
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

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EDITORIAL

Vivienne Williams, Vice Chairman APCP

WELCOME TO WALES!

The 18th Annual APCP Conference in Cardiff will follow on from the 11th International Congress of the World Federation for Physical Therapy at the Barbican in London from July 28th - August 2nd 1991.

Those of you who went to meet Merlin the dragon and 'Puff' at Loughborough will be pleased to know that they are working hard to make your conference a success. Puff took two of the Welsh Committee to the C.S.P. Annual Conference at Bournemouth in September to publicise the programme and aroused great interest.

1991 will mark the first International Conference organised by A.P.C.P. and the first conference run jointly with another Clinical Interest Group. Working with the Respiratory Care Group has opened our eyes to how much we all have in common as well as being great fun.

On Saturday 3rd August there will be a choice of Neuromuscular conditions or Paediatric Respiratory Care conditions. Sunday's programme, 'Caring for Children' brings it all together with a variety of workshops of interest to a wide range of professionals - so do invite your colleagues.

Realistic hotel prices have been negotiated. Family and friends will be welcome. Special social events will be organised to give you a flavour of Welsh culture. The Conference Dinner will be held in the Banqueting Hall of Cardiff Castle as the highlight of the weekend.

So, why not turn to the centre pages now and write to Lyn Horrocks at our Freepost address for full details.

Remember! We will be there to welcome you at St. David's Hall, Cardiff, from August 2nd to August 4th 1991. See you there!

SUBSCRIPTIONS FOR 1991 ARE DUE BY 1st JANUARY

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Health Services for Children

Professor D. Hull BSc MD PRCP

Foundation Professor of Child Health, Nottingham University

"The management of The Health Service for children has been occupying much of my time of late.

I am by training a childrens' doctor and not a professional manager or business man but I share with others the responsibility for ensuring services for children flourish under the new arrangements proposed by the current legislation on the Health Service.

Over the past year I have had numerous requests for information about various aspects of my work from Regional and District Health Authorities and the Administration of the University to which I am attached. They have asked for information on Model Service Specifications, Capital Asset Accounting, Clinical Directorates, Departmental Objectives, Staff Appraisals etc. etc. using the Management speak which is the trade mark for the current changes in the Health Service. Although I have served on 50 committees over the past 10 years, all linked with the development of childrens' services, I have still failed to understand the overall strategy for the proposed changes.

To help me understand the new world of management, I selected two text books - 'The Management Evolution' by C.A. Appleby, and 'Global Manager's Principals' by R. Lessem. I bought a paper back by Arthur Young, 'The Manager's Handbook' and re-read Lewis Carrols 'Alices Adventures in Wonderland'!

According to Appleby, 'management' is getting things done through the efforts of other people. This requires planning to: determine needs, establish objectives, outline procedures, and assign responsibilities: and control which involves drawing up a structure for the organisation, and, an agreed programme of supervision. Lessem suggests management is about organising people and discusses four domains:

1. Primal Domain - based on economics and anthropology.
2. Rational Domain - based on administration and behavioural science.
3. Developmental Domain - founded in ecology and biology
4. Metaphysical Domain - based on traditional wisdom and modern physics

Alice on the other hand had several encounters which illustrate the dilemmas experienced by many during the current reorganisation - whilst swimming in her own tears she asked a mouse swimming with her "Ou est ma chat?" The mouse objected strongly although he was the most likely to know.

The old man explaining why he stood on his head said that with time he had realised there was little in it. And the Cheshire cat remarked there was little point in asking directions if you don't know where you want to go!

We must have a vision of what we want (objectives), and look for ways to enable it to be achieved (strategy) if we wish to improve our service to children.

Objectives

In Nottingham we have accepted the simple view that it is better to say something rather than to stay silent, dreaming of an ideal.

The Government requires (through the White Paper) that Regional and District Health Authorities should ensure that the health needs of the population which they serve should be met through 'contractual objectives':

That there are effective services for the prevention and control of disease, and promotion of health;

That the population has access to a comprehensive range of high quality value for money services;

That they set targets for and monitor units for which they continue to have responsibility;

The aims of those concerned with the service for children in Nottingham are:

To give a quality service to all children when and where it is most appropriate;

To support the family in the care of their child;

To ensure that as many children as possible reach adulthood with their potential uncompromised by illness or environmental hazard;

To provide a single comprehensive service;

To introduce audit in the framework of quality management.

What is odd about all this is that it should be the management who determine the objectives. It is not for the providers to do so. No doubt with the passage of time and a clearer direction within the organisation this will change.

A single Comprehensive Service

The treatment service operates at three levels:

Primary - G.P.'s, health centres, surgeries

Secondary - the specialist referral

Tertiary - a highly specialised service possibly not available outside teaching centres.

The great problem is to defend resources and activities for the long term strategies of health promotion and sickness prevention against the immediate calls for sickness care.

Audit within framework of Quality Management

The problem with the introduction of audit as described by the White paper is that it suggests that it makes sense as an activity in isolation. It does not. It only makes sense against the background of quality management.

It is necessary to set up a quality system and then quality control before it is possible to consider quality assessment which includes audit... unless audit is used in the very limited guise of Doctors/Therapists reassuring themselves that they have achieved what they expect of themselves.

We must start by describing our services

Quality Management

In each service element, information is required on:

- Need
- Policy
- Management
- System
- Control
- Assessment

Only at this level do we reach a key feature of the new planning - that the service is driven by need.

Need and want are not the same:

Current usage may well end up being the accepted measure at the beginning:

We shall have to develop more sensitive measures if the service is to be equally available according to need.

To guide Government Ministers, it will be necessary to provide them with outcome measures as a basis for the redistribution of resources. There is a degree of urgency to establish the list of such measures and determine their worth.

Managing, Accounting, Marketing, Logos:

I have not ventured into cost accounting and when I think of marketing my anxieties increase further, yet I expect it cannot be avoided. Those around us are brushing up their corporate image: their logos change and project different images.

Should we have a logo that suggests stability, caring, old fashioned values? Or a more 'with it' dynamic image?

Conclusion

The object of a children's service is the delivery of health care to children: the item or service is the interaction between the health professional and the child. It is the quality of that relationship which is paramount.

The aim of good management should be to allow professional care to flourish.

At the present time, the principles, style and practice of the management that will best achieve this end are still to be defined.

There is no doubt the new legislation will clarify our thinking: it may well present opportunities to improve our service.

Whatever our views about the political philosophy behind the changes, for the children's sake we must do our best to ensure the management arrangements are effective."

(Transcription by Noreen Hare from The Hugh Greenwood Lecture, University of Exeter 1990)

Life in the Inner City

**Rowenna Hughes, Superintendent Physiotherapist
Camberwell, London**

To be able to organise an effective and acceptable Paediatric Community Service one must understand the background and mix of the people to whom the Service is being targeted.

The district I am working in is a suburb of London - Camberwell, which in the 1940s was a fashionable place to live with wide tree-lined streets, large houses with gardens, excellent schools, most families had cars and there was a great community feeling and people enjoyed a good standard of living. This changed, when in 1950 to 1960 Britain, to help the employment situation had to turn to the less developed countries with which it had historical links. This resulted in an influx into Britain of different nationalities and cultures who settled in the larger cities, London being one of them.

Two groups of people settled in Camberwell -

- 1) People who were hoping to come to England to make a fortune and return to their families and friends. This did not happen and is known as 'The Myth of Return' - an example of these are the West Indians;
- 2) Refugees who fled from their own country for safety and survival - an example of these is the Vietnamese Boat People. And so the district is now made up of groups of people in many different stages of settlement and motivation. There is also the second generation of migrants living in this country where they were born but their parents are from another country.

The social structure of the migrant community will be determined by a variety of factors and one cannot treat every group in the same way - every group has enormous regional differences. Some of the different ethnic groups we have in Camberwell are:

1. The West Indians - these are one of the largest ethnic minorities in this country and every island has its different cultures - for example Jamaica and St. Lucia.
2. The second largest are the people from the Indian Sub-continent, known as 'Asians' which is a name we have to reluctantly accept as these people share neither a common religion or a common language or culture. An example of these are the Moslems.
3. The Chinese - these people come from the rural and undeveloped areas, usually villages and some have come to England to escape political or racial persecution, but not hopeful of greater prosperity, especially the Vietnamese people. The needs of these people are so great, that the Health Authority found it necessary to appoint a 'Vietnamese Link Worker'.
4. The Afro-Caribbean are another group of people who have come over here and have had to accept cramped and decaying housing conditions, split families, no family support and the children have to be looked after if the parents go to work - they have to have kin fostering or else crisis fostering in this country.
5. One must also remember the geographical and genetic factors and in this Health Authority there are a large number of families with Sickle Cell disease.

So, in Camberwell, we have many different ethnic groups in different stages of settlement and motivation and this changes all the time. So if one is offering a service to the children in this

community, we must remember that cross-cultural care needs more than clinical facts and that:

1. Cultures provide their own rules and standards
2. Every culture has its own system of help, beliefs and ideas. We need to understand them and be understood by them in order to provide a good and effective service.

CAMBERWELL HEALTH AUTHORITY

Population approximately 220,000 - made up of the London Boroughs of Lambeth and Southwark, most of the area densely populated.

INNER CITY AREA CHARACTERISED BY:

1. Large multi-ethnic and multi-cultural population.
2. High level of unemployment.
3. High number of one-parent families.
4. High incidence of poor and overcrowded housing.
5. High incidence of child abuse and drug abuse.
6. Homeless and rootless.

The Sheldon Centre is based in Peckham which is one of the most heavily populated and deprived areas of Camberwell Health Authority. It is one of the first child assessment and treatment centres in the country and it is the base of the Community Unit as well as a base for the Therapists who provide a service for local schools and nurseries. Any child with special needs can be referred to the Centre for assessment.

The multi-disciplinary team comprises doctors, speech and occupational and physio-therapists, specialist health visitors, clinical psychologists and social workers. There is also a nursery for children with behavioural problems.

The physiotherapists are also part of the hospital team and they treat children in the S.C.B.U. and also the acute wards at Kings College Hospital. This is excellent both for the parents and children as well as for the therapist. It provides a continuity of treatment from the hospital into the community.

When one is thinking of offering a physiotherapy service, every child has a right to treatment and management of the highest quality within the resources available. Treatment and management must be tailored towards the child and carers' individual needs and consideration must be taken as to:

- a) Situation - where the child is at home or in nursery school;
- b) Culture; and
- c) The resources available

It has still been found that the most effective way and economical way of caring for the handicapped child is working with the parents or carers as partners, so a great deal of time and effort must be put in by the Therapist to foster links with the parents or carers of the children. One must remember when we are assessing the children, the parents norm may not be our norm and the service must be:

1. Acceptable, and
2. Accessible.

We may have to adapt our service to fit into the needs of the children. In some cases, our standards

may not be of the highest quality that we would like, but it is better to have some contact with the family than not to have any treatment at all. The physiotherapist must also accept that this is a two-way learning process. We have learnt many things about the different cultures in the community, such as the massage and exercise the African mothers or grandmothers perform on their children.

Another excellent idea for the Community Service are the multi-disciplinary groups set up for the children with special needs - these have proved very successful. We are now running five different groups - one is for Down's Syndrome, another is for the continuing care of the premature baby, and the other for children with special needs of varying disability. Parents are made to feel welcome to attend the groups as long as they wish - even if their child has overcome their problems they can then support other mothers who are having similar problems themselves.

Every child has an individual programme of treatment tailored to their needs for their treatment and management, photographs are provided which help parents and carers wherever the child is being managed - in nurseries or schools; this also overcomes the language difficulty.

Transport is provided by a Variety Club bus and this is very essential as many of the parents have no form of transport - they may also have one or more siblings plus a handicapped child. Other ways of helping the service:

- 1) The physiotherapists have recently had a simple leaflet printed describing the service and this has been translated into 8 different languages.
- 2) We have been raising money to start an equipment library and we are now able to assess children and lend equipment to parents when they need it. This again helps with the limited resources and fills the gap between the long delay at times for equipment that has been ordered.
- 3) On-going liaison meetings with staff in Education and Social Services - this is very important in the current trend of changes.
- 4) Teaching sessions take place at the Sheldon Centre - these can be for: a) Nursery nurses as we visit 18 nurseries; b) Teachers, as we are now providing a service for the seven special schools and the 19 schools in which our handicapped children are being integrated. These sessions have proved very successful and are on-going.
- 5) FLIP/PORTAGE meetings are held once a month where children are discussed who need the extra support.

One must remember when one is living in an inner city area like Camberwell, parents and families are less likely to have access to support and care which good housing, regular employment and good friends provide. Therefore the gap has to be filled by statutory and non-statutory services throughout the country.

When one is planning a service, one must not forget the staff - especially when one works in an area of such deprivation:

1. Support - it is necessary to have a base where discussion and teaching take place and also help and support can be given to every member of staff working at the Centre.
2. Security - Peckham has very many 'no-go' areas and the staff must be aware of this, one must know where your staff are visiting and time of these visits. Panic alarms have been provided and we are in the middle of discussion for two-way radios. There is a car-leasing scheme from the Health Authority, this again provides extra support and security for staff.

3. Skills - as well as aiming for the highest level of professional skills it is important that they have some idea of counselling as to how much they can give themselves and when to seek professional advice. Stress - they should be able to identify stress in themselves, their patients and their colleagues.

It is important that some research takes place in a department and at present 2 members of staff are involved in research projects. One is looking at the social deprivation in an area of Brixton, and whether it has any effect on the motor development of the children; the other is carrying out a follow-up of the premature babies at the age of 2 - 4 years.

One must realize that a Community Service changes all the time. Not only having to consider the changing population but also the new government proposals for Health Care and also for us the abolition of the Inner London Education Authority.

QUALITY ASSURANCE

One must always evaluate the service - looking at practice and resources. We may feel we are providing an excellent service but is it the best? To help us look at the quality of the service, we asked a group of independent professionals to assess our parent support group to see if we were meeting the service needs.

This was an interesting and worthwhile experiment both for parents and staff and we are now looking at other areas of our service.

We must aim with the available resources to provide the most effective and efficient treatment and management service to our handicapped children and carers. So helping to improve the 'Quality of Life' in one of the most deprived areas in this country.

Sensory Integration and the Dyspraxic Child

Jenny French B.A., M.C.S.P., Child Health Manager, N. Derbyshire H.A.

Judith Peters B.A.M.C.S.P., Sen. Physiotherapist, Ealing H.A.

Inge Gregorius M.C.S.P., Sen. Physiotherapist, Sheldon Centre, S. London

There are a variety of different treatment approaches that can be adopted to help the 'clumsy' child.

Sensory integration therapy is just one of these and refers to the theory and treatment originated by Ayres (Ayres 1972).

Many labels have been used over the years to describe the diverse problems resulting in clumsiness which may cause motor difficulties, learning difficulties and often emotional /behavioural difficulties. Parents have formed a support group named the Dyspraxia Trust. They have chosen the term Dyspraxia as they feel it best describes the many problems their children may have, including problems of motor coordination (praxis = motor planning). For this reason I use the term to describe the group of children we are concerned with.

WHAT IS SENSORY INTEGRATION?

Sensory integration is the basic neurological process by which we receive sensory input from the environment via vision, hearing, muscle and joint receptors, touch organs and the balance mechanism of the body. This information we correlate and interpret and an appropriate response is made. (Ayres 72)

Dr. A. Jean Ayres, an occupational therapist and psychologist, developed the theories of Sensory Integration over the past 30 years and although much research has been undertaken throughout the world, very little has been done in the UK. Physiotherapist and OT's world wide are using the principles of SI to treat children with sensory integrative deficits. The dyspraxic child may have problems that would benefit from SI input, but, treatment techniques chosen to treat the child will depend on a very thorough assessment by an experienced therapist, who has trained in the principles of sensory integration.

After thorough assessment the therapist will determine which form of intervention is most appropriate.

The treatment choices may be drawn from the following approaches:

- Visuo-Perceptual (Frostig, Kephart)
- Kinaesthetic Sensitivity (Laslo and Bairstow)
- Neurodevelopmental (Bobath)
- Skill acquisition training (Grimley and Gordon)
- Psychomotor Treatment (Baker)
- Sensory Integration Therapy (Ayres)



“Using through net to facilitate vestibular stimulation”

WHAT IS SENSORY INTEGRATION THERAPY?

Sensory Integration Therapy differs from different therapy in the following ways:

- 1. Hollistic :

The child is assessed as a whole in order to ascertain how sensory integrative dysfunction is interfering with his motor coordination, motor planning and the effect this may be having on his learning ability, his self esteem and his ability to cope in the world around him.

- 2. Non prescriptive:

The therapy intervention is not based on a programme of predetermined exercises but on providing a suitable environment to allow the child to explore and learn. Challenging activities (not too easy or too difficult) teach him to organise his body to produce appropriate adaptive responses for each situation.

- 3. Improving concentration.

Many of the children are unable to complete tasks and may wander from task to task because they cannot inhibit all the environmental information they are receiving through their senses. Sensory integration therapy helps them become more efficient at filtering information received and organising motor output.

- 4. Self Esteem

Works on building up the child's inner drive and therefore giving them the means to decide and plan activities in the therapy situation which can be carried over in classroom and at home.

- 5. The method of assessment is very thorough. The Southern California Sensory Integration and Praxis Test (Ayres) and post rotary nystagmus test (Ayres) are standardised tests and are used in conjunction with clinical observations. Thorough sensorimotor assessment can determine if dysfunction is present and can differentiate problem areas for appropriate remediation. (Montgomery and Richter 86)

Treatment is based on the assessment findings and is concerned primarily with difficulties in vestibular (balance), proprioceptive and tactile systems. Although sensory integration incorporates some of the principles of the sensory and motor perceptual approaches (Pratt and Allan 1989) the goal of therapy is to improve the way the brain processes and organises sensation and not to teach specific perceptual or academic skills (Morrison 1985).

The outcome of therapy is directed towards integration of sensory building blocks enabling the child to achieve success of more complicated tasks.

SI is fun. Use is made of the therapists skills and equipment (including scooter boards, swings, hammocks and other forms of suspended equipment) to help develop the vestibular, tactile and proprioceptive systems. Children usually require 6-12 months intervention as compared to much longer periods of treatment intervention using traditional methods.



"Judging space and distance and making full use of gym in ordinary school"

WHERE IS SENSORY INTEGRATION PROVIDED?

SI is an appropriate form of intervention suitable to use in schools or clinic, providing sufficient space can be made available. It is important that the child does not feel he is withdrawn into a medical environment which may only add to his idea that something is wrong with him, or that he is different from his peers. Often hall time can be booked in school if the school understand the nature of the child's difficulties and the type of intervention being offered.

WHO CAN PROVIDE SENSORY INTEGRATION THERAPY?

Physiotherapists or Occupational therapists who have undergone training may use the principles of sensory integration therapy in their assessment and treatment. However only those who are qualified testers are able to use the Southern California Sensory Integration Test or the new Sensory Integration and Praxis Test. For the younger child the Miller Assessment for Preschoolers (Miller) is a helpful tool.

The new Sensory Integration and Praxis test is not yet widely available in Europe, as the score sheets must be sent back to USA for marking. We are however in negotiation with the test owners to see if we can make a more appropriate arrangement for the UK.

The sensory integration tests are diagnostic and therefore not suitable to evaluate the child's progress. Other tests like TOMI (Test of Motor Impairment. Henderson Stott) may be used. Like all other forms of therapy treatment, continuous reassessment and evaluation are essential to measure the outcome of the intervention and determine accurately which form of intervention is most appropriate for the individual child.

Many therapists are beginning to use the principles of sensory integration in their treatment and there are a few fully qualified therapists in the UK who are developing training courses and looking at continued evaluation of sensory integration therapy.

(Fairgrieve: Berents, French and le Roux)

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European Academy of Childhood Disabilities

The second meeting of European Academy took place in early September in Durham - a most picturesque setting, looking up at the cathedral and castle, and close to the river Wear.

A wide variety of topics were presented both as teaching sessions and as paper presentations. The following are a few abstracts taken from the meeting. Perhaps one thing rather lacking this year was paper presentations from physiotherapists. We could change that situation another year.

Abstracts

"IT'S JUST NOT ENOUGH" -

HOW PARENTS PERCEIVE THE MANAGEMENT OF CEREBRAL PALSY

Dr R C Beach, Consultant Paediatrician
Dr K Yaxley, Clinical Medical Officer
Miss A Kew, Superintendent Physiotherapist
Jenny Lind, Children's Authority
Norwich Health Authority

OBJECTIVE	To investigate parental perceptions of the management of their children with cerebral palsy.
DESIGN	A structured interview/questionnaire study of parents' views.
SETTING	A child development unit attached to a district general hospital. Parents interviewed in their own homes.
SUBJECTS	Parents of 36 children 24-72 months old with a confirmed diagnosis of cerebral palsy.
OUTCOME MEASURES	Parental perceptions of the therapy their children have received - its amount, efficacy and adequacy. Parental and professional views of the nature and extent of the children's disability.

RESULTS

Three families declined to join the study leaving 33 for analysis. Individual time with therapists varied from zero to 120 minutes per week. Twenty two parents (66%) felt the therapy offered was insufficient. Thirty (90%) parents felt therapy enabled them to work with children in their own homes and parents spent between 10 and 360 minutes each day in such activities. Satisfied parents attended fewer group activities. There was no association between parental satisfaction and time spent in therapeutic activities or with therapist. All parents named their children's condition accurately. When parental and therapist's views of the extent of disability were compared parents significantly underestimated mental handicap but tended to over estimate physical handicap. Parental satisfaction was not directly related to the extent of mental or physical disability. There was a trend towards higher rates of parental satisfaction in families from lower socioeconomic groups.

CONCLUSIONS

Good management of cerebral palsy enables families to understand and work with their children. These criteria were met for 90% of the families in this study. Despite this 66% of parents of children with all severities of cerebral palsy expressed dissatisfaction with the amount of therapy provided. Is parental satisfaction an important and achievable objective? How is it to be achieved when resources are limited?

What is the best food for children with cerebral palsy who cannot chew?

Dr. R. D. Croft BA MB ChB MRCP

Children with cerebral palsy often have difficulty eating. They may be less likely to aspirate solid food but children with cerebral palsy, as well as able bodied children, take longer to eat solid than pureed food. It has been recommended that children with cerebral palsy should be weaned from puree to solid food, but it is not known whether or not this promotes the development of motor function.

SUMMARY

Video recordings were made of 67 children with cerebral palsy and 64 able bodied children eating soft boiled ("non mashed") and mashed potato. Those children with cerebral palsy who had no speech, presumed to have poor oral motor function, took significantly longer to eat non-mashed than mashed potato. Children with cerebral palsy especially those with no speech were more likely to cough or choke while eating non-mashed than mashed potato.

It is recommended that children with cerebral palsy who have poor oral motor function are offered food that they can eat with the least frustration or distress.

GAIT ANALYSIS IN CHILDREN USING A MICROCOMPUTER-BASED METHOD FOR MEASUREMENT OF TEMPORAL AND SPACIAL PARAMETERS. DATA IN PATHOLOGICAL GAIT.

R A Minns¹, E F Wheelwright, H T Law

¹ Department of Paediatric Neurology, Royal Hospital for Sick Children, 9 Sciennes Road, Edinburgh

The advantages of having available some means of objective measurement of disturbances of gait due to neurological disorders are now well recognised.

We developed a new microcomputer-based system which allows for spacial and temporal parameters of human gait to be measured quickly and accurately. This requires no specialised walkways and no foot-floor contacts.

The principal operation of this gait measurement works on the fact that during swing-phase instantaneous velocity of the forward-movement foot relative to the floor increases from zero at the incidence of toe-off to a maximum (about four times the velocity of the torso) occurring about mid swing, then decreases to become zero once again when the foot contacts the floor at heel strike. This

'Gaitway' system measures the position of each foot relative to the starting point at very frequent intervals during the test walk and is thus able to construct a foot velocity diagram for each patient or subject (Law 1987). The microcomputer will calculate from the accumulated data the left and right stride lengths, left and right step lengths, left and right stride times, double support times following the left and right steps, cadence, walking velocity and maximum foot velocity during the left and right strides. These data are determined for each completed gait cycle (stride pair) making up the test walk.

The data is obtained by punched tapes attached one to each foot which are the distance-measuring devices. Each carries a continuous row of accurately punched holes (10 per inch, ie 2.4 mm pitch), and as the subject walks, the tapes follow the feet and feed out through two optical reading heads contained in a floor mounted unit connected to the computer. The record is subsequently analysed to generate the velocity diagrams and to produce tables of the temporal/spacial parameters.

We have established a range of normal and temporal parameters derived from 134 normal children of varying ages. These show a close parallel with data obtained from other gait analysis laboratories.

We have used this equipment successfully for two years now in the study of aberrations of gait in neurologically deficiency children (Law and Minns 1987). Seventy-five children with disorders of gait as a result of neuromuscular handicap have been included in this study. Group 1 included children with childhood hemiplegia. Group 2 consisted of children with a paraplegia and Group 3 included a group of children with miscellaneous neuromuscular disorders. Our results have been analysed and relationships of average parameters to age and sex determined, standardisation of sex and height, statistic comparison among the three pathological groups and the gait asymmetry in hemiplegia. Some children in the study have had orthotics, pharmacological, surgical or therapeutic treatments and the 'Gaitway' system has been an effective means of assessing the change in gait abnormality.

The Evaluation of Therapeutic Intervention

Kevin Connolly and Margaret Martlew
Department of Psychology, University of Sheffield

Evaluation refers to the process of determining the worth or value of something, in this context to the value of some intervention procedure or programme. In everyday language it is usually expressed by the question 'Does it work?' Evaluation is a necessary component of any professional activity and arguably we all do it, the question rather is how effectively do we do it. A distinction can be drawn between 'intuitive' or 'clinical' evaluations and systematic evaluations. Common sense and intuitive approaches alone are not adequate and can be seriously misleading. If interventions, be they medical, social, behavioural or educational are to be of value to the handicapped it is essential that evaluations are undertaken. Evaluation is a task not only for research workers but for all professionals engaged in work with the disabled and handicapped.

There are four major components which need to be distinguished and considered in the evaluations of an intervention programme. These are (1) the design of the programme itself. (2) Monitoring the implementation of the programme. (3) Measuring the outcome of the programme. (4) A consideration of the costs and benefits associated with the intervention.

In one sense an evaluation is only as good as the programme itself. The goals and objectives must be specified. If they are not, how can the programmes' value be decided? The context in which intervention takes place and the actions of those delivering the programme must be specified in operational terms. Exactly what does the programme require to be done? The persons for whom the intervention is designed, the target group, must be clearly and precisely identified. The expected efforts of implementing the intervention and an indication of the expected magnitude of such efforts and their expected stability should be given. The process of treatment/intervention should be based on an explicitly stated model.

In order that an evaluation may be carried out it is vital to ensure that the programme implementation is as specified by the intervention model. This leads to two key questions; first is the programme reaching the population for which it was designed and second is the programme delivery consistent with the programme specifications. Methods of ascertaining target appropriateness (use of records, surveys), monitoring delivery of services (use of observational data, service records, specific information from service providers) and analysis of programme monitoring information will be discussed.

The assessment of outcome from an intervention entails identifying change, ruling out explanations for the observed change other than the intervention programme itself, measuring the magnitude of any effects and establishing whether there are any unintended effects, either positive or negative. Constraints or assessing the outcome of an intervention are examined and gross, net and confounding effects are distinguished. Sources of contaminating effects are briefly examined; endogenous changes, secular drift, maturational trends, self-selection effects, stochastic effects, problems of reliability, etc. Methods of outcome assessment are grouped into 'rigorous methods', which include randomised or 'true' experiments, quasi-experiments and use of reflexive controls, and approximate methods which are based in the judgement of experienced professionals. The limitations and dangers of approximate methods are emphasised.

Finally the costs and benefits of an intervention programme need to be specifically identified and a balance between these obtained in deciding the overall value of an intervention. The ascertainment of costs and benefits demands information other than financial since not all the costs and benefits can be expressed in monetary terms.

These principles and problems will be explored by a consideration of existing programmes and therapeutic interventions.

Recommended Sources

Consortium for Longitudinal Studies (1983) *As the Twig is Bent . . .* London : Erlbaum.

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Meisels S J and Shonkoff J P (1990) *Handbook of Early Childhood Intervention*. Cambridge : Cambridge University Press.

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The Chartered Society of Physiotherapy

Annual Representatives Conference - September 1990

(From 'Service Management' - Motion No. 92, as in July 1990 Journal, page 390)

"A District wide, integrated service model is the best way to deliver the Paediatric Physiotherapy service. This will better serve the overall interests of all concerned."

The Association of Paediatric Chartered Physiotherapists advocates that a District Wide Service Model is the best way to deliver the paediatric physiotherapy service. This will best serve the overall interests of those concerned. We intend to describe the advantages to the Client group, the staff and management of such a service, and hope to persuade the Chartered Society to give support to this proposition.

A District Wide, integrated service is a service which bridges Unit boundaries and which comes, both clinically and financially under a Paediatric Management or Directorate. This would be managed by a manager with specialist Paediatric expertise.

Why should the Paediatric service be structured in this way over and above other specialities? Children cannot give consent to their own treatment; consent and communication must take place through an intermediary, that is, through a parent, guardian or other carer. Therefore, clear communication is of paramount importance, needing to be consistent and apposite. This means that there needs to be continuity of records across Unit boundaries, wherever the child may be treated. Many families are involved with the physiotherapy service for a long period - often years or a lifetime - and this involvement is one of the whole family.

The advantages of an integrated service to the client group, therefore, are:

- continuity of care:

- a good flow of information:

- consistency of advice to parents and carers:

- and continuity of record keeping.

Such a service will be a good partner in a multidisciplinary network and will treat the child with a holistic approach. The involvement of families with the Physiotherapy Service may begin in the Maternity Unit, move to the Special Care Baby Unit, into the community, (often with frequent re-admissions to Hospital), into clinics, Child Development Centres, Playgroups, Nurseries, special and Mainstream schools.

This model of service will benefit staff by helping to build a good structure for career opportunities and Pre and Post registration Education. This allows rotational posts not only within sub-specialities with the District, but also with the paediatric sector. Without a district service it is often not possible to move staff between units, because of financial constraints. There would be opportunity for In-service training, regular specialist clinical meetings and wide experience for Clinical audit. Where appropriate, Clinical Supervisors would be able to supervise students and junior Staff across unit boundaries. These measures will help recruitment and retention of staff.

From the point of view of management, an integrated service would allow greater flexibility of Budget decisions and Staff deployment. There would be an ability to retain an overall view of the Service giving both Professional and managerial responsibility. Cover for Holidays, sickness and Maternity Leave would be more flexible. There would be some element of balance of caseloads and a close watch on waiting lists. A cost effective use of equipment can be planned. Evaluation and

research is possible, with adaptation of outcomes. Information can be provided to give a basis for forward planning, and adapting services to changing needs.

In order to convince our senior managers of the efficacy of this type of service, we have to sell it. The new district executives represent the purchasers of services with the individual services representing the providers. The providers must be in a position to present an acceptable service management agreement to the potential purchaser. Service managers must use the tools of the trade to collate an intergrated package which will persuade the purchaser of the integrity of the service agreement thus presented. Standards and quality must be specified, and appraisal and/or performance review can be used to justify aspects of service organisation.

We strongly believe that this is the best way forward, particularly for the Paediatric service, because of its multipathological nature. We therefore urge your support for this motion.

The motion was presented by your PRO, Caroline Dunn.

Acknowledgement is given for the assistance given, particularly by your Chairman, Mrs. M. Clegg, and to Mrs. C. Foster, W. Midland Representative. This motion was devised at the APCP conference at Loughborough in April.

The Children Act 1989

(A summary of "Introducing the Children Act" by Phillipa Russell - British Journal of Special Education, Volume 17, No. 1, March 1990).

The Children Act 1989 comes into force in 1991 and simplifies existing legislation to produce a more practical and consistent legal code. A new balance is struck between family autonomy and the protection of children; and social services, health authorities and education departments will be required to work together more effectively in the best interests of children.

Education authorities must consult social services before making supervision orders for children who do not attend school. Truancy orders are abolished and will no longer be a primary reason for removing a child from home. Education supervision orders will involve the appointment of a supervisor whose primary duty will be to advise, assist and befriend child and parents and ascertain their wishes.

To safeguard the welfare of children in Independent Schools, Social Services may authorise inspection of premises, school record sheets and children themselves. This new vigilance will offer significant new protection particularly for children with special educational needs who may have communication difficulties and/or be placed at a distance from home. This will have major resource implications for social services and education authorities.

Local authorities will have the legal right to make placements outside the U.K. e.g. the Peto Institute in Budapest if this is thought to be in the best interests of the child. However, no additional resources are to be made available for such provision.

The Act introduces a new single ground for compulsory care. The court may now only make a care order or supervision order if it is satisfied that the child is suffering "significant harm". This includes impairment of health or development and physical or emotional ill treatment including sexual abuse.

Court orders are generally simplified and directly descriptive.

Parents acquire rights as well as responsibilities and the transfer of parents legal powers and status can now be achieved only through a court hearing. The concept of partnership with parents is linked to prevention of family breakdown and removal of the stigma often attached to involvement with social services. The first responsibility of a local authority will be a 'welfare duty' which takes into account the wishes of parents and child (including ethnic origin, cultural and religious background). Regulations will govern 'voluntary agreements' but these are not legally binding on parents. If an agreement does not work the local authority may seek a care order. If this occurs the child will have 'party status' and a guardian 'ad item' report will be obtained. If a care order is obtained, parental rights of contact are safeguarded and efforts made to maintain family links. Provisions are made for emergency protection orders of 8-15 days duration.

The Act introduces a new concept of "children in need" e.g. those who are unlikely to achieve or maintain a reasonable standard of health or development; those whose health or development are likely to be significantly impaired without provision of certain support services; and those who are disabled.

This new definition of need means that local authorities will be required to provide services to promote the upbringing of such children by their families. Such services should include provision of support services, respite care, day care services and supervision for pre-school children "in need" and school age children "in need" outside school hours and in holidays.

The Children Act also encourages sensitivity to religious, cultural and ethnic considerations and requires co-operation of social services and education authorities in the placement of a child in an establishment where education is provided.

In conclusion, the Children Act presents major challenges and while daunting to education authorities in future duties it will also give teachers and administrators new powers to work with children.

It is an opportunity for children with special needs to be included within mainstream legislation, rather than being seen as part of a separate service.

*Your Editor
would like to take this opportunity
to wish all our readers a very
Happy Christmas
and
A Good New Year*



Summary of National Committee Meeting, 17th July 1990

Carole Hurran and Elizabeth Utter were welcomed as the incoming Regional Reps from the South West and Wales respectively.

The Committee is to review the current APCP publications regarding their suitability and need for updating. It has already to be agreed to revise the 'Clumsy Child' book first.

Three committee members will be attending the Representative Conference in September.

APCP had sent £108 to the CSP Members Benevolent Fund, from the Conference collection.

It was agreed to increase the honoraria paid to executive committee members to £120 per annum. The rate of pay for the membership secretary was increased to £4 per hour.

An Editorial Board meeting decided not to send out February Newsletters to APCP members who had not renewed their subscription for the current year.

There had been a problem obtaining summaries of the Conference lectures for publication in the newsletter.

It was agreed that APCP members could be co-opted onto the Editorial Board as necessary.

The Regional Reps. are to discuss the possibility of one Newsletter per year being produced by a region.

The Post-Reg Education Sub-committee reported that the 'Introduction to Paediatrics' course was being rewritten to involve a day release course over two years. Negotiations are underway with the North East London Polytechnic concerning the development of an M.Sc in paediatrics.

The London Region committee were concerned at poor attendance at meetings and has considered disbanding.

Viv Williams was elected Vice-Chairman.

There is now an APCP starter pack for new members to include an information leaflet, Good Practice Guidelines Booklet, current Newsletter and introductory letter.

ABSTRACTS

- Title: Communicating on evolutionary diagnosis of disability to parents
- Author: D.J. Cottrel - London Hospital Medical College,
K. Summers - Child Development Centre, St. George's Hospital, London.
- Source: Child-care, health and development 1990 16 pp 211-218

Numerous studies have been conducted on the manner in which the diagnosis of a child's long term disability have been imparted to the parents - although there is general agreement on basic essential points, more recent studies, have suggested a high level of dissatisfaction among parents of how this information is given to them.

Most studies of parental reactions have been involved with children who have a readily identifiable condition and a well defined prognosis which can make the imparting of information somewhat easier. In the case of many children seen in Child Development Centres the diagnosis is frequently less certain and outcomes difficult to predict, leading to a predictable increase of parental dissatisfaction.

The aim of this study was to explore ways in which communication of this sort could be improved. It was based on comments raised in a mother's support group held in the CDC of St. George's hospital and information gained from paramedical staff involved with children with long term disabilities.

The mother's support group consisted of mothers of five children who had suffered severe cerebral damage (meningitis and cerebral anoxia subsequent to near drowning) - in all cases the prognosis and life expectation were unclear.

Strong relationships are built up between therapists and parents in the regular non-threatening session which give the parents considerable support and opportunity for discussion. Findings were that parents wanted complete honesty, a number of follow-up sessions, a positive approach with ideas of action that could be taken, and a co-ordinated approach, so the advice from the agencies involved did not conflict.

Title: Reducing Spasticity and Enhancing Postural Control for the Creation of a Functional Sitting Position in Children with Cerebral Palsy. A Pilot Study.
Author: Ulla Myhr and Lennart van Wendt, University of Goteborg, Sweden.
Source: Physiotherapy Theory and Practice 1990 Vol. 6 pp 65 - 76.

The provision of functional seating for children with cerebral palsy frequently causes problems, these are often made worse with delays between planning and the delivery of expensive, complicated equipment and also the dearth of scientific information concerning Cerebral Palsy.

The aim of this study was to identify the essential factors which reduce spasticity as well as enhance postural control so a functional sitting position can be gained. Another aim was to evolve easily applied methods to assess the sitting patterns in these children.

Factors hindering sitting positions are then outlined and discussed, amongst these are the use of gravity to facilitate the body's ability to maintain an upright posture, the counteraction of spastic patterns of movement, symmetrical positioning and the line of gravity of the trunk.

Two children with severe cerebral palsy were studied - six sitting positions were analysed whilst they were sitting in their own chairs, each position being designed with the previously mentioned factors in mind so an optimum position could be gained. All the six positions were filmed and photographed, anatomical landmarks representing the joint axis of movement being marked on the children's bodies with pieces of adhesive tape.

The optimum sitting position was gained with the use of three factors:-

- the pelvis being firmly secured by means of a strap secured under the chair seat
- use of an abduction orthosis
- the chair seat being inclined forwards or held level with the child's forearms supported against a table.

The presence of these three factors obtained the greatest reduction in spasticity and encouraged good postural control, by gaining symmetrical weight bearing on the ischial tuberosities and the trunk in front of the axis of rotation.

Title: Painless Juvenile Rheumatoid Arthritis
Authors: David D. Sherry MD., John Bohnsack, MD, Kathy Salmonson, RN,
Carol A. Wallace, MD, and Elizabeth Mellins, MD. Dept. of Paediatrics,
University of Washington, Seattle.
Source: Journal of Paediatrics June 1990 Vol 116. No. 6 pp 921 - 923.

The presence of pain is a major aspect in the diagnosis and treatment of Juvenile Rheumatoid Arthritis and the effective control of it is emphasised in many publications. However there are many instances reported of children with this condition who do not appear to experience much pain, if any at all, which has led to a delay in diagnosis. This puts such children at considerable risk of complications such as untreated iritis and increased destruction of joints.

41 children among a group of 293 children all diagnosed with JRA were picked out as having no symptoms of pain - 30 of these children were girls, the average age of onset was 4-8 years. (0.5 to 17.4) years, 36 of the group had particular JRA.

The delay in diagnosing of the group of children with painless JRA was twice as long as in the group with symptoms of pain, they had a lower erythrocyte sedimentation rate and had a higher incidence of having had arthrocentesis. 12 children reported having early morning stiffness and occasional limps.

The authors conclude the diagnosis of JRA should be considered in any child who has chronic joint swelling, even with the absence of pain and should be automatically investigated for asymptomatic iritis and joint destruction.

Letters to Editor

Madam,

... Have other physiotherapists had any experience in the strapping of premature babies with talipes equinovarus? We have seen two babies in the last three months and have had problems with small sores and skin rashes. I would be grateful for any advice.

*Sue Danks, Senior Physiotherapist, LEON Gillis Children's Centre,
Queen Mary's University Hospital, Roehampton Lane, London SW15 5PN.*

Dear Editor,

I am currently working as a Paediatric Physiotherapist in Private Practice. Through the course of my work I am often asked about the availability of private physiotherapy for children in various parts of the country. I have not been able to find any record of Paediatric Physiotherapists who are either working solely in private practice or who are happy to work with one or two children on an occasional basis. I would like to compile a list of Paediatric Physiotherapists who are either already working in this manner or who would be interested in doing so. I would therefore ask that any Physiotherapists interested would write to me to give their details indicating any areas of specific interest.

Isabel Chilton, MCSP, SRP, 33 Stirling Rd., Stockwell, London SW9 9EK.

A.P.C.P. Matters

• FINAL NOTICE

In spite of continual requests over the last four years for members to cease paying their Annual Subscriptions by Standing Order, amounts varying from one to seven pounds are still being paid into the APCP account.

Please note that we cannot refund this money because the bank gives us your bank account number and not your name and address.

You are advised to check your bank statement and cancel any credit transfer arrangements to APCP.

Please pay your annual subscription by cheque direct to the Membership Secretary, Mrs. Jeanne Lamond, 22 Whernside Rd., Cross Hill, Lancaster LA1 2TA. Renewal notices are included with this Newsletter.

There will be no further reminders about standing orders.

Lyn Weekes, Treasurer

• **A.P.C.P. CONSTITUTION** - All members are asked to note that the National Committee will, in November, be discussing various items from the Constitution that may require amendment. Members will be notified of suggested changes through this Newsletter in February prior to the A.G.M. in April.

• **All Members please note that there are vacancies on the National Committee.** Nominations are invited, proposed and seconded, in writing to the Hon. Secretary at least one calendar month before the Annual General Meeting of the Association.

• **The Annual General Meeting of the Association will be held on Saturday 13th April 1991. The time and venue will be published in the February Newsletter.**

• The Post-Registration Education Committee has had a meeting with Judy Mead at C.S.P. regarding training of Health Care Workers, and how it relates to the specific needs of training in paediatrics. A report on this meeting will be published in the February 1991 Newsletter.

HERE AND THERE

• On 29th August, seven paediatric physiotherapists with a special interest in girls with Retts Syndrome met at Tadworth Court to share their knowledge and experience.

The group discussed aims and frequency of treatment and what advice could be given about management. There is a further meeting planned in November. Further details, if required, from APCP Treasurer.

• Much effort has been made by members of the Association of Community Physiotherapists to find a solution to the perennial problem in inner cities - that of parking. So far, little help is offered from CSP, BMA or the Police who are unable to give any legal exemption under the Road Traffic Act 1984.

- Guidance for Clinical Health Workers:

Protection against infection with HIV & Hepatitis Viruses

The above document is available from HMSO and aims to emphasise the need to be protected from certain body fluids. It does however emphasise that universal precautions are not required when dealing with sputum, unless they contain visible blood.

You are encouraged to find out what the guidelines are in your health area.

- **Courses in brief**

17th November -

S.E. Region - The Management of Spina Bifida.

Applications to Mrs. G. Hancock, Queen Mary's Hospital for Children, Carshalton, Surrey SM5 4NR (Tel. 081-643-3300 Ext. 343).

Castle Priory College, Wallingford, Oxfordshire OX10 OHE.

(Tel: 0494 37551/26350)

5-7 December 1990

'Building support for care staff and teachers'

Course No. 26/174

7-9 December 1990

'Working with the pre-school child with special needs'

Course No. 26/176

18-20 January 1991

'Clumsiness in Children'

Course No. 126/206

- **The Sensory Intergration Association (U.K.)** has open membership to registered Occupational Therapists, Physiotherapists and Speech Therapists. Associate membership is open to those closely involved with people who have learning difficulties. For further details, write to the Treasurer, Miss Julie Gray, 4 Coleman Avenue, Balderton, Newark, Notts. NG24 3DR.

What's it all about Alfie?

- The following is a brief summary of the address given at the Loughborough Conference in April by Rev. Ian Ainsworth Smith, Chaplain, St. George's Hospital, Tooting, London. His title was: 'What's it all about Alfie?', and he attempted to set the conference discussions in a wider content than just the usually accepted definitions of "cure".

He drew attention to the "business" of health care professionals, and how, frequently, especially with seriously ill dying children, this becomes a substitute for real involvement.

He pointed out how children who are sick or who have a handicap frequently know their story and their prospects very well if adults can bear to listen: Pressure from the press, especially when the combination is one of sick children, angelic or dedicated staff and the possibility of a miracle cure, can be a potent mixture, and everyone can suffer if the team cannot sometimes share and define together what they are really there to achieve.

"Carers" need to pay particular care to their own needs, since the alternative can so easily become cynicism or burn out.

He also raised the growing awareness of health care professionals that little attention has been made to the spiritual (which is not the same as religious) needs of patients and clients and in particular of children.

As a Chaplain, The Reverend Ainsworth Smith is frequently in a position to support in another dimension patients, relatives and staff. He reiterated the need of people, regardless of the label that they may carry, to receive respect, praise and support.

If the model of curing sick people is allowed to take over at the expense of all other ways of healing, the goals of care can become distorted and therefore need edifying and clarifying.

The function of pastoral care is not to offer solutions but to give depth and substance to the debate: "What's it all about? Anyway?"

The Derek Ricks Memorial Fund

The Derek Ricks Fellowship

The late Dr. Derek Ricks was a pioneer in the care and management of mentally handicapped children with a keen interest in his subject as clinician, researcher and teacher. He founded the Harper House Children's Service in 1981, establishing a multidisciplinary team aiming to support families and professionals caring for disabled children. In 1985, his contributions to this field were recognised by the formation of a sub-department of paediatric mental handicap within the paediatric department at University College, London.

The overall aim of Derek Ricks' Service was, through observation, assessment and open discussion, to arrive at an agreed picture of the whole child, attempting to gain a clearer view of how a particular disability, or combination of disabilities, interferes with the child's development. His interest was in all aspects of child development and developmental problems, in the interaction between parents and children and between families and the local professionals involved. He believed that, while combinations of handicap and are a frequent consequence of disability and often lead to fragmented care, close working relationships between professionals of many disciplines help avoid fragmentation and allow for a clearer understanding of the problems experienced by the children and their families. Such an understanding, in turn, facilitates negotiations for care and management.

Applications for the Derek Ricks Fellowship are invited from any person who can show that the work/project they wish to undertake further personal or professional development within such a service framework. A maximum of £500 is available to successful applicants.

Applications should be set out in no more than 400 words:

1. Description of the project.
2. Length of time to be taken.
3. Outline of how the money will be spent.
4. Details of assistance from other sources.

Short-listed applicants may be invited to make a presentation to the Fund administrators.

On completion of the work/project, the successful applicant will be required to make a presentation to the Fund administrators and the Harper House Team. Where appropriate, this may take the form of a report on a centre/centres visited and a personal statement on the work observed.

Enquiries: Mrs. Rae Chisholm (0923) 857315

The Derek Ricks Memorial Fund Harper House Children's Service, Harper Lane, Radlett, Herts. WD7 8HU.

Closing date for formal applications: 31st December 1990.

REGIONAL REPORTS

Trent

Reg. Rep. Jenny Gill, Child Development Centre, City Hospital, Hucknall Road, Nottingham.

Following this year's conference in Loughborough, a new committee has reformed with Miss Jenny Gill acting as Chairperson. In the coming months the committee are aiming to promote local paediatric courses within the area, once it has established itself fully. We would like to thank the previous committee for their hard work towards the conference and help and advice to the new committee members.

Wales

Reg. Rep. Elizabeth Atter, 2 Heol Harlech, Llandaff, Cardiff CF5 2HX.

On behalf of all the members of the Welsh Branch, I would like to thank Lyn Horrocks for her remendous commitment and energy given as our previous Regional Rep. Lyn is now figure-heading the preparations for the International Paediatric Physiotherapy Conference in 1991. She is a tough act to follow.

We have had a busy few months. In June, members from West Wales with colleagues from the A.C.P.R.C. held an evening lecture on Asthma.

June and July saw the second part of the eight week Paediatric Bobath course held in Cardiff. The course was attended as usual, by several overseas delegates, some of whom had come from Australia, Zimbabwe and Europe. The new course format of two four-week blocks and a four-week break in between seemed to suit most of the delegates. We hope that other health districts will benefit from hosting the course as much as we did here.

October saw the first joint APCP and NAPOT course held in Wales on Sensory Intergration, led by Jenny French and her O.T. counterpart Elizabeth Fairgreaves. Both teach the theory of Sensory Intergration as developed by Dr. Ayres in America. Also held in October was a study day entitled 'Prevention and Intervention in Orthopaedic Management of Cerebral Palsy with Mr. P. Wutheroe, FRCS and Mrs. J. Pyman from Bristol.

It is hoped to organise a study day on the Legal Aspects of Paediatric Care in the community before the end of the year. Preparations for the 1991 Conference are progressing steadily and excitement is mounting. The conference dinner is being held at Cardiff Castle with a superb menu. There are only a limited number of places available, so book early. A special discount applies when you book for the whole conference package before 1st April.

Please contact me at home if you would like to run courses or have any suggestions for future topics.

London

Reg. Rep. Karen Burchett, Squirrel's Leap, 6 Willersley Ave., Orpington, Kent BR6 9RS.

Apologies to anyone who was considering applying for the day on Research. It was postponed because of difficulty arranging the speakers. It will now be in 1991 with our AGM.

Next meeting is an evening lecture on 'Perception' at the Hospital for Sick Children, Great Ormond Street, on November 6th at 7.00 p.m. We are hoping for a good attendance because it may help to decide whether there is a programme next year.

Socially, we are getting up a singles, ladies only, skiing trip next March. Anyone interested, especially more mature beginners, please contact me or Marion Main for details. Sales of our sweatshirts are going well and keeping us afloat. Further orders welcome.

N. Ireland

Reg. Rep. Ruth Graham, 75 Ravenhill Gdns., Belfast BT6 8GQ.

The programme for 1990/91 was recommenced following the summer recess with an evening talk on the physiotherapeutic management of the paediatric burns patient. Other planned events include study days on CF and asthma and gait analysis with a team from Dublin. No definite dates at present. Bi-monthly evening lectures continue with such diverse topics as RGO's and Muscular Dystrophy.

Plans are underway for the 8-week Bobath course in 1992. This is being organised in conjunction with the Bobath Trained Therapists SIG and great interest is being shown at present.

*Copy for the February 1991 Newsletter
must be with the Editor by 12th December.
Please note the earlier date because of Christmas*

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

