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**CHARTERED PHYSIOTHERAPISTS**

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**NEWSLETTER**

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# Association of Paediatric Chartered Physiotherapists

Newsletter No. 55

May 1990

## VARIETY AND RUSHIN' ROUND THE U.S.S.R.

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## EDITORIAL

**Jenny McKinlay, Editor**

This edition spends much time describing to you, the reader, the experiences of a group who in March went abroad, their remit being to look at 'Aspects of Paediatric Physiotherapy in the U.S.S.R.' While they were faced with considerable organisational difficulties, which need not be listed here, this was a classic example of a group which went through various stages, where they were seen to form, storm, norm, and in the space of one week, start to perform to achieve their own objective - that of fulfilling their remit.

They have been pioneers for future groups, by attempting to make contact with childhood conditions we expect to see and beginning to open doors to appropriate places for future visitors. Please take time to read about their findings - and recognise that, despite the many frustrations we face in our own Health Service, similar and greater problems exist with colleagues abroad.

Also in this edition, we publish some excellent work being carried out by our therapists here, and give information about the Workshop Weekend which the National Committee undertook last autumn.

There appear to be times when National Committee is viewed as a 'closed shop', and this is not so. They are an elected body, elected by you the members. If you are not happy, then you must speak out, not allow feelings to boil underground. A most important member of that committee is the Regional Representative. Through her, you should hear about decisions made, hopes for the future and plans as they are formulated. She is also there to represent you on the Committee and to convey your views and thereby influence decisions.

Also, of course, there is this Newsletter where articles are published which are intended to be of interest to all members. Once again, you are invited to share your knowledge or your problems with your colleagues or simply 'get it off your chest' in the form of an article. Please help the editor by submitting in typescript.

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The final date for submission of the August 1990 Newsletter is  
**1st July 1990**

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**The A.P.C.P. Annual Subscription is due by 1st January each year.**

If members change either their name or address, please notify the **Membership Secretary** rather than the Secretary.

**Please note that, following the A.G.M., there are a number of new Officers of the Association.** Our grateful thanks go to all those who having worked hard for us are now given a chance to enjoy some of the personal time they have surrendered in the past.

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

## **ASSESSMENT AND EVALUATION**

### **Report on Committee Weekend Workshop**

**Sandra Holt, Superintendent Paediatric Physiotherapist,  
Newham Health Authority**

The committee of the Association spent a weekend, in October 1989, at David Solomon House, the South East Regional Training Centre, in Tunbridge Wells. A committee meeting was held for half a day and the rest of the weekend was devoted to looking at various forms of assessment and some of the reasons for, and methods of, evaluation. We tried, after looking at many assessment forms collected by regional representatives, to come up with a single, general, assessment form which could be used in all departments. This proved to be an impossible task and, eventually, we decided that the best solution was for departments to have check-lists for various conditions to be used as guide-lines for assessment.

The first, and longest, part of the weekend was devoted to looking at why we assess and how we use this information to plan and evaluate our treatment. The sessions were organised by Jenny French and Sandra Holt and we were joined by Mr. Bunny Le Roux, a statistician from Sheffield City Polytechnic, for the sessions when we discussed evaluation. Bunny's approach to the problems of carrying out meaningful evaluation were very thought provoking and it was wonderful to speak with a statistician who regularly works with physiotherapists.

#### **Why keep records?**

We came up with five main headings for this:

1. Evaluation of practice;
  - patient assessment
  - treatment given
  - outcome achieved.
2. Education
  - decision making process
  - intraprofessional learning facilitated
  - interprofessional learning facilitated.
3. Management; data can be used when considering;
  - cost effectiveness of service
  - acquisition of or regrading of staff
  - acquisition of equipment
4. Research;
  - retrospective studies
  - new approaches to patient care.

5. Legal aspect;  
- important in areas of consent and negligence.

### **Why Assess?**

We decided that, in addition to the role of helping to make or confirm a diagnosis, assessment is used to gather information in order to 1) determine strengths and weaknesses, 2) put everything into context, 3) formulate a problem list, 4) determine whether physiotherapy intervention can help to solve some of these problems. If physiotherapy intervention is felt to be necessary then the assessment will be used as a baseline to decide on the short and long term goals and to plan the management and/or treatment programme.

Once the planned programme of therapy has started, ongoing assessment should be used to monitor and evaluate the treatment which is being given.

Assessment may be seen as the first part of the clinical decision making process which is a complex process in which a series of choices are taken. These are: 1) identifying problems, 2) set goals and priorities, 3) decide which methods to use, 4) decide on timing and intensity of treatment, 5) decide degree to which patients or their carers are to be made responsible for their own treatment.

### **The problem list**

It is important to write a problem list as this establishes where to invest time, energy and talent, and is a key to useful, understandable treatment plans for the patient or carer. The focus should always be on the patient, not the diagnosis, and the patient or carer should be involved in this process as much as possible. When writing the problem list we are looking for the cause of each problem; can it be ameliorated?; is it likely to recur?; what steps can be taken to prevent it getting worse?; does it need to be broken down further?

We should be able to identify those problems that the patient or carer is capable of dealing with now and which affect physiotherapy treatment. From this we can then prioritise the problems and, thus specify realistic, precise, measurable goals.

Many physiotherapy departments use problem orientated records. These are useful form of treatment evaluation if they are used correctly but there appear to be some difficulties associated with these records in the field of paediatrics. This is especially so when used with the child with severe learning difficulties, since many of the problems need to be broken down into very small areas otherwise we may be left with a totally static problem list.

One of the suggestions which came from the weekend was that it may be more realistic to use goal orientated records. This would still make use of the problem solving approach which has three main components:

1. Solution development; - formulation of goals - formulation of treatment plans - selection of techniques.
2. Solution implementation; - application of treatment - modification if necessary.
3. Outcome evaluation; - actual outcome compared with desired outcome.

## Goals

In order to evaluate the results of physiotherapy goals must be set. A goal is the desired outcome. It is a description of a performance you want a patient to exhibit before you consider them ready for discharge/transfer/next stage. A clearly defined goal provides a sound basis on which to select a treatment plan. A written goal should contain the four components of:

1. who; - indicate whether the goal is set for the child or for the carer
2. what; - specify some activity which is measurable
3. how; - state under what circumstances
4. when; - specify date or time in which it is expected the goal will be achieved.

A goal may be concerned with quality or the level of performance. It should be sufficiently detailed to ensure that the desired performance would be recognised by someone else. If a goal is met in the set timescale then the desired outcome has been achieved. If the desired outcome has not been achieved then the goal and/or the treatment method should be reassessed.

## Evaluation

Goal setting, recording and monitoring are important in the context of quality assurance and medical audit, both high on the agenda in the current political climate.

One of the biggest difficulties we as therapists have is the ability to measure effectiveness. Until we start to evaluate what we are doing, by setting realistic goals and monitoring the effect of treatment, we cannot begin to judge the effect our intervention has at the treatment level or at the service level.

Evaluation may be done by: self evaluation, where we use some form of recording to measure treatment outcomes; internal assessment by peer review, also known as medical audit; external audit, which is conducted by an auditor outside our own service. If we do not start to practice medical audit and self evaluation then we are in danger of external auditors being imposed upon us, as more health authorities begin to demand more effective use of resources. If we are to cope with such a system we need to have defined our own standards in relation to the local population and the way we operate. External auditors don't know how we operate, they don't have the background to assess our work realistically. Therefore, we must be in a position to tell them what we do, why we do it, and to show how effective we are. This makes the definition of our own standards extremely important.

There was lively discussion as to whether we should use standardised testing to assess children. There was a question of who would set the standards since the results of tests can be standardised in different ways. Standardised tests would need to be national but, since we all operate on a basis of need, it was decided that local standards may be more appropriate. Examples were given to show that the diagnosis and, therefore, treatment of a child may change if the standard is changed. One of the examples given was that a child in one community may not appear "clumsy" but if he/she were to be assessed alongside a peer group from a different community then they may be diagnosed as "clumsy".

## Methods of self evaluation

We discussed the need to describe quantitatively what we do in practice and the need to know how to interpret any data collected. The result obtained when making a measurement can be either an absolute value or a random variable. Bunny showed us how the same measurements could be used to show both that a treatment had been effective, assuming that a measurement was an absolute value, and that a treatment was not effective, when the assumption was made that a measurement was a random variable. He used these examples to show that a statistical analysis is appropriate when it reflects what the therapist has done but is not appropriate when it does not reflect what the therapist has done. Some examples of the use of random variables were given, including the use of profiles to record change. Unlike absolute measurements this method can be used to look at the whole person rather than, for example, whether the range of movement has increased in a particular joint.

The key to all measurement is the definition. This must be set by the person who is carrying out the treatment/project. If a statistician is to be used they must be involved at the definition stage so that they know what the definition is. We must define what we do in a treatment session in order to identify the type of data which should be collected to show whether or not the treatment has been successful.

An easy way to monitor effectiveness of treatment is to set measurable goals and record the outcome of each treatment using pre-set outcome codes. Bunny has designed a treatment evaluation form which uses this method to give an overview of the effectiveness of treatment over a period of time. This form is divided into four sections.

Section 1 contains the patient details and the results of the assessment.

Section 2 contains the treatment objectives which are completed by the therapist, if necessary. These are divided into two sections of: i. physical objectives (PO), with a coding ranging from 0 - 5, where 0 = unable to perform function and 5 = able to perform function normally and ii) qualitative objectives (QO) where 0 = no pain/anxiety and 5 = maximum pain/anxiety.

Section 3 has to be filled in with a list of functional aims. In adjoining grids, under each date and for each functional aim, the codes of the treatment objectives achieved are entered into the appropriate columns (PO or QO). At the bottom of each column there is space to enter the number of codes 0, 1, 2 etc. achieved in the treatment session, and it is expected that a pattern will begin to emerge after a few treatments which will show whether or not there is any improvement.

Section 4 has to be filled in with the treatment plan, which is a list of activities used. These are ticked under the date in adjoining columns.

The aim of the form is to give an immediate visual feedback showing whether or not treatment techniques used are being successful. The form is being piloted in the Trent Region by physiotherapists who are members of a research group.

## LEGAL ASSESSMENTS

The second part of the weekend was spent looking at the growing area of involvement in legal assessments. The sessions were run by Sandra Holt and Penelope Robinson, Director of the Professional Affairs Department at C.S.P., who helped us to understand

some of the terminology. Penelope discussed some of the information in the Legal Work Pack which was, at that time, nearing completion. This pack, which is now available from C.S.P., contains an introductory section and sections on compensation requests, being a witness of fact, being an expert witness, appearing in court, and fees for expert witnesses.

It is becoming increasingly common for Paediatric Physiotherapists to be asked to be expert witnesses in compensation claims, either for the plaintiff or the defendant. The lawyer requires information which will help him to quantify the cost of the claim. He requires an outline of the present condition, prognosis and future care. This will include comment on the present level of physiotherapy, the suggested frequency of physiotherapy for the rest of the child's life, the requirements for care and the need for special equipment. It is also necessary to cost the physiotherapy treatment sessions plus any equipment which is recommended.

We then looked at some specific case bundles, supplied by Sandra Holt and Caroline Dunn, which showed the complex array of information which is collected for each case. The physiotherapist will normally be sent all the reports which have been completed, and may be asked to comment on these in addition to writing a physiotherapy report.

Once you have received documents from the solicitor it is important to read these thoroughly before deciding whether or not you are competent to form an opinion in this case. Remember, you may be asked to attend court to speak to your report and you may be cross-examined. Expert witnesses are there to assist the court and there may be an opposing expert witness who may disagree with your view.

## CONCLUSION

This was a valuable weekend. A lot of hard work was done by all participants and everyone gained some useful information to take back to their regions and their own places of work. In addition, the weekend gave the committee a chance to spend time together and get to know one another better. This is not always possible during committee meetings.

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## COURSE FOR CHILDREN WITH PERCEPTUO-MOTOR DIFFICULTIES

A multi disciplinary group of psychologists, occupational, physio and speech therapists held a summer course in 1989 at Archbishop Wake School, Blandford during the first week of the summer holidays to offer intensive help to children in mainstream school with these difficulties.

All disciplines involved in this course had recognised and tried to meet the difficulties of providing an adequate service for children with perceptuo-motor problems scattered throughout a rural area. After discussion it was felt this could be a way of helping to resolve the problem.

The children were recommended by their teachers and exhibited a number of the following difficulties:



1. Difficulty in dressing and undressing.
2. Delayed or impaired speech.
3. Difficulty in throwing balls, climbing and balancing.
4. Difficulty in letter formation and handwriting.
5. Difficulty in organising personal possessions and things round and about.
6. A tendency to knock into things, drop things and trip-up.
7. A gap between the child's attainment level and what the class teacher feels he or she is capable of.

All the children were 5+, 6+ & 7+ age groups.

Parents and teachers were encouraged to visit the course and observe the activities, many teachers and nearly all parents took advantage of this offer.

There was 100% attendance from the children, and as the week progressed their enthusiasm increased signifying we were meeting the number one objective of the course - 'to increase the children's confidence'. Some children enquired when they could come again.

#### **The professionals were assisted by colleagues:-**

- 1) SENSS Teachers attended to assist the psychologists despite it being a holiday period.
- 2) An O.T. student assisted the O.T.
- 3) Physiotherapists and Speech Therapists from WDHA district attended and assisted the therapists involved.

Prior to the course baseline assessments were made by each of the disciplines and individual follow up to parents and teachers is being made for each pupil who took part. We intend to use this information in the evaluation of the course.

Demand for this pilot course was so great it is intended to develop this course further and hold another early in 1990 with a group of children whose names were submitted during the initial planning stages of this course.

Colleagues who visited from other parts of the district expressed interest and the desire to follow up themselves.

We are appreciative of the financial support from the Education Department and Department of Child Health which made this course possible. We acknowledge the co-operation of the parents and teachers of all the children who took part and Archbishop Wake staff for loaning us the premises.

#### **Therapists.**

Ann Hyland (Physio)  
 Shirley Jackson (Occupational)  
 Margaret Scoular (Speech)

#### **Education Psychologists**

Margaret Hayward  
 Karen Morris  
 Jackie Fiander

**SENSS Teachers**

Jane Garnett  
Don Hewitt

**DORSET EDUCATION**

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**CASE STUDY - FIVE PATIENTS SELECTED FOR  
MULTIPLE INCREMENTAL LENGTHENING**

Jane C. Pyman, Supt. Physiotherapist, Bristol Sick Childrens

**AGE RANGE: 10.10 - 15 years**

**CEREBRAL PALSY - DIPLEGIA**

- |   |                            |   |             |
|---|----------------------------|---|-------------|
| 1 | Bilateral arm involvement  | — | PREMATURITY |
| 2 | Unilateral arm involvement | — | PREMATURITY |
| 2 | Arms not involved - 1 weak | — | RUBELLA     |
| 2 | Hearing loss - 1 profound  | — | EMBRYOPATHY |

**FUNCTION**

- 2 Walking unaided, functional but with deteriorating distance, increased energy expenditure and painful knees.
- 3 Non functional walkers with increasing contractures, increasing energy expenditure and painful knees.

**LOCATION**

- 4 from South West Region
- 1 out of Region.

## SCHOOLS

- 1 Mainstream
- 1 Unit attached to mainstream
- 2 Physical Handicap
- 1 School for the deaf.

## CASES

T.F.	R.G.	N.D.	J.B.	J.P.
b 21.6.73	b 4.10.76	b 2.12.74	b 5.4.74	b 16.1.79
Premature	Rubella	Premature	Premature-twin	Rubella
Walking unaided	Non functional	Non functional	Walking unaided	Non functional
M.I.L.	M.I.L.	M.I.L.	M.I.L.	M.I.L.
November/87	March/88	July/88	April/89	November/89
<b>OUTCOME AS OF FEBRUARY/89</b>				
Walking unaided	Walking unaided Ambulant around house on Carters city elbow support trolley Greater distance less effort.	Non functional	Walking unaided	Non functional Walking with Kaye walker - greater distance less effort. Still early in rehabilitation programme

## SELECTION

Each case was carefully selected for motivation and family support. Limited gait analysis was carried out using freeze frame video and where possible Performance Cost Indicator P.C.I. (Stallard et al) to assess energy expenditure.

Careful analysis of degree of joint range, tonal qualities, arm function and retained pathological reflexes. Combined assessment with Orthopaedic Surgeon and Physiotherapist.

A full explanation of the procedure and rehabilitation programme was given and previous video's were shown to the later cases. A decision was required from the patient before accepting them for Multiple Incremental Lengthening.

## PROCEDURE

	PSOAS	RECTUS	HAMSTRINGS	ADDUCTORS	POSTERIOR CAPSULOTOMY	TENDO ACHILLES	TIBIALIS POSTERIOR
<b>TF</b>	Right Nov 87 Left March 88	Bilateral Transfers Right to lateral intermuscular septum Left to sartorius	Bilateral elongation	Bilateral elongation			
<b>RG</b>	Bilateral	Bilateral transfers to sartorius	Bilateral elongation	Bilateral elongation		Percutaneous Left	Recession Left
<b>ND</b>	Bilateral	Proximal release	Bilateral elongation	Bilateral elongation			
<b>JB</b>	Bilateral	Bilateral transfer to sartorius	Bilateral elongation	Bilateral elongation	Left August/89	Percutaneous Left	
<b>JP</b>	Bilateral		Bilateral elongation	Bilateral elongation	Bilateral		

2 patients, N. D. and J. P. with overlong Tendo Achilles 90 + 35/45° needing Ankle Foot Orthosis with anterior tibial force plate to reinforce knee extension.

N. D. and J. P. still use wheel chairs, R. G. has discarded hers, T. F. and J. B. had not been supplied with wheelchairs.

### POST OPERATIVE MANAGEMENT

Full hip spica 3 - 5 days with appropriate infusion to control pain and flexor spasms. Change to above knee casts - feet included and begin programme of two one hour sessions daily in the Physiotherapy Department plus ward programme with regular periods of time prone and gradually raising to long sitting.

Standing commenced in parallel bars at 48 hours post application of above knee casts.

The children were all nursed on the teenage ward which has a school room, teachers, computers, radio lollipop etc. Parents are allowed unrestricted visiting essential for profoundly deaf J. P.

As pelvic control improves the above knee casts are changed to below knee with keystone wrap around splints for sleeping and standing until knee control is obtained.

At one of the plaster changes casts are taken for Polypropylene long leg night splints - we encourage these to be worn for at least six months post operatively and longer in the growing teenager.

We have found that approximately four weeks after surgery the patients who were walking unaided begin to gain the confidence to take a few steps allowing a further ten days to concentrate on weight transference, balance and stairs.

Discharge from the ward has been after six weeks except in the case of the local child who was discharged after one month - just before Christmas, but attended for two sessions daily as an outpatient for a further two weeks.

A careful hand over is necessary to the Physiotherapists at the referring centre as improvement is expected for twelve to eighteen months. Intermittant monitoring of the outcome is carried out here.

## **CONCLUSION**

This intensive surgery and rehabilitation can enable carefully selected diplegias to become more ambulant with a more efficient gait pattern.

It is best carried out at centres with specialised teams and interest to obtain good results.

- 1) Physiological cost index of walking for normal children and its use as an indicator of Physical Handicap. Stallard et al -

**Developmental Medicine and Child Neurology 1984.26.607-612**

- 2) Pre and Post Operative Gait Analysis in patients with spastic diplegia: a preliminary report. Gage, Fabion, Hicks and Tashman.

**Journal of Paediatric Orthopaedics Vol4, No 6 1984**

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## **CHOOSING THE RIGHT METHOD REQUIRES PHYSIOTHERAPIST FLEXIBILITY**

**Sophie Levitt, Consultant physiotherapist and Tutor, London**

**Reproduced by kind permission of 'Sjukgymnasten'**

During September 1987, Sophie Levitt was able to share knowledge and experience with colleagues from various parts of Sweden. This took place during Study Days and in discussion with teachers and staff at the Physiotherapy School in Stockholm.

The Study Days in four centres were specially planned as workshops in which both participants and Sophie could discover:

The problems faced by therapists in their daily work

The solutions that therapists already know

The information that the therapists still needed.

## **Individual Support**

In order to make these discoveries, a particular teaching style was used in the workshops. Here, both Participants and Tutor have to work! Everyone is expected to think, to discuss, and to carry out practical tasks. The tutorial role is to clarify and amplify the points made by participants.

Practical work with disabled children or adults occur in relation to the points raised. Thus, the participants indicate what they need in their education. All had to be challenged by changes in behaviour, ideas and attitudes. It is thus important to keep the group of learners small so that individual support and communication is possible. Learning new ideas is not always comfortable, though they may be exciting. We, as a group have to inspire one another in such ventures.

## **Themes based on Problems**

The themes that emerged from all the Study workshops clustered around:

- Shortage of time
- Motivation Problems
- Communication difficulties
- Therapy Methods

These themes were based on the problems presented by the participants themselves, in their own words. In addition my clarification of various questions asked, showed how such questions might be answered under the headings or themes already articulated.

The participants were mainly physiotherapists but our discussions were enriched by the participation of doctors, occupational therapists, preschool teachers and speech therapists. It is interesting to note the numbers of questions or problems under each heading/theme.

Communication problems	46
Time shortage	30
Therapy Methods	25
Other problems	12

## **Communications problems**

These included the parents understanding aims of therapists, therapists' communication with other disciplines, how to tell parents about the child's future and how to best present our work and worries to directors and administrators.

## **Motivation problems.**

These include how to motivate the child, his/her family assistants/carers, other professionals and ourselves.

## **Time Shortage**

For carrying out adequate treatment, training parents or other carers, keeping abreast of new developments in the field and organising the many arrangements for a child's equipment, visits and relevant professional follow-up.

## Other Problems

These consist of individual questions which cannot be answered under the other headings. They were much fewer in number.

## General Approach

The Main Problems will be discussed giving a general approach which helps to solve them. It is obvious, perhaps, that the above are interwoven problems. For example: Unmotivated parents or children make more time demands on a therapist. Time is needed to clarify the goals of therapy to avoid lack of communication. Time is needed to communicate aims of therapy within the team of professionals. Lack of communication can result in lack of motivation and much time pressures on everyone.

**Selection of Therapy Methods** cannot be isolated from the main problems. If we wish to communicate and motivate parents we should consider what they need in their day to day care of their child. What are their daily pressures in parenting their child? In addition, each parent has some parenting skills with which we can start. Parents are then not overwhelmed by strange specialised neuromuscular therapy methods. These methods are for a skilled physiotherapist. Only a few may later be selected and taught to some parents. But it is the therapy principle in each method which is transferred into the parenting activities for a child.

This also applies to others involved with the child's care, education and development. What, for example, does a teacher require a child to do, using motor abilities in the classroom? What does a nurse have to do in the care of patients into which we can 'work in' therapy principles?

## Need to listen

We physiotherapists have to observe all these situations and need to listen to the day-to-day problems of others. Listening to others involves steering the conversations to the motor aspects which present problems. This is our expertise. If we offer our expertise in the context of the daily lives of carers and others, we are more likely to give meaning to our aims and methods of therapy.

Once others are motivated by this meaning for them, they are more likely to contribute to motor training and time pressures may well be diminished. We must, however, emphasise that time must be allotted for communication, motivation and selection of appropriate methods for parents and others working with the child. Time is used for our roles in this assessment, therapy plans and evaluation of both carers and the child.

## Assessment

The physiotherapist will use her knowledge of neurology, orthopaedics and body mechanics to analyse the motor elements in each activity the child needs for his life in his home, school or playground. Both the child and his parents will be made aware of what he can do first. This builds confidence and associated motivation. Once the motor elements which exist are detected, then the disabilities are assessed.

All this is carried out in the contexts of daily activities such as feeding, playing and communication. There will be recurring assessments to say head control, trunk control,

limb movement and hand actions. These motor elements will also be part of the training of walking. This will have to be explained to parents and others so that the value of all aspects of the child is appreciated. Parents/carers then perceive that their daily parenting actions contribute therapeutic motor training at the same time.

During the assessments, suggestions for consolidating the child's existing abilities are given. Following this, suggestions are given to develop further motor control within the daily activity. The suggestions themselves need assessment. They may or may not work for the individual child. This may be seen immediately or the child and parents may still have to try the suggestions out in the child's familiar environments and report on their efficacy.

The parents and the child begin to participate in the assessments in this way. They also begin to offer their own ideas which the therapists seriously consider. This motivates their participation. The therapist accepts and appreciates their good ideas and makes modifications if ideas are not acceptable.

### **Therapy Planning**

Assessments overlap into therapy planning. Assessments are not a series of tests which seem unrelated to daily function. This may be required for some medical diagnoses or for research, but are unmotivating for those who have to work from day to day with a child or for the children who try to find their way to master their symptoms.

This does not deny that we must all know the child's symptoms and related diagnoses. It is possible to modify these symptoms, decrease them or even accept them if motivated motor function is promoted.

Therapy planning involves judgements as to what is possible for each child. The medical picture of the mental, social and emotional aspects are all involved in such judgements.

The therapy planning requires both child, parents and therapist to participate. How much can each of these people take on in the therapy programme? Each one has a responsibility so that the burden is shared. It is unwise for either a mother or a therapist to be 'over-devoted' and take on all of the therapeutic activities. This is always a changing scene.

For example, when a family go through a period of stress, then the physiotherapist will shoulder more of the therapy programme. Other workers with the child take on more responsibilities at different times.

If parents or carers are given time for communication and training, their increased confidence allows them to carry out therapeutic activities for longer periods without a physiotherapist being present. It is said that the measure of a good physiotherapist is what happens when she is not present, because of her work when she is around.

### **Therapy methods**

In order to carry through the therapy plans, the physiotherapist has to draw on as large a repertoire as possible. She should have as much training as possible in a variety of



specialised techniques as well as in methods that can be used by parents/carers and others. If a therapist limits herself to one set of methods, she limits what she can offer the wide range of problems which are seen in many different children and families.

In the comparative studies I have made of different therapy systems, I have found that most systems assess and offer methods for the various postural mechanisms and voluntary movements. It is these motor elements which are fundamental to motor function. It is also the prevention and correction of deformities which interfere with motor function, which most systems consider essential.

Therapy methods for motor function in the context of daily skills must be developing particular postural mechanisms and voluntary movement synergies. These can be observed by a physiotherapist who has learnt what these neurological mechanisms are. The physiotherapist creates methods and draws on any methods from any system to train these motor elements.

If necessary, methods to counter deformities are also used. In some cases the training of the postural mechanisms and corrective movement synergies will be adequate for dealing with these deformities which are unfixed or not yet contractures. We have in the past isolated all these motor elements for study and for treatment methods. Today, we may still do so in selected cases. My priority is to first observe and use methods to train these in the context of daily living activities. Locomotion is considered as part of these activities in that the child has to get himself to the places where he eats, plays or uses the toilet. The play of the child also uses locomotor abilities. Once all this is worked out, then separate treatment sessions by a therapist or by particular parents can be designed.

Time for these specific sessions may vary according to how well progress is made. The motor aspects can be reinforced within a daily skill which also intergrates the sensory, perceptual, cognitive and emotional aspects. The motivation to practice such whole activities by the child and families and by others augments the motor training.

## **Evaluation**

As the child and parents have actively participated in assessments in the selection of methods which suit their lifestyles, then it naturally leads to their participation in evaluation. They will know when there are great strides in the child's independence. Through the close collaboration with the therapist they will also be able to observe many small gains in the child's progress. The physiotherapist follows this feedback from them with her own special re-assessments.

## **Analyses of motor function**

Physiotherapists have to continue to study how best to observe patterns of motor function. This, however, should also be studied in the context of daily activities. Presence or absence of particular postural mechanisms, movements and deformities can be checked and corrected or further control developed with these activities. In a short article, it is not possible to describe the many different ways this is done in practice. As always we therapists are 'doers' and this is best shown in practical work with children and their families and with other carers and educators.

## **Motor Learning**

The analyses of motor patterns are related to motor developmental levels. Both in children and adults with disabilities there are patterns which are seen at earlier levels of motor control than the chronological age of the persons involved. Motor learning is helped by activities which begin at the child's level of motor development. The stages of further development have to be small enough so that the child experiences success.

Other avenues of development of sensation, perception, cognition must be taken into account in the planning so that the child's learning is integrated. All aspects of each daily living activity are analysed by various professional disciplines. They are all brought together into the daily tasks that the child will want to use.

The goal or purpose of motor tasks are chosen by the child and his parents. Once again the daily tasks have more meaning and are repeated each day of the week. Repetition helps learning.

## **Attention of the child**

The attention level of each child is important. Can he attend, for how long and what attracts his attention? We follow the child's likes and develop his attention span there initially. His likes are then associated with more demanding situations for learning. We also clarify for the child on what aspect of the motor pattern he should focus his efforts. Usually children focus attention on the goal of the motor pattern. For example, a child may attend to his balance at one stage, and attend to what he can reach whilst balancing at other stages. Bombardment of a multiply handicapped child with too many stimuli cannot help concentration and development.

The results of the child's efforts are often recognised by him or can be clarified for him. There is pleasure and formation of self esteem at this recognition by the child. We should then not cheer and clap his achievement. This gives the message that he is doing things to please adults. When we do not clap he may feel distressed and fear the loss of adult approval. Our aim is for him to become more independent and responsible for his own efforts and achievements. Naturally we say 'How well YOU are doing' in appreciation of his hard work.

## **Flexibility demanded**

Today, physiotherapists are increasingly interested in how children and adults with disabilities learn to move. Treatment methods are progressing from the neurophysical approaches to being incorporated into learning methods. We have to explore each disabled person's styles of learning. This demands flexibility on the part of therapists so that appropriate methods are found for each person in their care.

Psychological research and teamwork with teachers and parents help physiotherapists in these explorations.

It is my experience that the way physiotherapists themselves are helped to learn is part of this process of change for future development. Observing our own ways of learning in small group workshops illuminates much of what we already know about learning. It is after all in the process of giving therapy that we show our own intuitive gifts for communication and motivation of our patients.

*(many references were given with this article, in Swedish.) - Ed.*

# RUSHIN' ROUND THE U.S.S.R.

DAY ONE - Monday 19th March 1990

**Bobbie Hillman, Superintendent Community Paediatrics  
Rotherham**

The 1990 trip to the U.S.S.R. for Paediatric Physiotherapists began in Leningrad where a visit to a Children's Polyclinic was arranged on Monday 19th March, 1990. This was to be the introduction to our Russian colleagues and was anticipated with great interest among us.

We were welcomed by the Clinic's Paediatric Director, who gave us a brief explanation of the history. She proudly told us that it was only one year old, one of 22 similar clinics in the city, serving a population of approximately half a million, 18,000 of which are children.

The clinic provides antenatal care, when pregnant mothers are taught how to await care for their future offspring, and diagnostic screening is available to all. There is a close link with the gynaecology clinic and special attention is paid to the prevention of Ricketts. This is a fairly common problem in Leningrad, due to poor diet and lack of sunshine.

The clinic staff consists of the Director, who is a Paediatric Doctor, and several Doctors of Curative Physical Culture. As far as we could ascertain, these were doctors who had undertaken postgraduate training to become 'physiotherapists' and had then specialised in either massage, hydrotherapy or electrical treatments. An interesting concept, we felt. We also saw a nurse who was trained in exercise therapy.

We were then taken on a tour of the Clinic, beginning in the Hydrotherapy department. This consisted of a large pool, where a class of children with either orthopaedic or asthmatic problems was in progress and a smaller pool, where babies could be treated. It seemed as though underwater massage would have been used here. We asked about their involvement with neurologically damaged children, but received no definite answers, and could only assume that they would be referred to other institutions. The children attend twice weekly for hydrotherapy and gymnastic classes, to coincide with the shift system of Russian schools - either morning or afternoon sessions.

The massage department contained several high plinths where babies 'at risk', or with congenital deformities, could be treated. All babies are screened at one month of age: any child requiring physical therapy is then seen regularly in the polyclinic. Older children suffering from neurological diseases, orthopaedic problems or post-operative conditions are also likely to receive massage.

On entering the electrotherapy department, we felt we had stepped back in time. There were rows of silent, yellow-curtained cubicles housing every machine imaginable from faradic stimulation, ultra violet, galvanic ionisation, S.W.D., ultrasound etc. We saw children with pneumonia being treated with retonin ionisations and a boy with nephritis with two pads placed anteriorly and posteriorly in the kidney area having similar treatment. We again asked about children with cerebral palsy and were told that they are sometimes treated with faradism in order to stimulate muscle activity.

We were interested to hear that every child is examined originally by the Paediatrician who then prescribes the treatments. Electrotherapy is greatly favoured and widely used in all clinics. They were extremely proud of all the machines. The therapists all wore long white starched coats; walls tended to be bare; there were hardly any toys about and there was usually complete silence. In fact it was difficult to imagine that behind the yellow curtains children were receiving treatment.

We could only assume that cerebral palsied children attended other institutions as we persisted in asking about their treatment and care, and were given no definite answers. Apparently difficult cases are referred to specialist clinics and Kindergartens.

Once per week Professors visit to give advice when required and to provide postgraduate training. We were informed that a Paediatric Doctor would earn a maximum of 200 roubles per month - £20 (at current rate of exchange) - in competition with miners earning £60 - £70!

There was a scarcity of equipment in the building as we have come to expect although charities are in the process of being founded to provide certain appliances. Perhaps we should take another look around our own departments and count our blessings, as we trip over toys, stack our equipment in corners and wish for a little peace and quiet.

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## DAY TWO - Tuesday 20th

**Margaret Smith, Physiotherapist, University Hospital, Nottingham.**

### Leningrad Childrens' Hospital

We were greeted on arrival by a bearded man with deep brown eyes, round spectacles, and a receding hairline. He was Dr. Alexander Kharchev, Assistant Director of Leningrad Childrens' Hospital, the second clinical visit of our Russian tour.

Opened in 1977, this imposing pink-tiled building surrounded by a high metal fence serves north-west Russia as a regional surgical and research centre. Totalling 700 beds, it includes three intensive care units (total 30 beds) and has a 120 neonatal department. Among its specialities are renal neonatal surgery, leukaemia, burns and trauma. Following close liaison with American medics, a cardiac surgery unit will be opened in the near future.

From a total staff of 1,200, the physiotherapy department is comprised of a doctor of physical medicine, 2 doctors of curative physical culture and 13 middle rank 'sisters of physiotherapy'. They have completed 2 years medical training before specialising for 4 months in one area of physiotherapy.

We visited the neonatal surgery unit, with facilities to operate on infants weighing as little as 1 Kg. These babies are usually referred from local Maternity homes shortly after birth. Along a silent echoing corridor were a series of poorly lit rooms, each containing 3 or 4 infants, cared for by 2 nurses.

The incubators and monitoring equipment, although of Soviet make, appeared similar

to those seen in this country, if somewhat larger in size. Several infants were nursed under antiquated U.V. tubes, but all were well positioned and comfortable. Gowned and masked nursing staff handled the babies minimally, washing their hands thoroughly. Glass feeding bottles were plugged with wisps of cotton wool to keep the feeds warm! None of the children we saw were intubated and there was no evidence of suction equipment. When questioned about respiratory complication, we were told that these arose only occasionally. The removal of secretions was aided by percussion or vibromassage, but staff did not seem to understand the concept of suction. Vibromassage involves the application of an interferential type of current via pads on the thorax, to dislodge secretions. We were not given details of current frequencies, length of treatment or its regularity and did not witness the method in use.

Once stable, the infants are cared for by their mother in 4 bedded cubicles along an adjacent corridor. Although a paediatric neurologist is attached to the unit, infants with such problems are referred to other centres.

The hospital operated no follow-up programme as children are discharged to the care of the local Polyclinics.

We were briefly shown the surgical I.T.U., again barren, without murals or toys. The surgical wards were crowded while children sat silently on their beds. The physiotherapy department we visited boasted the usual menage of electrical machines, faradism, inductotherapy, ultrasound etc. used for pain relief and to aid post-operative healing. The Russian therapists were extremely surprised we did not do likewise and wondered how we occupied our working day!

We were struck by the silence and starkness of the centre with drab decor, few toys and lack of playroom facilities. Throughout this hospital, and most of the centres we visited during our stay we were permitted to freely photograph children, some partially undressed for our benefit, without parental consultation or permission. Although the surgical techniques may be modern and pioneering, this hospital appeared large and institutionalised with an evident lack of privacy and little consultation with parents in decisions regarding their childrens' management.

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### **DAY THREE - Wednesday 21st - MOSCOW**

**Jackie Reynolds, Supt. Physiotherapist, Paediatric Services,  
Gt. Yarmouth and Waveney H.A. (James Paget Hospital).**

**Visit to the Orthopaedic Surgery Rehabilitation Hospital No. 19 in the  
Preobrazhanka area of Moscow.**

We arrived in Moscow several hours late after an overnight train journey from Leningrad. Due to chaotic arrangements - or rather lack of them, we left our luggage at the hotel and went 'as we were', unwashed and unchanged, not fed and watered and all rather tired and not at one with the world. The coach took us out into the suburbs first to a large Polyclinic, No. 51, where we were greeted by the Clinic Director, Dr. Shepetinovsky. This

contact had been made by our English interpreter, Brian, who had met him on a previous visit. Polyclinic No. 51 serves a population of 36,000 adults, the children of this area being under the care of the Children's Polyclinic. We were told about the staffing which is well served by 70 doctors and specialists. All services are provided locally. There was a large physiotherapy department with rows of machines of every type. Treatment is largely by electrotherapy, and we were interested to see their laser which they told us was used for arthritis, trophic inflammation and tennis elbow. We met their specialist in Curative Physical Therapy, who seemed more involved with exercise and 'hands on' therapy. There was a delightful lady who was in charge of acupuncture, who had learned her techniques from a Chinese doctor who came to work at the Polyclinic. She spoke good English and was proud to have the opportunity to practice it. Amongst the patients she sees are those with frozen shoulder, pain, headaches and people wanting to slim. She inserts a microneedle close to the ear weekly for a month for the slimmers and said it was most successful.

We were then taken over the adjacent Orthopaedic Surgical Rehabilitation Hospital and were introduced to the Director, Dr. Vladimir Popov and taken to his office. He talked to us about the hospital and its services. The children's problems are diagnosed at the Polyclinic and any defect or deformity is reported to the hospital for follow up and the children remain under the care of the hospital until they are adults. Dr. Popov talked about some of the different surgical procedures and management of certain conditions such as Perthes, Congenital Dislocation of the Hip, Scoliosis, Arthrogyposis and Talipes.

The surgical correction of scoliosis is mostly by Harrington Instrumentation and Leuke's. They are also developing their own dynamic rods which are made from 'metal with a memory'. As far as we could understand, the metal is heated and moulded to the curve; after fixation to the vertebrae, the rods are cooled and returned to their original state, thus straightening the curve. This technique is already being used at the clinic. A large number of children with scoliosis are seen at the clinic and conservative treatment by bracing is preferred. In the country hospital where children go for ongoing rehabilitation, one third have a scoliosis and they have special boarding schools just for this group of children. The percentage going on to surgery is variable and results not always good.

The hospital is also using new instrumentation for Perthes Hip which combines initial pressure at the hip joint followed by distraction. There is also a rotational component, each part capable of daily alteration. This new appliance shortens the treatment period omitting the 1st and 2nd stage. It would appear that Perthes is quite common and surgical intervention preferred.

We had some discussion about congenital dislocation of the hip and asked about use of ultrasound diagnosis. This is only used for babies at risk. Dr. Popov quoted large families with all children having CDH. He told us that there are many problems with children in the Caucasus and Middle Asia with large families, high birth rate and poor services. There are many home births and he described the area as 'socially low'. The women grow old quickly and find it difficult to take their children to hospital for treatment.

We enquired again as to children with cerebral palsy and were told that they were treated at a special hospital in Moscow. Dr. Popov promised to contact them to arrange a visit. We were really beginning to wonder where they were all hidden.

During this discussion, a large jug of apple juice and glasses was produced. Ashamed to say, we fell on this like a man in a desert as we were by this time feeling absolutely

dehydrated. The jug was readily replenished several times which was most welcome.

We were then taken to look at the hospital - to see some children, we requested. By this time we were beginning to get withdrawal symptoms as we had not seen many since our arrival. First the physiotherapy department was shown, with its now familiar succession of machines. We set eyes on a wheelchair and everybody's eyes lit up. It is very evident that physiotherapy and electrotherapy are synonymous. We were glad to press on to a ward where we were introduced to another orthopaedic surgeon who proudly showed us his patients. We were free to look, talk, and photograph and they were obviously delighted by our interest. We were all upset that our chocolate buttons, sweets and presents were at the hotel and had to make do with smiles and gestures. You can manage a great deal without language.

The ward consisted of many small rooms off a long wide corridor, each room with four or five narrow beds. Almost all the children were in bed and obviously must remain in hospital whilst in plaster. Some of the children had a toy, but play material was not evident, very different from the clutter of toys in beds and cots we see at home. The rooms were clean but not really decorated although there were some lovely plants around. In spite of the clinical appearance, the ward seemed happy, the nurses carrying children around or sitting talking to them or comforting them. The nurses wore different wrapover overalls and tall stove pipe caps, some in a very pretty pink. We were shown the Perthes apparatus, children in traction and in plaster. We mostly wandered round informally taking loads of photographs and talking to the children. Frustrations disappeared at this contact, and we all started to feel better. Children are children the world over.

Once out of plaster or free from these complex appliances, the children are sent to a rural rehabilitation centre 80 kms. from Moscow for mobilization. We asked for the address so that we could try to visit.

Dr. Popov took us back to his office where they had laid out tea and coffee and delicious cake. All the best china was out and tables pushed together covered with a cloth. Dr. Popov sat down with us. He was obviously delighted at our interest and enjoyed the attention of sixteen women! Katja, our guide, was anxious for us to return to the hotel but this was the best cup of coffee imaginable and we refused to move. We promised to return to present our host with a C.S.P. Medallion and with sweets and presents for the children. He bade us goodbye by kissing our hands and Maggie had a kiss on the cheek! I wonder how long she will last before washing it away! What a delight this afternoon had been. This is what glasnost should be.

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#### **DAY FOUR - Thursday 22nd**

**Brenda Hodgson, Sr. Physiotherapist, West Fife.**

**Sue Hudspith, Sr. Physiotherapist, Eveswell Children's Centre, Newport.**

With spirits low, we set off to visit "The National Research Centre of Medical Rehabilitation and Physical Therapy". Having assembled in an old boardroom, we were greeted by Dr. Bogooyoubou, who began to talk to us about this enthusiasm for electrotherapy.

However, at the beginning, Shirley lent forwards and snapped the leg off her chair, which caused quite a stir and a good distraction.

The most interesting bit to us was the suggestion that electrotherapy was used on C.P. kids, using 27 megahertz situated temporally or fronto occipitally. This was to stimulate existing nerve cells and spasticity could be reduced. Research has been on 4-10 year olds, and has been good. There have been no contraindications, but it is not advisable to do it on children who have epilepsy. Physiological effects are by stimulating the hypothalamus to increase the production of endorphines and encephocenes which in turn can stimulate dormant and damaged cells. The dosage is 20-30 megahertz 15 minutes daily, 15 to 20 times. The effect lasts for 6 months. A placebo treatment may be given first to see how the children tolerate this. The children are reported to sleep better and with an increased resistance to infection.

Other interesting treatments include the use of S.W.D. over C4-T4 for Ischaemic heart conditions, and the use of microwaves on the reflex areas in the "collar area" to promote a feeling of well-being.

Infertility was also successfully treated at the clinic, with a 30% success rate by a combination of electrotherapy S.W.D. to the hypothalamus, bathing in mineral, sulphur and radon baths, together with vaginal irrigations.

Climate therapy was discussed along with the use of spa therapy. Children with TB, asthma, and skin conditions would be sent with their parents for 5-6 weeks to the country or mountains. We thought this a lovely idea, and thought the National Health should start buying premises in Spain and Switzerland immediately for our inner city kids.

Mud also appeared to be the order of the day. Vast amount of hot black, sticky stuff full of minerals from the Crimea was smeared over various locations whilst the patients languished in tranquility until we turned up with our flash cameras. I must say, I think at this point none of us would have minded having their treatment ourselves.

We finished the day off with a shopping trip into busy Moscow and watching a 4-hour queue curl round into the new MacDonalds.

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#### **DAY FIVE - Friday 23rd**

**Carol Foster, Supt. Physiotherapist, Central Birmingham H.A.**

**Hazel Warner, Community Physiotherapy Service, Central Birmingham H.A.**

Waking to brilliant sunshine and blue skies we wondered what Moscowvite delights the day might hold for us, considering the unpredictable vagueries we had already encountered. Fortified by the usual breakfast of cheese, brown bread, scrambled eggs, yoghurt and black coffee we rendezvoused with Dr. Popov, who escorted us onto the coach to the Central Scientific Research Traumatological and Orthopaedic Unit in Priopov Street.

Arriving at the large white rambling Victorian Hospital, we were met by the Director of the Rehabilitation Unit (Russian style Physiotherapy), Irina Geroeva, a petite, vivacious and attractive lady.



The hospital consisted of approximately 450 adult beds in 8 wards, which included wards for trauma, sporting and ballet injuries, osteopathology, a sceptic wounds department and a spinal pathology ward.

The three paediatric wards had 45 beds with a ward each for orthopaedics, bone pathology and trauma. We were told by Irina that the Institute served a very wide local district but would take patients from all over the Soviet Union as there was much research carried out and they were able to deal with fairly complicated cases - they also would take paying patients from Arab countries.

As with most of the other clinics and institutes we visited, there seemed to be great emphasis placed on electrical treatments for most ailments, massage and curative gymnastics were also used.

In the orthopaedic ward there seemed to be a high incidence of Perthes Disease, which was treated by plaster of Paris and bed rest, the children staying in hospital for several weeks. There was also much congenital dislocation of the hips, also treated by broomsticks and staying in hospital for several weeks. Research into spinal surgery with the use of non-metallic implants for bone rehabilitation was being carried out and we saw external fixation for spondylolysis. The fixators went into the laminae above and below the "slip" site, and an adjustable screw gradually pulls the vertebrae into position, the fixators remained in situ for 1 to 6 months, much of that time the patient was in hospital, but a 14 year old girl was mobile during this time and had lessons from teachers. Harrington Rods were also used for Scoliosis and sometimes Leuke's procedure. All the spines were kept under review until patients were 18 years old.

Leg lengthening was also carried out for congenital shortening of 3 cms plus, by an Osteotomy of the top one third of the tibia, followed by distractions. They did not acknowledge any difficulty with avascular necrosis or neurological problems.

There were six to eight beds per ward with a wide age range of 3 to 14 years and there generally seemed to be adequate nursing staff.

The supporting services were a hospital school, the teachers visiting the ward for bed-ridden children and if the children were hospitalised for several weeks there was a social organiser who had a games room, where handicrafts were taught "as Mothers would teach children". Music lessons both instrumental and vocal were available, and local celebrities and famous people were invited to visit the children. These activities could if necessary be taken to the wards.

Each floor of the institute had a Physiotherapy room with all the electrical equipment seen at every establishment, plus a gymnasium for the ballet, sports and trauma injuries.

After the institute visit, a most enjoyable 1 1/2 hours was spent visiting a friend of our Russian guide - Katya. We travelled to the outskirts of Moscow, where her friend, Irina, lived on the 11th floor of a 14 floor block with her two daughters. The flat was sparsely furnished but comfortable and warm and there were many beautifully leather bound books in Russian and also a complete works of William Shakespeare in English. Irina's two daughters could both speak a little English and Irina had been learning for a month. Many Russian people are eager to learn English, and go to night classes to do so. The family were most welcoming and not at all worried with 18 English visitors for afternoon tea and cake - 4 large delicious cream gateaux cost us 4 roubles (40 pence).

After dinner at the Hotel Russia the day was completed by a walk across Red Square, which is very beautifully illuminated at night, and especially beautiful when a light fall of snow occurs, as it did for us.

The ride on the palatial chandelier lit, marble walled and floored, fast moving, litter and smell free Metro (5 kopecks, less than a farthing, go anywhere) finished our day and we returned to our hotel very tired with some more lasting impressions of the Moscow scene.

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**DAY SIX - Saturday 24th - CEREBRAL PALSY AT LAST**  
**Judith Lott, Sr. Physiotherapist, Poole Community Paediatrics.**

To most of us in the group the visit to a Soviet Cerebral Palsy Centre was the highlight of our tour, but the road to this was beset with many obstacles and it was not until our final day, Saturday that we achieved our object.

After all the disappointments and delays of the past week, we were so excited about seeing our first Russian Cerebral Palsy children that we arrived early at the City Children's Psychoneurological Hospital No. 18, Pelshe Street, No. 6, Moscow to meet its Director Dr. Sologuvob.

The hospital was plain on the outside with cream washed walls and steps up the front but, joy of joys, ramps too. It was about half an hour's coach ride from the centre of Moscow in the Yuri Gregarin district with high rise flats all around.

We left our coats and at about 11.45 were led into the modern lecture theatre where we sat in the front rows. In a few minutes Dr. Sologuvob came in. He was a lovely friendly man and we instantly warmed to him.

He told us that the hospital was built in 1983 and that he had set up the whole concept.

Dr. Sologuvob then gave us a run down on the Cerebral Palsy situation in Russia and in this hospital in particular, which is a research and pioneering centre.

He said that there are about 40,000 adults and children with Cerebral Palsy in the U.S.S.R. and that although the centre does treat children from all regions of U.S.S.R., and also from other countries with a Russian affiliation, it is basically for the children of Moscow.

The hospital has 420 beds and receives children from a few days old to 17 years. One section with 30 beds takes the newborn, another with 120 beds takes those up to 3 years, another of 90 beds takes pre-school children from 3-7 years, and there are three departments from school age children with 80 beds.

The centre has two schools within the hospital, one which gives a general basic education, and one which gives a "helping" education for the mentally handicapped.

Also within the hospital are 180 surgical beds and 60 beds for spinal trauma doing neuro-surgery for paraplegics. There are about sixty children suffering from double incontinence.

In a year the centre sees 3,000 children for treatment of various sorts and altogether 30,000 receive consultations. The centre has its own polyclinic.

Dr. Sologuvob told us that the centre has a total of 800 personnel. Of these, forty were scientific colleagues, i.e. consultants in such specialities as Neurology, Psychology, Orthopaedics and Rehabilitation.

Forty other personnel worked in the schools, there were 90 Physiotherapy doctors (you will see from other articles that the profession is very differently organised from the U.K.).

There are twenty Speech Therapists, 20 Psychologists, 350 Nurses and the rest were assistants.

At the centre there are two departments of Physiotherapy, 5 doctors of Acupuncture and 8 doctors of curative gymnastics.

There are also 15 doctors of surgery, 30 Neuropathologists, 5 specialists in functional analysis, EEG, EMG, 6 in X-ray, 6 in Resuscitation and Anaesthetists and 8 other specialists in various different areas who consult and give advice.

There is a workshop for prostheses and 32 subsections for curative gymnastics.

After giving us all this information without any notes Dr. Sologuvob was open to questions from us.

The following notes are a resume of his answers to some of our questions.

The first question was about the methods of Physiotherapy treatment used for the children. When Dr. Sologuvob replied that they are using Petro, Bobath and Vojta - an eclectic approach, a great cheer rose from us all. At last we had found someone who thought along the same lines as us.

He was then asked about the facilities in other areas, and he said that there are two other hospitals of 300 beds and one of 150 beds for infant encephalo pathology. Other children receive treatment in the ordinary neurological hospitals. Some big cities have local centres.

The institute trains people to work in the regions and it is for the second stage of rehabilitation, i.e. not SCBU.

The children's stay in the institute averaged 45 days, but children having operative procedures stayed up to 3 months. With children under 3 years old mothers can visit from 8 a.m. to 8 p.m., as can the parents of seriously ill older children.

When asked about Special Education, Dr. Sologuvob said there are three boarding schools with 700 places and 2 colleagues for special training. These children are outside the State examination system. If a child can look after himself, he will go to a normal school, but many kids prefer the special school because they get more attention and can continue treatment. Those with very severe degrees of handicap have home tuition.

In Moscow there is a school for parents to instruct them in the methodology of their child's treatment.

The institute is open for consultation with the staff of the child's local polyclinic, where he attends for regular check ups. A small child will have 4 check ups per year, one from 4-7 years 2 check ups, and the older child will have one.

There was a question on operative techniques used, and we gathered that like us, they operated on TA's and hamstrings and did some bony operations for the spine; and after trauma linked the vertebrae with plates. Dr. Sologubov did not go into details as time was limited. We were told they used electro-myography, bio dynamics and podography - gait analysis to decide on the best operative procedures.

One of us asked about the provision of equipment, chairs etc. Dr. Sologubov replied that equipment and also prostheses are paid for by Social Services.

We were also told that Physiotherapists do not go into the children's homes.

The Director said that no-one lives permanently in the institute, but there were special boarding homes and twenty-two children's homes in Moscow.

After 18 the local council has to give the handicapped person a place to live and 3% of dwelling places in blocks of flats are set aside for the disabled.

The Russians have a Cerebral Palsy society with meetings for professionals and also for parents. There is a children's charity called the Lenin fund, which is associated with the setting up of forty large country villages on the Austrian model.

The Director felt that the disabled should be integrated into society. Up until a short time ago the disabled were forgotten, but in the last 5 years a lot has been achieved in U.S.S.R. There was a lack of adapted housing, good prostheses and good wheelchairs and a lack of sporting opportunities for the disabled but things are improving.

Dr. Sologubov said that pensions for a disabled person have recently gone up from 30 to 70 roubles per month. There are no allowances for a person who looks after the handicapped one, but they are trying to make a law change in the Supreme Soviet to give the carers an allowance. He said fathers often abandon their handicapped child, and divorce is high in these families.

When asked about child abuse he said it was just being investigated in Russia. It is a Police affair there, but there are registered children's doctors in each area who look out for abuse.

He was asked whether parents could be deprived of their rights, he replied that in the 20 children's homes in Moscow only 5% of children were orphans, the rest had problem parents.

Dr. Sologubov was asked whether he saw changes in the types of Cerebral Palsy seen, as in Britain, he said yes, because they are managing to reanimate and resuscitate more newborns, he also thinks ecology and diet are affecting the cases, he is seeing more severe cases. Alcoholism of parents is a problem too. He thinks the number of cases in U.S.S.R. will rocket. In 1985 80,000 such children were born. He felt they needed early ultrasound diagnosis as in Japan, and termination of a pregnancy may have to be considered.

On this rather sombre note we finished our question and answer session, and followed Dr. Sologubov on a tour of the hospital. As it was Saturday we had to be content to see empty rehabilitation rooms and school rooms. (Soviet children go to school on Saturdays, but it was the holidays.)

Each unit of 60 beds had its own physiotherapy, acupuncture, plaster room, treatment room, special therapy room and classroom. To keep infection to a minimum, an infected

child is stopped swimming and isolated.

We just saw two small pools where the children could receive therapy, vibro massage and cryotherapy. There was also some electrotherapy but not really so much as we had seen elsewhere. They have a lot of Dutch equipment.

We were very impressed by the light airy and loving atmosphere we saw everywhere. The children were very cheerful and happy and just adored us to take their picture, especially when they were rewarded by a mini mars bar. We felt a bit guilty about this, as on the diet sheets on the wall chocolate was forbidden! The nurses were hardly recognisable as they were wearing attractive flowery wrap-over overalls. This added to the general brightness of the wards.

All the walls were decorated with colourful paintings and there were also many advisory posters on diet, positioning etc.

Many of the children, who incidentally seemed to be fairly mild diplegias and hemiplegias were riding their tricycles in the corridors, there were several children in plaster in wheelchairs and one little athetoid girl was eating her bread as they were getting ready for lunch. We noticed she was sitting on a normal infant chair at a normal table. The corridors had low rails to help with walking.

The physiotherapy treatment rooms were bright and sunny - we noticed the trampolines, parallel bars, a treadmill rather like an abacus presumably for sensory integration, an overhead suspended walking aid, mats and carpets on the floor. We also noticed a rather nice arrangement of paving stones with various textures, ramps and stairs.

We saw the pre-school classrooms with toys and dolls houses for younger children. There was a department of Vocational Guidance with instruction in photography and handwork. This department had an entrance called the Fairy Tales where beautiful life size characters were displayed in a semicircle, and the children or child could sit in the middle like in a theatre. Dr. Sologubov said this provided a relaxed and calming atmosphere for the child. He said they also have a soft play area but that was closed so we couldn't see it. Dr. Sologubov said that 15% of the children were selected for research but did not go into details.

He said they had young very mentally handicapped children, but those of school age were in places run by Social Services.

The whole place had such a lovely atmosphere, cheerful and bright that many of us wanted to stay and work there.

We shall always be grateful to Dr. Sologubov for finally showing us how Cerebral Palsy is managed in Russia and for this we presented him with Chartered Society Medal.

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#### **BRIAN REEVE - our interpreter - speaks:**

Since accompanying as interpreter this group of 16 paediatric physiotherapists - whose exploits you will have read about in these pages by now - to the U.S.S.R., I have not dared to show myself in the street here in London. By the end of the trip, I had decided that I must

be some kind of Frankenstein monster. Within the first 3 days, I was told by various members of the group that, from their experienced observations, they could tell that: (a) I had a Trendelenberg Gait; (b) I had a mild scoliosis at the bottom of my spine; (c) was anorexic; (d) had a strange shambling walk.

I have had very wide experience in a lot of fields, including accompanying over 30 trips to the U.S.S.R. as interpreter, ranging from youth workers, through teachers and social workers, to accountants. I have also been a journalist, play-leader, and builder. But, in dealing with this group of physiotherapists, I think my most relevant experience was my 3 years teaching maladjusted adolescents!

Each visit of a Soviet hospital or institution included a lecture and question-and-answer session by the senior doctor. One of my functions was to act as interpreter at these sessions. Never have I had a group that was so eager to ask questions that they would interrupt each other to such an extent that finally I would have to use my teaching experience to lay down the law and tell them in what order I would select them. On some occasions, I had to bang on the table in front of me because neither the doctors' answer or my translation could be heard above the uproar - caused, of course, entirely by enthusiasm and interest.

It was sometimes a struggle to convert between Russian and English such terms - unknown to me previously - as Perthes, Arthrogryposis, Harrington Rods, osteocondritis, Schree Baths, and spondylolysis.

No wonder then, that, on returning to London, I collapsed into bed, slept for 12 hours solid and feel as if I am only just beginning to recover 3 days later.

But, in case I have given the wrong impression, in spite of - or because of - the pressure, and certainly because of the enthusiasm of the group, this trip was one of the most memorable I have ever accompanied. In addition, I learned a lot about physiotherapy, which will be useful if ever I accompany another group to the U.S.S.R. I have also made many friends among the group, with whom I believe I will continue to be in touch in years to come. Of all the trips I have made to Russia, this one will remain, every detail and person, vivid in my memory for a very long time.

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## ABSTRACTS

**Title:** Early Physical Experience and Cognitive Development.

**Author:** Jeffrey Rothman Ed.D. P.T.

**Source:** Clinical Management Vol. 9. No. 3.

Although it has long been recognised that physical therapy is necessary to facilitate the motor development of children with physical problems, its role in facilitating cognitive development has received scant attention.

Piaget emphasised the importance of early physical experience and activity in cognitive and intellectual development. All knowledge derives from motor activity, manipulation of objects and physical exploration of the environment, the development of spatial

concepts beginning in infancy as children reach for and move towards and away from objects.

The environment should be structured so it allows exploration to allow for movement experience to enable children to develop the experience necessary to help them prepare for eventual academic skills i.e. prediction of succession of movements etc. This is especially so for children with physical difficulties who need more time to develop explorative skills. It is especially important to provide diverse experiences to help these children to learn to interact with and learn from their environment.

It is then important for physical therapists to help parents and teachers to construct and provide such environments. Treatments out of doors and in differing situations, the use of objects with differing colours, textures and weight - several ideas being given in this article.

Planned physical activities can help lay foundations for life long problem-solving processes - the physical therapist working with the child's carers can be invaluable in helping design such activities.

\*\*\*\*\*

**Title:** Injuries in Children's Sport  
**Author:** Ray Welford B.M., M.F. Hom., D.R.C.O.G., G.P., Glastonbury, Somerset.  
**Source:** The Practitioner, September 1989. Vol. 233.

The winter games of rugby, soccer, hockey and netball are associated with injury. Any Contact sport can lead to direct trauma, but many injuries are caused by faulty techniques, inadequate equipment and poor management of previous injury.

Children are susceptible to most of the injuries seen in adults but the relative frequency differs. Growth is the main physical quality that differentiates the types of injury between children and adults, as it results in different characteristics to physical structures, bones in children being more pliable and tendons and ligaments comparatively stronger. Two common injuries in children are apophyseal and epiphyseal fractures, the stronger tendons and ligaments tending to transfer the traumatic force to the bone, whereas in adults, the tendon would rupture.

Severe contusions occur when falling on hard pitches, resulting in marked synovial swellings, particularly to knees and shoulders. Running on hard surfaces, exacerbated by poor footwear can lead to malposition of the heel.

The management of these injuries is conservative i.e. rest.

Other major sports injuries seen, include Osgood-Schlader's disease, Patellar tendonitis and Bursitis. Treatment of such injuries is rest, application of ice and progressive resistance exercise.

Children are often poorly prepared for sport resulting in badly pulled muscles, especially where there has been insufficient warming up periods. Those most likely to be

involved are hamstrings, quadriceps, occasionally adductor muscles of the hip and muscles of rotator cuff of the shoulder. Commonly apophyseal fractures occur when excessive strain is put on the adductor muscles.

Faulty rugby tackling and poor scrum techniques cause long standing neck strain and acromio-calvicular joint problems, serious injury to the brachial plexus can also occur leading to neuropraxia.

Ordinary sprains of knees and ankles are frequently seen and require good management with rest and adequate physiotherapy.

Good, well fitting equipment is of high importance in preventing injury in children, and careful frequent checks are required to prevent skeletal deformity.

Players and coaches must be encouraged to heed early warning signs, frequently check all equipment and enforce correct management techniques. Each injury should be taken seriously and given thorough and effective treatment.

\*\*\*\*\*

**Title:** Acquired Cerebral Palsy

**Authors:** P.O.D. Pharoah, T. Cooke, and L. Rosenbloom.  
Dept. of Community Health, University of Liverpool and Royal  
Liverpool Children's Hospital.

**Source:** Archives of Disease in Childhood, 1989. Vol. 64, p.p. 1013 - 1016.

Recently, interest in the epidemiology of Cerebral Palsy has been more noticeable, as the necessity of outcome measures to ascertain the effectiveness of neonatal intensive care has increased.

Several definitions of Cerebral Palsy exist but common to all are three basic facts - it is a lesion of the brain, it is non-progressive and it results in a motor disorder leading to abnormal postures and motor control. Some of the variation between definitions is associated with the timing of the original insult, the present tendency is to separate the babies in which the presumed aetiology is pre-natal, peri-natal or acquired in origin.

This study was involved with the epidemiology of "acquired" Cerebral Palsy in the Mersey region.

833 cases of Cerebral Palsy recorded in registers of children born to mothers living within the Mersey Regional Health Authority in the years 1966-67 were studied, 147 (18%) of these were considered to have become brain damaged between the 28th day of life and up to the end of the 5th year of life. Bax's definition of Cerebral Palsy was used which excluded all cases of tumors or lesions of the spinal cord.

The male/female ratio of these cases 1.3:1, 52% had spastic quadriplegia, 40% spastic hemiplegia, others included ataxia, dyskinesia and hypotonia. The commonest cause of brain damage was infection of the brain or meninges, a significant number were attributed to circulatory collapse consequent to other infections.



Ages when brain damage was acquired differed according to cause, head injury after road traffic accidents was more common in the older child. 11 out of 12 cases of N.A.I. occurred within the first 18 months of life. Infections causing brain damage in 54% of cases were in the first year of life, 27% in the second year. Gastro-enteritis and dehydration lead to 9% in the first year of life.

As a result of this study the observation that 15% of cases of Cerebral Palsy are acquired, is higher than in several other studies. The differences in definitions make comparison difficult.

The major tragedy of cases of acquired Cerebral Palsy is potentially preventable - also those children show a significantly higher proportion with moderate or severe learning problems.

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## BOOK REVIEWS

### CEREBRAL PALSY PROBLEMS AND PRACTICE

by Margaret Griffiths and Mary Clegg.

Souvenir Press, London, 1988.

170 pages. £10.95; paperback £6.95.

This book is written primarily for the parents of children with cerebral palsy, as well as for the professionals working with them. In fact, as in all books for parents, the material is best discussed with the professional who knows the child and family well. The book brings together a great deal of current information on the medical aspects of cerebral palsy, what can be done to help parents and their child, and the provision of services in Britain. The implications of Education Act 1981 is clearly discussed as well as the patchy provision of services and the need for progress.

The book paints the pictures of cerebral palsy with a broad brush so that details of physiotherapy or psychological help for both child and his/her family are not given. The essential ingredient of motivation in child and family is repeatedly underlined and an excellent general chapter on The Family is given. The important role of the physiotherapist as "Keyworker" in the community is linked with her personal qualities as well as her professional expertise, so that she can be of real help to a child and the family. A multidisciplinary back-up for any Keyworker is also well presented. The physiotherapist and parent are made well aware that movement difficulties are not only due to motor factors but also involved with other aspects such as vision, communication, learning and behaviour.

The authors' broad and open-minded view inevitably lead to statements such as "there is no such person as a typical child with Cerebral Palsy and why it is impossible to be dogmatic about any single method of treatment or education ..." (page 44). They recommend "flexible use of all possible approaches" which a number of us heartily support. Their views on the limitations of Conductive Education for British children are interesting as are their comments on a neurological approach to treatment. The fact that a child's motor development also depends on his relationships, his understanding of all

stimuli from his environment and not only from receiving sensory stimuli provided by handling, must surely show the limitations of a purely neurophysiological approach such as that of the Bobaths. We as physiotherapists need to be aware of how a child learns to move and not be limited to the one model of sensory-motor experience provided by a therapist. In various chapters this book develops such a wider awareness.

The reader should not expect "how to do it" from the book although some general principles are presented. The tempting morsel of detailed motor patterns given in a normal, spastic and athetoid baby in pictures, only presents a way of looking at a child's motor difficulties. It is not followed by what should be done for them.

This may be disappointing for parents studying this book, but if they can refer this to a paediatric physiotherapist, then help can be provided. Unfortunately, such a physiotherapist is not always available in every area of this country. Nevertheless the many other features of the book will illuminate parents so they have some knowledge with which to deal with what the neighbours, media or relations recommend they do with their cerebral palsied child. This book is certainly worth having!

Sophie Levitt

### **Overcoming Difficult Behaviour**

**John L. Presland.**

**BIMH Publications. £19.95 Pbk.**

Written on the assumption that the reader has little previous knowledge of dealing with, and overcoming difficult behaviour, this book is an endeavour to enable help to be given to people of all ages with a severe mental handicap.

It is heartening to note that particular care has been given to include those with a profound mental handicap and those with multiple handicaps, and the author recognises that whilst the key principles of dignity, rights, independence, availability of professional services and protection from exploitation must be remembered, often the behaviour problems to be overcome make these problems difficult to apply. A systematic account of the range of techniques available is given in the first section, with suggestions on how they may be implemented whilst the next section takes a group of related problems, discusses them and makes practical recommendations for intervention, giving many examples, and stressing the need for recording, planning and putting into practice.

In the final section the need for high staffing levels to carry out programmes is discussed, together with training for staff, and the legal and ethical concerns associated with intervention procedures. There are four appendices and an extensive bibliography. Anyone who has worked with a mentally handicapped child or adult, will undoubtedly recognise many of the behaviours which are highlighted and find the recommendations helpful, whilst agreeing that difficult behaviours are more manifest when boredom sets in if interesting activities are not available.

This is a thoroughly interesting and readable book for any bookshelf on the subject of behaviour in mental handicap, and well worth careful study. However, one does just wonder if the trained staff necessary to carry out the programmes will ever be available in sufficient numbers.

J.E. Lamond

APCP

## **Action Record for Problem Behaviour.**

**J.L. Presland 1989**

**£0.95 post free from:-**

**BIMH Publications, Stourport House, Stourport Rd., Kidderminster, Worcs.**

This Action Record is intended for use with the book "Overcoming Difficult Behaviour" (Presland, 1989) and consists of a pack of 19 forms, to be used for recording intervention techniques, and some which may be helpful for some interventions, but not others. There is a brief guide on how to use the forms and permission is given to reproduce them where duplicate copies are needed. They provide a guideline for staff embarking on recording of problem behaviours and one set should give an overall picture of the interventions needed for one person.

J.E. Lamond

APCP

## **A Guide to Training Resources in Mental Handicap**

**1st Edition**

**L. Averill, H. Lee and D. Felce.**

**Published by BIMH £7.50 pbk.**

This book will be found useful for anyone involved in staff training, as a resource for lists of films, video cassettes, booklets and tapes. Divided for easy reference into sections covering Attitudes and Philosophy, Planning and Managing Services, Working with Service Users, and Areas of a Person's Life, it provides quite a wide scope for use with training courses. The last section of the book has a useful list of addresses offering other sources of Training, Development, Evaluation or Consultancy. I feel that this is a book which will expand in further editions as more material becomes available, but is still a convenient source of reference as it stands.

J.E. Lamond

APCP

## **COURSES**

**Date:** 21st June, p.m. (for time, see Reg. Rep.) **WELSH REGION.**

**Subject:** Paediatric Neurological conditions requiring physiotherapy.

**Speaker:** Dr. Sheila Wallace, Paediatric Neurologist.

**Venue:** Child Devel. Unit, West Wales General Hospital, Carmarthen.

**Date:** 22nd - 24th June (Fri. - Sun.).

**Subject:** Developing Services - Residential Workshop.

**Course Organisers:** Assoc. of Professions for Mentally Handicapped People.

**Venue:** School of Advanced Urban Studies, University of Bristol.

**Cost:** £60 - APMH Members £80 - Non Members

This workshop will examine the major issues facing consumers and service providers as we prepare to enter a new decade. Together we will explore how the resources tied up in services can be used most effectively.

Further information from:- APMH, Greytree Lodge, Second Avenue, Greytree, Ross-on-Wye, Herefordshire HR9 7HT.

<b>Date:</b>	<b>5th - 8th July 1990 (Thurs. to Sunday)</b>		
<b>Subject:</b>	Sensory Intergration		
<b>Course Tutor:</b>	Jenny French & Team		
<b>Venue:</b>	Chester College Conference Centre		
<b>Cost:</b>	Residential	APCP Members	- £110
		Non Members	- £125
	Non Residential	APCP Members	- £55
		Non Members	- £65

This is a residential course but there will be a limited number of non-residential places.

Further information and application form from:- Lyn Wakley, 2 Ash Bank, Pipers Ash, Chester CH3 7EH.

<b>Date:</b>	<b>7th July - all day WELSH REGION</b>		
<b>Subject:</b>	Legal Aspects of Paediatrics		
<b>Speaker:</b>	Mrs. Brigit Dimond, Dean of Faculty of Law at the Polytechnic of Wales.		
<b>Venue:</b>	To be decided - ref. to Reg. Rep.		
<b>Cost:</b>	Ref. to Reg. Rep.		

All professionals working with children will be welcome to attend. Brigit Dimond is well known for her work in the legal field of the Health Service, and has written many articles or legal topics for 'Physiotherapy' and 'Therapy Weekly', and has just published a book on legal matters for health care professional.

The A.G.M. for the Welsh Region of APCP will be held at lunch-time during this study day.

## CASTLE PRIORY COLLEGE

Details and application forms from Castle Priory College, Wallingford, Oxfordshire OX10 OHE. Tel: (0491) 37551.

<b>Date:</b>	21st - 23rd May	<b>Course No.</b> 26/25
<b>THE AVOIDANCE OF LITIGATION - COPING WITH THE CONSEQUENCES.</b>		

<b>Date:</b>	10th - 14th June	<b>Course No.</b> 26/49
<b>HALLIWICK SWIMMING METHOD PARTS A &amp; B.</b>		

<b>Date:</b>	15th - 17th June	<b>Course No.</b> 1 26/53
<b>THE PROFOUNDLY HANDICAPPED CHILD WITH CEREBRAL PALSY - CHANGING MOTOR PATTERNS.</b>		

Tutor: Ester Cotton.

<b>Date:</b>	29th June - 1st July	<b>Course No.</b> 26/63
<b>AN INTRODUCTION TO PORTAGE.</b>		

<b>Date:</b>	6th July	<b>Course No.</b> 26/64
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**QUALITY ASSURANCE - A FRONT LINE APPROACH.**

## HERE AND THERE

### \* **Conductive Education**

The Spastic Society and Star Organisation for Spastics will spend £2.3 million on providing 52 more places for Cerebral Palsied children at Ingfield Manor School - this will almost double the full time places for children there, bringing the number up to 60 places.

The Spastic Society are also intending to establish Conductive Education parent training centres in Scotland, Nottingham and the West Country.

ASBAH has rejected media claims that the Peto Institute can help with incontinence and warns that C.E. could harm children with Spina Bifida. It advises families to consult paediatricians - or ASBAH itself - before going to Hungary.

- \* An article about Emmett de Monterey, the 13 year old boy who underwent intensive orthopaedic surgery at Newington Hospital, Connecticut, after first having his gait analysed in three dimensions in a computersised gait laboratory, has won a prize. The Chartered Society for Physiotherapy awarded the author a £500 prize for the best newspaper coverage of disability - the article appeared in the South London Press, July last year.
- \* The Handicapped Adventure Playground Association has produced a video showing a typical day at a H.A.P.A. playground.

Further details are available from Maggie Walker, H.A.P.A., Fulham Palace, Bishops Avenue, London SW6 - Tel: 01 (or 071 after 6th May) 731-1435.

*"The New Information Leaflet....."*



The new information leaflet published by ACP was launched at the National Conference in Loughborough this year. This well produced informative leaflet can be used in many ways, and is available from: The Hon. Sec., ACP, c/o Professional Advisor, The Chartered Society of Physiotherapy, 14 Bedford Row, London WC1R 4ED.

## Some steps in TEACHING YOUR CHILD TO SIT

Evie Bower M.C.S.P.  
Illustrations by Alison Chapman



- Ask advice from your child's doctor before starting on these steps.
- Your child should be 5-6 months old before starting on these steps.
- Ask advice from your child's therapist if you have difficulty with any of these steps.

This pamphlet has been produced on lines similar to 'Some tips on Lifting Your Child'. It shows how to help children with physical disabilities get themselves into the sitting position and various methods of support. It can also be used as a poster.

Available from:-

Dragon R. & D. Ltd., 6 Church Row, London NW3 6UT.

Cost 1 copy - £1 incl. p. & p.

10 copies - £6 incl. p. & p.

- \* T.A.G. - The Arthrogyrosis group has reproduced their information leaflet which describes very briefly the disability, development and aims of the society, and how the public can help.

Available from regional contacts or the Secretary, Lawrence Robinson, 27 Mellesham Close, Macclesfield, Cheshire SK11 8NH.

- \* Pupils at Northumberland Park Community School, North London, demonstrate a blow football game they have designed as part of the Access for All Scheme organised by Andy Somers, head of craft, design and technology at Haringey comprehensive. The aim is to improve the quality of life for disabled people.

### \*APCP CONFERENCE 1992

The 1992 Annual Conference is being held in March in Norwich.

It is planned to have a European flavoured programme as this is the year we go into Europe. I would be delighted to hear from anyone who has worked in Europe who

could suggest speakers or offer contacts with paediatric centres of excellence.

Please ring: Lyn Weekes 0582 460447 evenings or 092385 7315 day time as soon as possible.

- \* 'Paediatric Interest People' has now changed its name and is known as the National Association of Paediatric Occupational Therapists.
- \* Congratulations to Sophie Levitt who has this year been awarded the Swedish Foundation FOLKE BERNADOTTE STIFELSEN. She is the first physiotherapist from outside Sweden to be granted this award, and it is normally given to doctors. Count Folk Bernadotte, nephew of King Gustav V, had much to do with the setting up of services for Cerebral Palsied children in Sweden. Following his murder when in service with the UN in Israel, the Foundation has continued to develop research and studies concerning children with physical disabilities. As their guest lecturer in 1990, Sophie will be in much evidence in Sweden this year.

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## LETTERS TO THE EDITOR

Hello!

I am a Swedish physiotherapist working with handicapped children.

We live in the northern part of Sweden, in Ostersund, nearby the Great Lake. In this lake lives a monster, a cousin to Nessie!

I have read a lot about your treatment of handicapped children and found it more varied than it is here in our country.

I would like to visit your country this summer, of course as a tourist, during my vacation, but if it is possible, have the opportunity to see and learn something about my work.

My secret dream is: Rent a summerhouse and the owner be a physiotherapist whose work is with handicapped children.

My family: My husband Kenth (Med. Lab. Tech.), Frederik 15 years, Kristin 12 years, and Anders 3 years. and myself Annika.

Can anyone help me!

Annika Kampenber, Frosövagen 57C, S - 83200 Frosön, Sweden.

Dear Madam,

### **Vitalograph.**

A Vitalograph machine is used in the CF Clinic at Southampton General Hospital to assist the patient's current lung function.

In order to minimise the risk of cross infection between CF patients, a valved cardboard disposable mouth piece is used for each individual.

Unfortunately Vitalograph do not manufacture a paediatric size disposable mouthpiece, forcing our younger children to have to stretch to use a large adult one.

Vitalograph assure me there is not a demand for such a mouthpiece and do not have plans to make one.

I would be interested to hear any comments you may have.

Claire Olsen, Sr. Paediatric Physiotherapist, Southampton General Hospital, Southampton SO9 4XY.

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## REGIONAL REPORTS

### E. ANGLIA

**Reg. Rep. Mrs. Jackie Reynolds, Physiotherapy Department, James Paget Hosp., Gorleston, Gt. Yarmouth NR31 6LA.**

Our Annual General Meeting was held on Friday 2nd March at Hillingdon General Hospital. Three committee members were re-elected and five new members were elected. Jackie Reynolds is our new Regional Rep. Your committee now consists of:-

CHRIS BURNET, The Hollies, High Street, Taplow, Berks. SL6 OEX.

SHEILA CREE, Tanglewood, Burtons Lane, Chalfont, St. Giles, Bucks. HP8 4BB.

BERYL DALE, Marchmont, Loudhams Wood Lane, Chalfont, St. Giles, Bucks.

LINDA FISHER, Branwood School, Gruisch Avenue, South Ockendon, Essex.

ANGELA GLYN DAVIES, 52 Southdown Road, Harpenden, Herts. AL5 1PQ.

MARY GOY, 39 Tithe Barn Drive, Bray, Maidenhead, Berks. SL6 2DF.

JO HIMMONS, 37 John Street, Lowestoft NR32 OEX.

PIPPA JURY, 51 Eastfields, Narborough, Norfolk.

PAT MESSAM, 62 Lynn Road, Frunstone, Kings Lynn PE32 1AB.

FRANCES THOMAS DAVIES, Collins Farm House, Loosely Row, North Aylesbury, Bucks.

LIZ WAUGH 'SANDERSON', 18 Rosthay Place, Bedford MR40 3PZ.

LYN WEEKES, 37 The Cedars, Milton Road, Harpenden, Herts. AL5 5LQ.



A most informative study day on "Juvenile Polyarthritis" was held on 2nd March. Our special thanks to the people who took part in the patient demonstration.

Our next study day will be held on Saturday 23rd June in Great Yarmouth and the topic is "Chronic Chest Conditions". Application form enclosed with this newsletter or apply to Chris Burnett, address above.

#### **N. WEST**

**Miss L. Wakely, 2 Ash Bank, Pipers Ash, Chester CH3 7EH.**

On Saturday 10th March 1990 the region held its A.G.M. at the District Education Centre, Halton Hospital, Runcorn. It was combined with an extremely interesting Study Day entitled: "Neonates At Risk". The next meeting: "Cystic Fibrosis Update" is being held at Alder Hey Children's Hospital on Saturday 12th May 1990. This is followed in July by a 3-day residential course in Chester on Sensory Intergration (see details under forthcoming courses). The final study day this year is being organised in S. Cumbria for early October. It will be covering several different aspects of Mental Handicap.

#### **N. EAST**

**Mrs. J. Baigent, Physiotherapy Dept., Scarborough Hospital, Scalby Road, Scarborough, N. Yorks.**

On March 17th we had a very interesting study day on the hip joint in cerebral palsy. In the morning Mr. R. Baker, Orthopaedic Surgeon from Sheffield, spoke briefly on the surgical management of the hip, and then very bravely answered questions for well over an hour. In the afternoon, David Scrutton spoke on the natural history and physical management of the hip and told us about his research project. This was a very stimulating day and well attended.

We held our A.G.M. on the same day, when it was decided that, in future, we will have more study days and less evening meetings. This is because of the difficulty a lot of people have in travelling the long distances involved in such a large region.

Helen Hyams resigned from the committee, after 2 years as Chairman because of family commitments and we would like to thank her for all her hard work in the past. We have three new committee members, hopefully all with masses of new ideas, and we held our first meeting in April to arrange the programme for this year.

#### **N. IRELAND**

**Ruth Graham, 75 Ravenhill Gardens, Belfast BT6 8GQ.**

Our programme of bi-monthly evening lectures continue. The speaker for the March meeting was Dr. Barbara Bell, Consultant Paediatrician, who spoke on cot death in N. Ireland and provided us with a very interesting and thought provoking look at this subject.

A 2-day course on the Bobath approach to the treatment of children with cerebral palsy is planned for May 11th and 12th. The speaker will be

Colin Stephens from the Bobath Centre who will be making his third visit to the N. Ireland Branch. He will be concentrating on the more severely affected child. Response has been very encouraging.

**W. MIDLANDS Carol Foster, Supt. Physiotherapist, The Children's Hospital, Ladywood Middleway, Ladywood, Birmingham B16 8ET.**

The A.G.M. of the West Midlands Region was held on Tuesday 6th March 1990 in the Physiotherapy Gym at Solihull Hospital with the kind co-operation of Mrs. S. Bazin - Superintendent Physiotherapist at Solihull Hospital.

It was attended by some 35 members and the evening was enlightened by Mr. C. Bradish FRCS, from the Children's Hospital, Birmingham, who talked about "Funny Walks", a perennial problem to most Physiotherapists.

West Midlands membership presently stands at 76 paid up members, including some 17 new members to whom we offer a warm welcome. We also have some 50 lapsed members - so come on - renew that membership and support your local committee.

Three new committee members were elected and the new committee will be meeting on the 21st April 1990 when a new programme of meetings for this year will be drawn up. Please let me know of any specific topics that you are interested in and we will try to include them in the programme. The new programme will be circulated to all members.

**S. WEST**

**Miss G. Riley, Children's Unit, Odstock Hospital, Salisbury, Wilts. SP5 5BD.**

The study day organised for May 19th on Conductive Education will take place at Southmead Hospital, Bristol. Speakers include Lillmore Jernquist, director of the Hornsey Centre, London, and Anne Cresswell from the Ormerod School, Oxford. This day will be especially useful for those people who are still uncertain about the benefits of Conductive Education. There will be ample time for discussion.

There are some changes on the regional committee as Anne Hyland has resigned as Treasurer having got our finances in excellent working order. She is being replaced by Judith Lott from Poole. A nomination has been received for the new Regional Representative. This will be confirmed at the A.G.M.

The Physiotherapists in W. Essex are planning to meet together to discuss changes in education and the possible formation of several Conductive Education groups in schools within the area.

A study day is being planned for the autumn.

## SCOTLAND

**Miss Anne Harden, Physiotherapy Dept., Royal Hospital for Sick Children, Yorkhill, Glasgow G3 8SJ.**

Our study days continue to be well supported - thanks to all members.

A highly successful day was held on March 3rd - the topic being Hip Management - Current Trends. The main speaker was David Scrutton and there was noticeable lively discussion throughout the day. Our A.G.M. was also held pre-meringues!

The committee is eager to hear members' views on future topics for study days. Ideas can be sent to Anne Harden or your local committee member.

## TRENT

**Mrs. Meagher, 9 Oak Road, Thulston, Nr. Elvaston, Derby DE7 3EW.**

The sixth A.G.M. of Trent A.P.C.P. was held at the school of Physiotherapy, City Hospital, Nottingham on Wednesday 7th March 1990. Members heard Jenny French talk on Differences in Paediatric Services between U.S.A. and Britain. Jenny's whistle stop tour was truly amazing. She completed three courses within 18 days in U.S.A., was observed completing the Sensory Integration and Praxis Test battery, (a four hour practical test and completed a four hour final paper). Her talk provoked lots of questions afterwards.

As most of the committee were due to retire and nominations had been received, new members were duly elected onto the Trent committee. Because there was not sufficient time at the A.G.M. there will be a meeting to elect these new committee members to their new positions. We give them a hearty welcome.

The committee would like to thank all local members for their loyal support and hard work in arranging the National Conference at Loughborough and for the help given by the national committee.

## WALES

**Reg. Rep. Lyn Horrocks, Children's Centre, University Hospital, Cardiff, Wales.**

On 19th March, the first day of National Physiotherapy Week 1990, we held an evening meeting at the Children's Centre in Cardiff. This was an opening meeting for any professionals to come and hear about Paediatric Physiotherapy in the Nineties.

Julie Wilding talked about doing the Second Bobath Course - this is the first stage in becoming a Bobath Tutor, which Julie completed in October/November 1989. She will now be able to assist in teaching on the eight week Bobath course being held in Cardiff, starting in April.

Viv Williams talked about the work involved in the writing of the recently published 'Code of Good Practice' Guidelines for Paediatric Physiotherapists. This was launched in time for National Physiotherapy Week and should provide positive publicity for paediatric

physiotherapists. We heard from local therapists about their projects during National Physiotherapy Week, including posters, display boards, coffee mornings in Special Schools, selling pens and balloons, and sponsored events.

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## NOTES