."

The response from the Medical Officer:

"... a policy decision was made by the D. S. A. in London. The rational being that most parents are faced with the option of buying bicycles or tricycles for their offspring at some time in their lives. It can justifiably be argued that disabled children often require specialist hardware, or at least modifications to standard vehicles.

...budgets have now been devolved to regional DSCs, and there is less money available this year than last, despite a 15% increase in overall demand. Priorities therefore must be determined within that budget...

...mobility needs of severely handicapped children and young adults must be given that priority. Come 1991, priorities will probably be argued on a district basis, and it will be possible for all of us to argue for the needs of our clients.

....I have sent copy of your letter to the Chief Executive of the Disablement Services Authority"

* * * * *

Dear Colleagues,

Ehlers Danlos Syndrome

A six year old boy has the above syndrome which mostly affects his feet and hands. He has hypermobile feet and his heels pronate. He walks with his feet everted taking his weight through his medial longitudinal arches. Part of the lateral edge of each foot is off the ground. His feet are long and narrow. He has a heavy and ungainly gait, but his feet are pain-free. He wears Pedro boots with valgus insoles which do not fully correct his foot position.

Surgery had been suggested when is is eight years old – in the form of a bone block on the inside of each ankle.

Has anyone met this condition? If so, how was it treated

(a) conservatively (b) surgically (c) Do extended posted heel cups have a place?

If anyone has treated a young child's feet (who has this syndrome), I would very much like to hear from them

Hilary J. Smith, Supt. Paediatric Physiotherapist, Musgrove Park Branch, Taunton and Somerset Hospital, Taunton, Somerset TA1 5DA

* * * * *

Dear Madam,

We are concerned about the level of physiotherapy input to Duchenne's Muscular Dystrophy boys, which we should attempt to achieve in the interest of the patient. We are wondering how physiotherapists in other districts resolve this problem and would be pleased if they could let us know how much/what type of treatment programme they use.

We have a questionnaire regarding physiotherapy involvement, and would be happy

to forward it to any enquirers.

Mrs. S. Jackson, Supt. Physiotherapist, Child Health Centre, Red Hill Street,
Wolverhampton WV1 1NR

WORLD CONFERENCE 1991

August 2nd - 4th 1991

(Weekend after World Congress in London)

St. David's Hall, Cardiff

Three professional courses:

- A) Muscle Disorders organised by APCP
- B) Neuroplasticity organised by Welsh Board
and C. T. I.
- C) Respiratory Care organised by ACPRC

PLUS: Trade Exhibition for two days.

High profile for charities

Opportunity to present papers/posters/display photos

Children's Concert

Conference Dinner at City Hall

BRING YOUR FAMILY

Choice of accommodation: Self catering/Hotel

Family programme planned

Local activities, places of interest

Concert for children's orchestra/choirs

DON'T MISS IT! WATCH THIS SPACE!

REGIONAL PROFILES

SOUTH EAST

Broadly speaking, the South East Region encompasses the counties of Surrey, West Sussex, East Sussex and Kent. The South London suburbs are also included, but members in these areas have a choice of belonging to the London or the South East Region.

The northern section, e. g. S. London, Gravesend and the Medway towns, are cosmopolitan and densely populated, as are certain parts of the south coast. Otherwise, the southern half of the region tends to be more rural with services stretched to the limit.

Paediatric community services are based in hospitals, special schools, health centres and child development units. The degree of cover varies from district to district, the widespread country districts and numerous villages putting a considerable strain on resources.

Integration into mainstream schools is variable, though well established in some areas. Parent support groups are beginning to make their presence felt in the push for adequate paediatric services in schools.

Within the region there are several centres with particular specialities:

1. Chailey Heritage near Brighton, which is a resource centre for seating, orthotics and the management of conditions such as muscular dystrophy and arthrogryposis.
2. Queen Mary's Hospital Carshalton, which has a regional Spina Bifida Unit with a Hip Guidance Orthosis Centre. It is also well known for its speciality in surgery for scoliosis.
3. Ingfield Manor which uses the Conductive Education approach to the treatment of cerebral palsy.
4. Dorton House School in Seal for Blind and partially sighted children.
5. John Horniman School for speech impaired children.

In addition, children are frequently referred to Guys Hospital (our regional centre) as well as other London hospitals. In this situation, care is needed to ensure communication is efficient, both to provide follow through for advice given and to avoid duplication of services.

A. P. C. P. membership at present stands at 93. There are approximately three study days per year and these are usually over-subscribed. The committee members represent most districts in our region, and meet regularly to plan study days, and to discuss matters of common concern.

We hope the South East Region provides the opportunities for mutual support, for the updating of theory and techniques, and for making the valuable inter-district contacts so necessary in our field.

WEST MIDLANDS

The West Midlands Region is the largest in England. It has 22 health districts within boundaries which encompass North to South, North Staffordshire and Hereford, and East to West Shropshire and Rugby. There are four schools of Physiotherapy namely Oswestry School. The Queen Elizabeth School Birmingham, The Woodlands School

Birmingham and The Wolverhampton School, from where The Chartered Society validated post graduate paediatric course is run with great success by Mrs Mary Clegg. Coventry Polytechnic offers a CAPAM course (Credit Accumulation for Professions Allied to Medicine).

The 200 bed Birmingham Children's Hospital situated in the heart of the five Birmingham Health Districts (North, South, East, West and Central) provides a Regional service of specialities including Cardio-thoracic surgery, Haemophilia and Oncology, Neurology and Neuro surgery, Neo-natal and infant general surgery, Inherited Metabolic disorders, Nephrology, and very soon the new Bone Marrow Transplant Unit will open its doors. There are also Supra-regional services of Neo-natal and Infant Cardiac Surgery, Cranio-Facial service and Liver Disease. The controversial Birmingham Peto Institute is located within South Birmingham Health Authority and some children within the West Midlands have availed themselves of this facility.

Because of the geographical area covered by the West Midlands Regional Authority many of the 85 members of the A. P. C. P. travel considerable distances to attend the programme of lectures and study days organised by a small, but hard working, committee headed by Mrs Caroline Dunn the Chairperson, who has recently been elected as Public Relations Officer on the national Committee.

The forthcoming programme for 1989/90 includes a six session course on counselling to be held at Selly Oak College Birmingham, a day on Down's Syndrome at Birmingham Children's Hospital, a Respiratory day at Dudley Road Hospital and hopefully a day on Gait Analysis - venue not presently known - further details will be announced and circulated in the News-Letter. A very warm welcome is extended to all Paediatric Physiotherapists to join the West Midlands branch of A. P. C. P. to facilitate exchange of ideas and prevent any feeling of isolation which could exist in such a large but active region.

REGIONAL REPORTS

Wales

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

We had a successful meeting in August at O. R. L. A. U. Gait Laboratory in Robert Jones and Agnes Hunt Orthopaedic Hospital at Oswestry. Penny Butler, research physiotherapist, and Richard Major, Bio-engineer, took us through biomechanics of gait, including floor reactions. Demonstrations of the gait laboratory and excellent slides/videos, illustrated the principles of floor reaction splints and the fine tuning of A. F. O. s for children with mild cerebral palsy.

This day certainly gave us all food for thought and we shall go to our orthotic clinics for children who are walking independently and coping in mainstream school, armed with shoe soling rubber and carpet tape to experiment with tuning of A. F. O. 's.

- N. Ireland** **Reg. Rep. Mrs. Jenny Saunders, 149 Queensway, Co. Antrim, BP27 4QS**
 The regional group continue to meet bi-monthly with a wide and varied programme, copies of this are available from:–
 Sheila Montgomery, Fleming Fulton School, Upper Malone Road, Belfast.
 An interesting study day was held in October on Head Injuries with speakers covering various aspects of care and rehabilitation.
 Could I take this opportunity to remind you to renew your ACPM Membership for 1990.
- S. East** **Reg. Rep. Miss Terri Fearn, 38 Woodlands Close, Peacehaven, E. Sussex BN10 7SF.**
 We will be holding a workshop on March 3rd 1990. The venue is Chailey Heritage, E. Sussex, on 'Measurement of Windswept Deformity of Hips'. Numbers will be limited. More information in the January Physiotherapy Journal.
- N. East** **Reg. Rep. Judith Baigent, 16 Valley Bridge Parade, Scarborough, N. Yorks YO11 2PF**
 Unfortunately the Jabadao day had to be cancelled because of a very poor response. Following this we would be glad to receive any suggestions from members about subjects you would like to cover either on a day course or for an evening lecture, or any speakers you would like to recommend from your part of the region.
 We have an evening meeting at York on November 27th when Dorothy Penso, O. T. at the C. D. C., York will discuss 'Skills for handwriting'. Any Bobath trained physiotherapists who have not joined the B. A. B. T. T. but would be interested in getting together for an evening please contact me, and again let me know what you would like to discuss.
- S. West** **Reg. Rep. Miss G. Riley, Meadows, Bowerchalke, Salisbury, Wilts., SP5 5DB**
 Preparations are now finalised for the study day on Juvenile Arthritis being held on November 11th in Salisbury.
 The Spring Study Day is to be held in Bristol on Conductive Education – during this day the regional A. G. M. will be held.
 Exciting new developments are taking place around the region, including the formation of 2 Child Health Centre, in which all professionals involved with children are based, leading to a more co-ordinated service. There are also interesting projects being carried out, which hopefully will be published in due course.
- Trent** **Reg. Rep. M. Meagher, 9 Oak Road, Thurlston, Derbyshire, DE7 3EW**
 Trent are beavering away organising the conference for 1990 with help and enthusiasm from members in all areas. Jenny French has sent a report of her memorable trip to the U. S. A, where her task was to take

a certificated course in Sensory Integration Therapy and to complete a comparative study in paediatric management. As Jenny said, "It was an exhausting but memorable trip." She completed the Sensory Integration and praxis test battery, had a four hour practical test and sat a four hour written final paper. Jenny visited New York, Georgia, Texas Colorado and Washington D. C. and met innumerable therapists and hospital managers. Her thanks are given to those who helped sponsor her trip – i. e. North Derbyshire Health Authority, and American sponsor and Trent Branch of A. P. C. P.

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

Our study day on 'The Hand' was held at Mount Vernon Hospital on 22nd September. A very full day included visits to the children's ward, lectures and a demonstration on splinting.

**1990
ANNUAL CONFERENCE
AT LOUGHBOROUGH UNIVERSITY
'QUALITY OF LIFE'**

organised by the Trent Region of A. P. C. P.
APRIL 5th to 7th 1990

The programme will cover
*The Quality of life of:
The Acutely Ill Child
The Chronically Sick and
Disabled Child.
The Paediatric Physiotherapist*

Programme will include:
*Conventional Lecture Sessions
Short Lecture presentations
Workshops
Splints and Things
Poster Session
Equipment Exhibition*



Closing date for application February 2nd
Preference will be given to A. P. C. P. members until January 16th
Send large s. a. e. to Miss S. Foster, 33 Stonehaven Close, Coaleville, Leicester LE6 3RY

VACANCIES

Handicapped Children's House, P. O. Box 8557, Ruyjadh 11492, Kingdom of Saudi Arabia

This is a magnificent purpose built centre, opened 3 years ago and the only one of its kind in Saudi Arabia. Children are brought here from throughout the Kingdom.

It is lavishly equipped and has a large physiotherapy department, pool and orthotic workshop.

The criteria for the children attending the centre are physical handicap, Saudi nationality, age 0 – 12 years, and I. Q. of 50+. In fact most of the cases are C. P. s.

The centre includes houses for up to 10 children each for weekly residence, with mothers if desired.

Children are initially assessed by a neuro paediatrician with the physiotherapist and O. T., and there are frequent orthopaedic paediatric clinics.

The staff should consist of 9 physios and 5 O. T. s, but at present we are short staffed. If any experienced paediatric physiotherapists are interested I would be pleased to hear from them. Tax free salaries are negotiable and luxurious accommodation and use of pool is free.

The environment is stimulating and it is a great experience working in a very different culture with staff of many nationalities.

Isabelle Johnson MCSP

Plymouth Health Authority

PAEDIATRIC SENIOR II PHYSIOTHERAPIST ROTATIONAL POST

This exceptionally attractive post is based on a two year rotation, one year being based within the Physiotherapy Dept. of a special school educational establishment, and the other being based at the Plymouth Child Development Centre, covering domicillary work, other special schools in the area and work within the CDC itself.

It offers a broad range of most paediatric conditions in children ranging from a few months old to eighteen years.

As a Senior II position, the person in post will work under the guidance of the Senior I physiotherapists, but will be given full support in developing new ideas and treatment approaches, if appropriate, and will be encouraged to attend relative courses. There is an existing local paediatric specific interest group, together with an active in-service training programme, and future clinical and managerial development will be encouraged.

Prime attributes for the post are a keen interest and desire to work within the paediatric field, rather than proven clinical skills.

For an informal visit, further information, job description and an application form, please contact Miss Joanna Pine, Senior Physiotherapist in Charge, Physiotherapy Dept., Woodlands School, Bodmin, Whiteleigh, Plymouth, PL5 4DZ (s. a. e. please)
Tel: (0752) 778229

