
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

Association of Paediatric Chartered Physiotherapists

Newsletter No. 59

May 1991

CONTENTS

Therapy for Cerebral Palsy - Part II - Ian McKinlay	3
Physiotherapy for the Visually Impaired Infant and Child - MA van der Velde	8
Visual Disability in the Pre-School Child - Dr. A. Elliman	15
The story of a Teacher for the Deaf - Elizabeth Watts Read	18
Hydrotherapy for Pre-School Children - Gillian Laverty	20
A Parents View on Hydrotherapy - Mrs. P. Thompson	21
The Scottish Centre for Children with Motor Impairment	22
Childs Orthotic Walking Trainer - David Hart	24
Summary of National Committee Meeting - January 1991	25
PRO Report for 1990/91	26
Abstracts	28
Letters to the Editor	30
Courses	32
Regional Reports	34

* * * * *

Officers of the Association

Chairman & Post. Reg. Education

Mrs. M. Clegg

Norton House,

5 Church Street,

Bishops Castle, Salop SY9 5AA

Vice Chairman

Mrs. V. Williams

5 Larch Grove,

Lisvane

Cardiff CF4 5TH

Secretary

Mrs. M. Lee

15 Ropemaker Road,

Rotherhithe

London SE16 1QG

Treasurer

Mrs. L. Weeks

37 The Cedars

Milton Road,

Harpenden, Herts AL5 5LQ

P.R.O.

Mrs. C.L. Dunn

The Haven

Knightwick Road,

Martley, Worcs. WR6 6PQ

Editor

Mrs. J. McKinlay

3 Stanley Gdns.

Sanderstead, S. Croydon

Surrey CR2 9AH

Membership Secretary

Mrs. J. Lamond

22 Whernside Road

Cross Hill

Lancaster LA1 2TA

Editorial Board

Miss G. Riley, Miss C. Young, Mrs. C. Dunn,

Mrs. J. Saunders, Mrs. A. Lyon, Mrs. M. Diffey.

EDITORIAL

Jenny McKinlay, Editor

When first contemplating this editorial, thoughts evolved around the complexities of 'change' and how we have to adapt to the many pressures that encompasses us, and indeed have done so in recent months. For many the 1st April has come and gone without drama, indeed, some may be asking 'What was all the fuss about' Regrettably, for many, the uncertainties have taken their toll, morale has been adversely affected, and it has been hard to keep smiling when facing those we aim to serve - our patients.

But what of the future? There are several storms ahead which we will have to dodge, shelter from and face up to. Let's be cheerful for a moment! We have one great event to look forward to - that of the International Conference in Cardiff. It is surely a great time of meeting, sharing and enjoying each other's company while we learn more in clinical terms and recharge our batteries. We have to thank the Welsh Region for their momentual efforts in arranging this particular conference, providing a much wider range of activities for physiotherapists and all the family. Let's make it a success, not just for ourselves, but for the many visitors we will welcome as they join us from all over the world.

ANNUAL SUBSCRIPTION - £15.00

Send direct to Membership Secretary

Mrs. Jeanne Lamond
22 Whernside Rd., Cross Hill, Lancaster LA1 2TA

If you do not have an application form, write to the membership Sec. with name, address for correspondence, telephone no., place of work, CSP No. and APCP No. if you have one and a cheque made payable to the Association of Paediatric Chartered Physiotherapists.

Copy for the August 1991 Newsletter must be with the Editor by 1st July.

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

THERAPY FOR CEREBRAL PALSY

PART II

Ian A. McKinlay

This article is reproduced by kind permission of W.B. Saunders, and comes from 'Seminars in Orthopaedics', Vol. 4, No. 4 (December) 1989, pp 220-228. Please note that Ian McKinlay can now be reached at the Mackay-Gordon Centre, Royal Manchester Children's Hospital, Pendlebury, Nr. Manchester, M27 1HA.

Psychological Aspects of Therapy

The case for incorporating a psychological component in the physiotherapy curriculum⁵⁷ is clear: to inform research design as well as management.^{58,60} If the relationship between parents and young children can be fostered with increased parental warmth and reduced criticism, there is a diminution of conduct problems.^{61,62} The family should not be expected to take up yet another set of appointments with professionals to deal with the psychological aspects of management unless specifically indicated. Psychiatrists and psychologists can be very helpful in staff training and counselling, however.⁶³ Much therapy is a process of helping children with cerebral palsy, as well as their families, to come to terms with their condition.

Physiotherapy Methods

Several methods of physiotherapy for cerebral palsy in current use are described by Scrutton.⁶⁴ The purpose was to provide an opportunity for description rather than a critical review. There are many other sources of description of individual approaches (e.g. Bernstein,⁶⁵ Ayres,⁶⁶ Finnie,⁶⁷ Levitt,⁶⁸ Scrutton,⁶⁹ and Bobath⁷⁰).

Aims of Therapy

The main aims of therapy for cerebral palsy are to promote independence, confidence, and ability to compete.⁷¹ This depends on emotional well being of children and their families at least as much as on motor attainments. Early access to a high-quality curriculum and facilitation of peer group interaction are part of this.⁷² Martlew⁷³ gave a detailed report of observations of twins, one of whom has cerebral palsy; at home and in an integrated nursery the disabled girl's interactions with nursery staff were reduced in quantity and quality in comparison with her sister's, though both enjoyed the nursery. This indicates the need for structured and monitored support.

Though there are some children with severe learning difficulties and multiple disabilities, including cerebral palsy, who are not able to attain full integration within existing resources, there has been too much emphasis on protected education (if any) in the past. Access to frequent therapy has been used as a justification for this.

Competition between Agencies

The best way to give movement education advice for pre-school children is still unclear. There is potential competition between agencies, Education services may provide Portage programmes⁷⁴ at home or in play groups and nursery schools. Social services may provide

nurseries or play schemes. Health services provide home or hospital therapy programmes, play schemes, or special classes in child development centres. Other organisations offer a way of life, e.g. the Peto Institute ⁷⁵ or Institutes for the Achievement of Human Potential. Charlatans offer special diets or bizarre remedies. A wide range of advice, from constructive to unhelpful, is offered by relatives. In this potential muddle it is right to consider what is in the best interests of the child and family. Conflict between professionals and duplication of effort should be minimised. There may not be a "best buy", and choice for the child and parent has many advantages so long as neither is exploited.

Educational Integration:

Implications for Therapy

There is no doubt that the policy of moving from special schools to more integrated, dispersed education will mean reduced treatment time for children with cerebral palsy, a smaller range of on-site resources, and a greater risk of disabled pupils losing contact with health professionals. Maintaining an observation register ⁷⁶ should become an interactive process between school, parents, and health staff to try to minimise this.

Therapy for Cerebral Palsy

There are issues for pupils with cerebral palsy and learning difficulties whose cognitive abilities are below the range of other pupils in mainstream schools. Parents may have been happy to allow the children to attend special schools for pupils with physical disabilities but resist attempts to place the children in special schools for pupils with learning difficulties. As many pupils with cerebral palsies have sensory defects and health problems such as epilepsy, deformities, chewing and swallowing difficulties, secretory otitis media, recurrent chest infections, or incontinence, the coordination of information, advice, and support services for teachers, parents, and pupils is a formidable challenge. ⁷⁷⁻⁷⁹

Coordination of support may be more feasible for young pupils who have the same teacher all day than for older pupils who move from one subject teacher to another throughout the day. Because such pupils are infrequent in the general child population, it is difficult for teachers to maintain expertise. It may be necessary to identify one person as the main special support for a particular child and for that person to use the other colleague as a resource. This might be a therapist or a teacher.

Management Priorities

A medical specialist may request daily therapy which is obtainable only in special schools, but the education authority may decide to place the child in mainstream school which a therapist can visit only once a fortnight. Even if therapists try to cope by home visits or treatment in local clinics after school they will still be unable to offer as much treatment as in schools with physiotherapy departments. Travelling takes up professional time, and many children resist intrusion into their free time. Therapy sessions in school may cause problems as children miss portions of school work and feel conspicuous. If doctors or therapists believe that particular treatment programmes are essential, it is for us to be able to justify this in order to compete for resources and time. ^{80,81}

Cognitive Therapy:

Understanding Cerebral Palsy

Professionals have to convince their child and adolescent patients that treatment is worthwhile. Young people should understand their disabilities and be involved in making decisions about treatment. If a child with cerebral palsy wants to learn to get on and off the toilet independently he or she will be much more likely to cooperate with a teaching programme than someone who is the passive recipient of an "Activities of Daily Living" package. The benefits of greater independence may need to be negotiated with some children who derive secondary gain from sloth.

Promoting Independence

There are many aspects of independence which are outside the perceived remit of mainstream schools. One of the most important of these is getting about. Using shops or recreational facilities, dressing, continence, eating, and development of social competence are other examples. There may be problems in the family, such as bereavement, parental illness, a sick or elderly relative in the home, unemployment, or marital discord. Neighbourhood difficulties, such as bullying, vandalism, dearth of suitable recreational facilities, or lack of a local network of support because of frequent changes of address may be relevant. Many schools will regard these as matters in which they cannot engage. Social workers are usually too involved in child protection or truancy work to become involved. It may be health service staff, often therapists, who pick up these aspects through regular contacts with the children. Pastoral help has been a prominent feature of special schools but is less developed in mainstream, especially as applied to disabled pupils.

Physiotherapists' Contribution to Teams

Physiotherapists are valued members of diagnostic and rehabilitation teams. They call clinical findings to the attention of colleagues and can participate in decision making about treatment if allowed to do so.⁸² In a double-blind, randomised, crossover study of the effectiveness of baclofen for children with cerebral palsy,⁸³ the therapists reported lower tone or better movement during baclofen treatment in 14 out of 20 children as compared with 5 receiving placebo. The doctors found no significant difference in muscle tone, clonus, manual dexterity, speech articulation, or respiratory function. It is possible that therapists were alerted by side effects which affected 12 children (drowsiness) in more routine circumstances than the special tests. However, the therapists were more accurate in their estimates about the time of active drug treatment than doctors, teachers, or parents, and this may have to do with their expertise in observing quality of movement.⁸⁴ Admittedly, the number of subjects was small and the therapists' differentiation did not quite reach statistical significance ($P = .064$).

Prevention of Deformities

Another key prior for rehabilitation is the prevention or mitigation of deformities. A large component of that is provision of opportunities through which the child's posture and activities are enabled to be varied and interesting. Another is the provision of suitable appliances, especially for seating. Assessment of these needs should involve therapists. Unsuitable seating for travel, study, and leisure leads not only to discomfort but to

deformities - initially postural and gravitational but eventually fixed.⁸⁵ The advice of the therapist is especially important in school where furniture, access, and toilet facilities are unsatisfactory for some disabled children, affecting their performance, enjoyment, and movement around school. Sometimes it is possible to persuade schools to relocate classes to reduce difficulties for disabled pupils. It may be necessary to install special means of access or to purchase equipment, and schools will welcome the advice of therapists for this.

* * * * *

REFERENCES:

57. Baddeley H, Bithell C: Psychology in the physiotherapy curriculum: A survey. *Physiotherapy* 75: 17-21, 1989.
58. Rutter M, Graham P, Yule W: A neuropsychiatric study in childhood. *Clin Dev Med* 35/36: 1970.
59. Seidel UP, Chadwick OFD, Rutter M: Psychological disorder in crippled children: A comparative study of children with and without brain damage. *Dev Med Child Neurol* 17:563-573, 1975.
60. Taylor DC: The sick child's predicament, in Gordon NS, McKinlay IA (eds): *Neurologically Handicapped Children: Treatment and Management*, Oxford, England, Blackwell, 1986, pp 1-14.
61. Richman N, Stevenson J, Graham PJ: *Pre-school to School: A Behavioural Study*. London, England, Academic, 1982.
62. Rutter M: Pathways from childhood to adult life. *J Child Psychol Psychiatry* 30: 23-51, 1989.
63. Hewitt K, Hobday A, Crawford W: What do health visitors gain from behavioural workshops? *Child Care Health Dev* 15:265-275, 1989.
64. Scrutton D: Management of the motor disorders of children with cerebral palsy, *Clin Dev Med* 90, 1984.
65. Bernstein N: *The Co-ordination and Regulation of Movements*. Oxford, England, Pergamon, 1967.
66. Ayres J: *Sensory Integration and Learning Disorders*. Los Angeles, CA, Western Psychological Services, 1972.
67. Finnie NR: *Handling the Young Cerebral Palsied Child at Home* (ed 2), London, England, Heinemann, 1974.
68. Levitt S: *The Treatment of Cerebral Palsy and Motor Delsy*, Oxford, England, Blackwell, 1977.
69. Scrutton DR: Developmental deformity and the profoundly retarded child, in Apley J (ed): *The Care of the Handicapped Child*, London, England, Heinemann, 1978.
70. Bobath K: A neurophysiological basis for the treatment of cerebral palsy. *Clin Dev Med* 75, 1980.

71. Crothers B, Paine RS: *The Natural History of Cerebral Palsy*. Philadelphia, PA, Lippincott, 1988.
72. Chen D, Hanline MF, Friedman CT: From playgroup to pre-school: Facilitating early integration experiences. *Child Care Health Dev* 15:283-295, 1989.
73. Martlew M: Observations on a child with cerebral palsy and her twin sister made in an integrated nursery and at home. *Child Care Health Dev* 15: 175-194, 1989.
74. Reville S, Blunden R: A home training service for pre-school developmentally handicapped children. *Behav Res Ther* 173: 207-215, 1979.
75. Robinson RO, McCarthy GT, Little TM: Conductive education at the Peto Institute, Budapest. *Br Med J* 299: 1145-1149, 1989.
76. Colver AF, Robinson A: Establishing a register of children with special needs. *Arch Dis Child* 64: 1200-1203, 1989.
77. Buultjens M, Aiken S: Assessment of vision in multiply impaired children. *Br J Spec Educ* 14: 112-114, 1987.
78. Andrew AK: Meeting the need of young deaf-blind children and their parents. I. *Child Care Health Dev* 15: 195-206, 1989.
79. Andrew AK: Meeting the needs of young deaf-blind children and their parents II. *Child Care Health Dev* 15: 251-264, 1989.
80. Partridge CJ: The effectiveness of physiotherapy: A classification for evaluation. *Physiotherapy* 66: 153-155, 1980.
81. Ferry PC: Infant stimulation programs: A neurological shell game? *Arch Neurol* 43: 281-282, 1986.
82. Fontenrose A, Miller J, Hallum A: Physicians' and physical therapists' evaluations of cerebral palsied children for Achilles tendon lengthening. *Dev Med Child Neurol* 26: 028-213, 1984.
83. McKinlay IA, Hyde E, Gordon NS: Baclofen: A team approach to drug evaluation of spasticity in childhood. *Proceedings of a symposium: Baclofen: A broader spectrum of activity*. *Scott Med J* 26-28, 1980 (suppl).
84. Irwin-Carruthers SH: The results of early treatment of children with cerebral motor disturbances. *S Afr J Neurodev Ther* 13: 6-9, 1989.
85. Fulford GE, Cairns TP, Sloane Y: Sitting problems of children with cerebral palsy. *Dev Med Child Neurol* 24: 48-53, 1982.

* * * * *

The following article has been reproduced here by kind permission of the South African Journal of Neurodevelopmental Therapy

PHYSIOTHERAPY FOR THE VISUALLY IMPAIRED INFANT AND CHILD

**Paper presented at the 18th Congress of the South African Society of
Physiotherapy: Durban, May 1989**

**Paper presented at the International Symposium on Visually Handicapped Infants
and Young Children: Edinburgh, Scotland, August 1988.**

MA van der Velde

**Senior Physiotherapist, Johannesburg Hospital Centre for Visually Impaired
Children, Transvaal Memorial Institute for Child Health, Johannesburg.**

The purpose of this paper is to emphasise the importance of movement in the general development of a young child. I would like to show movement can be affected by severe visual impairment and how physiotherapy, by encouraging normal or near normal sensorimotor development, can help these children.

The development of movement occurs as an integral part of the whole development of a child. This includes the aspects of sensation, perception, language, intellect and social and emotional interaction. Development progresses as the central nervous system matures. This process is influenced by information received, interpreted and integrated from the sensory organs of sight, hearing, touch, taste, smell, proprioception and from the vestibular system.

The sensation of movement helps the child to learn about his own body, his position in space, spatial relationships and the basic perceptual concepts of size, shape, number, speed, direction and distance. He requires all these for higher cognitive learning. A blind child needs these concepts to form a basis for learning the skills of orientation and mobility. Vision plays a major role in the development of a child. The blind child must compensate for the loss of vision by making more than normal use of his other senses. This compensation may not occur automatically and may require outside intervention.

1. THE ROLE OF MOVEMENT IN THE EARLY LEARNING PROCESS

1.1 Body Image

Body image is the concept a person has of his own body and the relationships of the different parts to one another, including size, shape, proportion and function. Body image begins to develop early on in an infant's life with the bringing together of his hands in the midline. He learns about his hands by looking, touching, moving and mouthing them. This knowledge of his hands is a prerequisite for reaching. Knowledge of the rest of his body develops through exploration in a similar manner.

A blind child lacks the visual motivation to bring his hands together and to monitor their action. This results in a delay in the development of body image and in reaching.

1.2 SPATIAL RELATIONSHIPS - BASIC PERCEPTUAL CONCEPTS

A child learns about the relationship of his body to space and to objects in space, by moving himself through space, towards, around, over, under and behind objects. This helps him to building up an idea of shape, size, distance and direction. This is aided by manipulating the objects in his hands.

For example, Arie found a plastic bin, then proceeded to feel it all over. He found it to be hollow. He confirmed this by climbing inside. Later he placed his toys inside. Spatial relationships are also reinforced during 'rough and tumble' games. A blind child tends to be frightened as he cannot see what is being done to him. Therefore his family tend to avoid playing these games thus denying him these opportunities for learning.

.3 Object Constancy

Object constancy is the process whereby a child learns that people and objects continue to exist even though they cannot be seen or touched.

A child first confirms that people and objects exist by looking, moving towards and then by touching them. Without sight this concept takes much longer to learn, because the child needs to move around in order to establish it.

1.4 Interaction with the Environment

A child learns about his environment through his caregivers who interact with him and introduce him to the environment. Later he learns about danger and the cause and effect of his actions on his surroundings by reaching, dropping and finally retrieving objects. This is mainly monitored visually. The blind child takes much longer to perceive these effects as he must move with the objects to experience what happens to them.

Visual cues awaken desire in a child to move out into space in order to explore his surroundings. The lack of visual cues, plus over-protective and over-helpful caregivers present lower opportunities for learning and place fewer demands on the blind child, thus impeding his interactions with his environment. The development of self-motivated and self-initiated exploration is also affected. A blind child may be concentrating on listening to sounds around him and may appear to be unresponsive, too good, too passive or even retarded.

1.5 Exploration of the World - Functional Skills

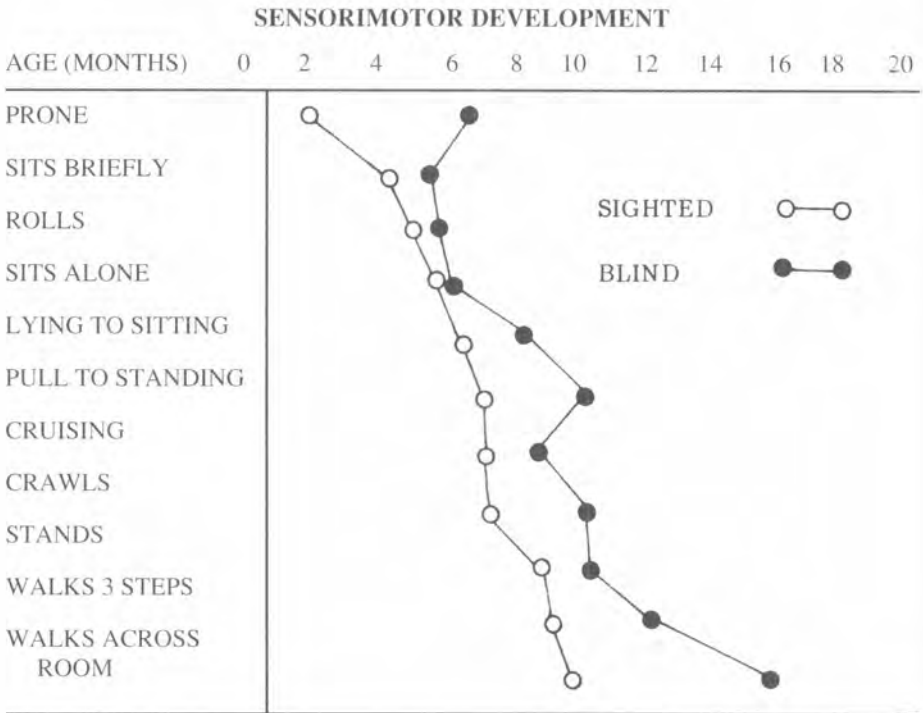
With the acquisition of movement skills, the development of body image, spatial relationships, perceptual concepts and object constancy, a child gains the abilities to explore his world. He is also enabled to learn functional skills of independence. This learning is largely influenced by vision as seen in the amount of copying a child does. A blind child needs to be very confident in his own abilities before he will have the courage to let go and move out into the unknown world to explore it.

2. DIFFERENCES SEEN IN THE SENSORIMOTOR DEVELOPMENT OF THE VISUALLY IMPAIRED CHILD

We have seen how movement plays an important role in the learning of basic concepts. The blind child is hampered in these processes by his lack of vision, reduced opportunities and motivation to move. This can be compounded by additional handicaps such as deafness, cerebral palsy and mental retardation.

There are specific areas of delay in the motor development of the visually impaired child which are delay in

- 2.1 Development of head control and weight-bearing on his arms in prone
- 2.2 Reaching
- 2.3 Postural control
- 2.4 Self-initiated mobility.



FRAIBERG AND ADELSON (1977)

This graph compares the sensorimotor development of a group of blind infants with a group of sighted infants according to the Bayley Developmental scale, drawn by Adelson and Fraiberg in 1977. We see that the blind child tends to closely follow the sighted child in attaining static postures, but that a definite delay is seen in the development in prone and in mobility skills such as crawling and walking.

I would like to go into some detail about the development in prone, reaching and self-initiated mobility.

Development in Prone

A child primarily lifts his head up in order to see. This results in the development of neck and trunk control associated with weight-bearing on his arms. The visual stimulus continues to excite the child, who then learns to transfer his weight on to one arm so that he can reach out for objects with the other arm. Without the initial visual stimulus the blind child is not motivated to lift his head. Furthermore he cannot explore as he needs both his hands for support, resulting in his disliking this position. This leads to a delay in head control and weight bearing on his arms and a delay in reaching.

Reaching

In order to reach, an infant needs to have discovered his fingers and hands in the midline. This discovery is impeded firstly by the lack of vision to motivate it and secondly by the tendency to lie with his arms in contact with the surface for security. The delay in bringing his hands to the midline hinders the development of reaching. This is further impaired by inadequate knowledge of the objects in space. Until touch and sound make an object interesting, the blind child will not be enticed to reach for it. Reaching is also hampered by toys being placed into his hands with no expectation or encouragement being made on him to reach for them.

Without the ability to weight-bear adequately on his arms, a blind child is unable to crawl or to develop the protective parachute reactions. Weight-bearing on the hands on different surfaces, plus the feeling and manipulating of objects, prepares them for finer co-ordinated activities and decrease tactile defensiveness. These opportunities are often denied blind children.

Self-Initiated Mobility

This is an area of great delay. Until a blind child starts to reach out to a sound or touch he will not be motivated to move out of or into other positions. He needs to be confident in his own abilities to balance, to protect himself when falling, and to perceive the environment around him before he will initiate mobility himself.

His drive to move can be further impeded by lack of demand being placed on him by his caregivers to move from one place to another.

The effects of all these delays often cause the blind child to withdraw into himself, with the emergence of blind mannerisms. These may also be an attempt to substitute for his lack of movement and lack of awareness of his body parts. Even if he is mobile, he moves more cautiously than the normal hyperactive toddler.

Insufficient mobility and poor balance lead to anxiety, lack of self-confidence and an attitude of dependence. These all interfere with the child's emotional, intellectual and social development.

3. PRINCIPLES OF PHYSIOTHERAPY INTERVENTION

The assessment and treatment of a visually impaired child should be based on a thorough knowledge of normal and abnormal development and on a good understanding of normal

THE STORY OF A TEACHER FOR THE DEAF

Mrs. E. Watts-Read, Sutton Education Authority

Although I enjoy my job as a teacher of the deaf, it is a career I arrived at by a very tortuous route.

Like many people of their generation, my parents regarded a woman's job as an interval between school and marriage. So, at 15, I was forced to leave school and packed off to secretarial college much against my will. I found the course tedious and boring but did acquire the necessary skills to earn a living. I found secretarial work frustrating and boring so soon left my native Glasgow to see if more interesting work could be found in London.

By my mid-20's I had achieved an interesting, responsible and varied job in industry - but I was still bored and frustrated much of the time. I also realised that having no formal qualifications and, in those less enlightened days, being a woman meant that I had no future career prospects. I also realised that however hard I worked to make directors and shareholders rich - it was never going to make me rich.

I started to study for O levels at evening classes and then decided to be very bold and study for a degree with the Open University. For the next 6 years I worked full time and studied in the evenings and at weekends. As an added bonus I met and married a fellow student.

Whilst studying I met a girl with cerebral palsy who was trying to study for a degree. She had a great zest for life, a love of literature and an intelligent mind in a body over which she had no control. Her speech was barely intelligible and so she was frequently treated as mentally handicapped. This seemed to me the most cruel affliction of all - to have so much to say and be unable to use a telephone or have easy stimulating conversations. This experience reawakened a schoolgirl ambition to be a speech therapist.

I finally achieved my degree and was offered a place on a post-graduate speech therapy course. My Local Authority, however, refused to give me a grant for this course.

Another fellow student was a teacher of the deaf and she encouraged me to consider this as an alternative. The Local Authority agreed to pay the necessary grants and so, at last, I became a real student. I trained first as a teacher and then as a teacher of the deaf.

During my training my experience was mainly in 'oral' schools in which sign language was forbidden. I was very anxious to experience a school which did use sign language. I was fortunate in getting a job in an excellent school in Brighton.

When I had become reasonably proficient in sign language I discovered that teaching, although still difficult, could progress at a reasonably normal rate and that it was possible to have quite complex discussions on all subjects. I must make it clear that sign language, by itself, is not a magic wand. It is still necessary to concentrate on good language teaching, lip reading and speech. Sign language offers another layer of reinforcement but communication can still be difficult and confusing.

I gradually came to realise how hard deaf people have to work. Apart from their obvious difficulties of communication, they never pick up incidental information, they never overhear things and because of their delayed language development many find reading and writing difficult.

Being able to use sign language helped me to discuss the emotional problems that deaf children have to cope with, problems of frustration, low self-esteem, loneliness and isolation, and often violent anger. Many deaf children live in hearing families and often feel excluded. I hope I have been able to help resolve some of these feelings by talking about them and finding strategies to help them cope. None of these, often long, conversations would have been possible without sign language. It is hard enough to express emotions without being forced to use an almost unintelligible voice - and who can lip read when crying?

I have now had 4 jobs in different schools and am at present working in a Hearing Impaired Unit in a mainstream school and still using sign language where appropriate. I am also learning about the benefits and difficulties of integration. I find all the mainstream children anxious to learn this fascinating new language.

Over the years I have taught deaf children with a wide variety of additional handicaps, the most common being cerebral palsy and Rubella. I have also dealt with children with eye and heart defects, severe diabetes, petit mal, retina problems, spina bifida and cleft palates, to name but a few.

At present I am teaching a 3 year old with a tracheostomy and have learned to deal with that. Recently one of my 4 year olds choked on her phlegm, (although I didn't know that at the time) collapsed and stopped breathing. More by instinct and panic rather than any training I got her breathing again and found myself rushing to hospital in an ambulance with her. Happily she is fine now, but those 5-10 minutes while I was alone with her and the other children before help arrived were among the longest in my life

I never stop learning - I constantly seek advice from doctors, nurses, speech therapists, educational psychologists and, of course, physiotherapists.

I try to integrate all the advice into my normal teaching routine. When tackling P.E. I often have to help children overcome problems of balance and apprehension. I try to incorporate the advice given by physiotherapists to improve their motor control. I use visual clues rather than oral ones - red, amber and green 'traffic lights' for stop, walk and run. I try to encourage them in a tactile way as they cannot hear my voice. I always look cheerful and encouraging, however apprehensive I feel inside. The slightest flicker of anxiety can be picked up by a deaf child in an instant.

So, after a day of teaching speech, wiping noses - and occasionally bottoms - sucking out tracheostomies, thumping chests plus, of course, meeting the demands of the National Curriculum, I wipe the paint of my clothes, hands and sometimes my face and remember the girl in the smart suit who sat in an office dealing with the telephone, high finance and adults! I've still not become rich but I've never regretted my change of career. Each child I teach is a challenge but their resourcefulness and courage are a constant source of inspiration and their affection and humour a constant refreshment and joy!

* * * * *

HYDROTHERAPY FOR PRE-SCHOOL CHILDREN

Mrs. G. Laverty, Senior Physiotherapist

Beechgrove School Hydrotherapy pool was opened in May 1989 and since then has been used for the treatment of disabled schoolchildren in the Ballymena area.

In May 1990 a need arose for a few pre-school children to have hydrotherapy. This started with occasional sessions when there was time available and school children were not using the pool. However as interest in pre-school children using the pool grew, we were able to give over one morning per week to treatment of this group.

At present seven children attend regularly and the benefits of this morning session seem to have been much further reaching than was first thought. Their disabilities include varying degrees of cerebral palsy, stills disease and a sacral agenesis with ages ranging from 6 weeks to 4 years.

As well as the therapeutic value parents and siblings are supportive of each other. Mothers are encouraged to come into the water and to be involved in the handling of their child. Appointment times are spaced so that each child receives individual attention from the therapist, is involved in continuing therapy through play with the mother and also is involved in group activities.

This venture has also been of great social value to both parents and children, and has been instrumental in setting up mother/child sessions in other hydrotherapy pools in the area.

The sessions have been recorded on videotape and this seems to be the best method of assessing what the children have been doing in the pool and to adjust the treatment as necessary for the individual need of each child. It also is beneficial to record each child's progress especially the increasing confidence of both mother and child in the water.

We have been studying with interest one particular child who was referred for hydrotherapy at six weeks of age and has been attending on a regular basis for nine months. The treatment of this child in the hydrotherapy pool has been very successful and we have obtained considerable carry over from moving his limbs in the pool to moving on land. This has been very obvious on the regular video recordings we have done both in the pool and during physiotherapy sessions at home. We will be continuing hydrotherapy with Luke aiming for further progress and are looking forward to more success in our pioneering venture in hydrotherapy in the Ballymena area.

* * * * *

A PARENTS VIEW ON HYDROTHERAPY

Mrs. P. Thompson

Luke - Spastic Cerebral Palsy. Left side being the most affected side. Aged 9 months.

Luke started hydrotherapy when he was 6 weeks old. On commencing hydrotherapy Luke was a very irritable baby. He cried continuously throughout most of the day and night. His little body was very stiff and tight, and it was almost impossible to nurse him like that of an ordinary child.

At that particular time both his physiotherapist, and I had to work very hard on trying to get Luke to relax. As he had a lot of muscle spasm some of Luke's problems were a result of his Epilepsy. I noticed when placed in the bath Luke not only enjoyed the experience, but he also relaxed a great deal. This was probably the only real break we got from his continuous crying. I spoke to his physiotherapist about this on one of her weekly visits. She suggested hydrotherapy and that is how it began.

We didn't notice any great change to start with except that he slept much better on his return home from the Pool and he didn't seem to be just as tight. With continued physiotherapy at home and a few extra sessions at the pool the change became more evident. There was less resistance on Luke's part, allowing us to exercise his limbs. He became very relaxed in the pool, even falling asleep on a few occasions! With very little support to his head Luke was floating on his back moving his lower limbs beautifully.

Today Luke's head control is probably the best I have ever seen. Sitting he holds his head with very little support. On his tummy he moves his right side - leg and arm as normally as you or I, where at the start there was little movement. We can even get some weight bearing of his legs.

All this lovely movement of his upper and lower limbs is now taking place at home too! Especially during playtime. I will always be grateful to Luke's physiotherapist for her suggestion. She has taught me a great deal about my Cerebral Palsied child. We still have a long way to go, and I know Luke would revert back without continued physiotherapy and hydrotherapy, but I look forward as each day passes I grow in confidence. It has been said that the sooner treatment starts with children like Luke the better. I agree with this statement. In my opinion we need more hydrotherapy pools and more physiotherapists, and to add to that we need a bigger effort on the part of parents. Our hydrotherapy pool now has a lovely Mother and Toddler Group. Luke loves the company. Eyes wide like saucers for fear he might miss something. He cries very little these days, but smiles alot.

I would like to say a very big thank you to all the hydrotherapy pool.

* * * * *

THE SCOTTISH CENTRE FOR CHILDREN WITH MOTOR IMPAIRMENTS

The Scottish Centre for Children with Motor Impairment is planned to open by September 1992, and will be located in Cumbernauld. It is envisaged that up to 40 children will attend the Centre at any one time and that, initially, the Centre will cater mainly for children with cerebral palsy. The age range will be from 2 to 7 years, with a particular emphasis on the younger children within this group and with the possibility of some under 2's attending on a sessional basis with their parents. Most children are expected to attend on a daily basis and the Centre itself will not have any residential facilities. Housing will, however, be offered near to the Centre to those families unable to travel every day.

Origins

The proposal to establish the Centre is part of the Government's response to the aspirations of parents of Scottish children with motor disorders who wish their children to receive conductive education and who, at the moment, must go to the Peto Institute in Hungary. Conductive education is a highly developed system of special education directed to teaching children and adults with motor disorders how to function independently.

The Scottish Office Minister of State with responsibility for Education, Mr. Ian Lang MP, announced to Parliament in December 1989 that the Government was allocating £2.5 million, spread over 3 years, to establish the Centre.

Aims

The Centre will be, first and foremost, a school providing education to children with cerebral palsy. It is anticipated children will attend at the new Centre for a period of time before receiving long term placement at a mainstream or special school. The Director, under the guidance of the governing body, will have the leading role in devising the system of education. The Peto Institute provides the inspiration for the project, and its methods will be followed closely; at the same time the best of good educational practice in Scotland and elsewhere will be incorporated.

The Centre must strive from the outset to meet parents' aspirations for an education that will give their children the maximum degree of independence and the best possible chance of continuing their education in a normal school environment. Except for the very youngest children attending classes with their parents, the children at the Centre will be expected to have an intensive school day. A high degree of parental involvement both in the running of the Centre and in the individual children's programmes is envisaged.

As well as its teaching role, the Centre will provide staff training to teachers and other professionals seconded to it, and may, in collaboration with one or more colleges, participate in the training of students. It will aim to develop a body of knowledge and expertise in relation to conductive education and other progressive methods of intervention with motor disorders, which will form the basis of outreach support to schools throughout Scotland.

Constitution

The Centre's governing body, is a non-profit making company, limited by guarantee. Its sources of income are likely to be government grants, fees paid by education authorities who

place children at the Centre, and fees from other sources. It is hoped also that charitable donations may supplement funding from public sector sources.

Staffing

The Director will work out, in consultation with the governing body, a plan for staffing the Centre. Some staff may be secondees from education authorities, health boards or colleges. The organisational structure will reflect the specific requirements of a holistic system.

Buildings

The new Centre is to be located at Craighalbert, Cumbernauld New Town and is scheduled to open in 1992. Meanwhile the work will begin in temporary premises in April 1991.

Referrals

Referrals to the Centre will be through the Education Authorities. The initial group will consist of children with cerebral palsy aged 2-3 years. The children will attend four sessions (3 hours) per week with one parent.

* * * * *

AWAAZ

Awaaz is the title of a video and booklet, a new project which will tell asian parents about help for their disabled child. The video is available in Hindi, Urdu, Punjabi, Gujarati, Bengali and English and the running time is 53 minutes. The video is intended for parents to view in their own homes or with friends.

Parents talk about their experiences and workers explain about health, social services, education and benefits.

The booklet summarises information about these services and how to use them and is also available in the above languages.

Videos are £12 with reduced prices for multiple orders, and booklets start at 50p.

For more details, contact Manchester Council for Community Relations, Elliot House, 3 Jacksons Row, Deansgate, Manchester M2 5WD.

CHILD'S ORTHOTIC WALKING TRAINER

David Hart

An orthotic device to provide adjustable support and control to a child suffering the effects of cerebral palsy or of similar medical condition, allowing a child to stand and walk while leaving the hands free.

There is no known cure for cerebral palsy, therefore, treatment for the condition is aimed at helping the child make best use of his or her physical abilities. For many children, the severity of their condition prevents them from even attaining an unaided standing position. This orthotic device is designed to offer the necessary support and means for a child to stand and learn to walk, the orthosis providing the means for setting the gait so as to be harmonious with that of the child, thus aiding learning by repetitive accurate cycles of motion. The walking action eventually becoming an automatic reaction to wanting to move, rather than having to think out and execute each step.

The orthosis comprising a wheeled frame, support mechanism, means for body bracing, means for releasably securing body brace to support mechanism, means for patient to control steering of wheeled frame, means for adjusting gait, means for adjusting amount of lifting support to the patient, means for automatically braking the rear floor wheels in the event of the child failing to maintain an upright posture.

The amount or extent of body bracing needed for a child to use and gain benefit from the orthosis is dependent on the condition of the individual child. The child being supported in an upward direction renders any hip, knee or foot bracing to be of a gait guidance or corrective application rather than that of a floor to upper body weight bearing support.

The steering system is designed so that when the child turns their body and body brace within the frame to face the intended direction of travel, so too do the front floor wheels.

The adjustable support mechanism allows for control of the upward support force being applied to the child through his or her body brace. The amount of lifting support being exerted so that when added to the amount being exerted by the child, is sufficient to support the child while walking. The more able the child to support their own weight then the lesser the proportional support force required. It is hoped that a child making use of the orthosis will gain strength, muscle control and balance so as to be able to decrease the amount of orthotic support proportionally, to the point where the device becomes obsolete to the child.

If a child using the orthosis should, for whatever reason, no longer provide their own proportion of lifting support, then the downward force and movement of the child is used to apply braking to the floor wheels. The reason for doing this are many, for example:- Preventing the child from losing control of the device, preventing the more abled child from lifting their feet and joy riding. The most constructive reason being that of encouraging a capable child to walk with a correct upright posture, gradually taking more of their own weight and thus make progress towards independence, preventing a child from using the device for more support than is necessary.

By supporting the braced child within a wheeled frame, at a point from the rear, makes it unnecessary for the child to use their hands to hold onto any additional support. This fact

allows the child for example, to carry hand held objects while walking, or to approach a table and engage in any desired hand activity on its work top. The front of the frame being low so as to pass under such.

Although the orthosis provides hands free mobility, it is intended to encourage a child's progress to the point of independence, the gait and support settings at the initial fitting stage and any follow up adjustments made during the stages of progress monitoring, will be to encourage the child to work towards that independence, rather than offering the child unnecessary support and easy mobility. However, it must sadly be accepted that not all children will become independent of the orthosis, for them, it will remain a hands free mobility aid and, in these cases, all settings will be aimed at helping the child to achieve maximum mobility from the orthosis, an orthosis providing a practical means to a better quality of life.

For further details of the 'Childs Orthotic Walking Trainer', and a video of the device at work, contact David Hart, Thorncliffe House, Dawson Road, Keighley, West Yorks BD21 5PH.

* * * * *

SUMMARY OF MINUTES - JANUARY 1991

1. Retired members to pay half the subscription payment, to begin in 1992.
2. Overseas members to pay £2 less for their subscription and their newsletters to be sent by airmail.
3. Jill Brownson was nominated as the representative of the C.S.P. for the Spastics Society Committee Board.
4. A leaflet is underway on the APCP as a means of improving the profile of the Association.
5. Standards of care of Paediatric Physiotherapists to be looked at by the Post Registration Education Board.
6. Booklist of Paediatric Books is now complete.
7. Building Society Account stands at £8130.17
Current Account stands at £152.71.
8. A sub group was set up in order to look at the Children's Act and Comunity Care Act and to consider the implications for Physiotherapists.
9. APCP has given its support the CSP for a Paediatric Day to be held in 1992. A conference will be held on Multi disciplinary Approach during this time.

PRO REPORT FOR AGM - 13 APRIL 1991

Caroline Dunn, Hon PRO

The function of a Public Relations Officer is to assist in presenting the Flag Ship role of the Association and to act as a link between the Regions and the National Executive Committee. In this capacity, your PRO is a member of the Executive Committee, sits on the APCP committee and is on the Editorial Board. She holds two meetings a year with the Regional Representatives, when local matters, both anxieties and developments, are discussed, the summary of which is agreed and relayed to the Committee.

A regular flow of information is received from the CSP, and, wherever appropriate and or possible, this is forwarded to Regional Representatives.

There is a good deal of correspondence coming in from UK and overseas. This is answered if possible, with the information required. Increasingly it seems appropriate to refer such requests to the Regional Representatives. This kind of correspondence highlights the necessity for us to move forwards as soon as possible to an integrated network.

We have looked at information available to new Members, who now receive an introductory letter, a leaflet "Physiotherapy in Paediatrics" and "Good Practice Guidelines". This highlights the importance of these two documents which were both published in early 1990. To fill a further gap in information, a leaflet is now in draft giving information on what APCP is and what it has to offer.

Your Chairman and PRO attended the CSP Congress in Bournemouth in September. This was a most stimulating experience, with some excellent lectures and research papers, giving an opportunity to meet colleagues from a wide field. Your Motion, relating to the importance of an integrated District Paediatric Service, was presented as motion 92 in the Service management section. This motion was devised at the April conference in Loughborough. Attendance at this congress necessitated a day's training beforehand. The delegate Congress is well worth attending and gives an opportunity for the members voices to be heard. The organising Committee is to be congratulated on the way in which they maintained momentum and retained delegates to the last.

The PRO Board accompanied us to Bournemouth. The main photographs, which were donated by Carol Foster of the Childrens' Hospital, Birmingham, are much admired. It is important that we maintain flexibility by introducing displays that you, the membership want there. Please do not hesitate to ask for notices, pictures etc., to be introduced. The PRO Board is available to those who wish to borrow it. Please remember that is heavy and quite big, but I live near the Midland Motorway network and could arrange to meet the borrowers at a halfway point.

It is encouraging to hear the Regional responses to the way in which Physiotherapists working with both school and pre-school children are working in a truly multidisciplinary manner. It is important for us all to remember the effects of grief and the 'Crusade' factors in the search by increasingly well informed parents for their ideal treatment for their children. It is distressing to be aware that some preferred changes in local services are impossible because of poor funding and gaps in staffing. Sometimes a little thinking time for objectives leads to useful lateral moves.

Three of us attended a day set up by IHMS and Hospital Trusts on the new Childrens Act. A sub-committee is consiering the implications of the Act for APCP.

There have been considerable anxieties from the Regions because of courses set up and finally cancelled because of poor response. It is difficult to know why this is happening, because responses to questionnaires were between 0% and 3%. In one reigon a concerted effort is being made to increase the size of the committee and to arrange Courses on weekdays instead of Saturdays.

A News sheet/letter has now been initiated with the Overseas Members. In the first instance this is to establish contact, it is hoped that this will build so that the overseas members contribute to future News sheets.

PRO should be resonsive and flexible; it should be good at listening and drawing out information. At the same time we attempt to keep a sense of proportion when the boat seems to be being rocked, sticking by our professional judgement.

* * * * *

A.G.M. AND STUDY DAY - 13TH APRIL

A most successful and thought provoking day was held at the Institute of Child Health. Presentations evolved round 'The Unified Approach', Bobath, and Conductive Education.

At the A.G.M., the following were elected onto National Committee -

Viv Williams, Jenny McKinlay, Ann Shanks, Fiona Corkhill.

We wish the old hats well, and welcome the new to an exciting term of office.

Following the AGM, National Committee met to co-opt Mary Clegg and Caroline Dunn onto committee and elected them Chairman and PRO respectively for the coming year. Viv Williams was elected to continue as Vice Chairman.

CEREBRAL PALSY HELPLINE - 0800 626 216

Provides information, advice and initial counselling on anything associated with cerebral palsy.

ABSTRACTS

Title: The Relationship between arterial blood gases and removal of airway secretions in neonates.

Author: Paul T. Dall'Alba and Yvonne R. Burns
University of Queensland, Australia.

Source: Physiotherapy Theory and Practice 1990 Vol 6, pp 107-116.

Respiratory physiotherapy has become an integral part of neonatal intensive care in many units, based on the view that it will assist in the removal of secretions and improve the oxygenation of the baby. However there is as yet no direct evidence that secretions and arterial blood gases have any effect on each other. While removal of secretions from the airways may reduce respiratory resistance, there may well be other reasons for improved oxygenation such as the tactile input of physiotherapy which can lead to increased rate of respiration.

The main aim of this study was to determine if there was any consistent relationship between the amount of secretions removed from the airway and oxygenation of the babies - it was hoped this could then lead to a greater understanding of the effect of physiotherapy.

The study involved 10 infants with RDS in September to November 1987. All were pre-term with birth weights of less than 1500 grams and had undergone a period of IPPV. They were studied following cessation of IPPV and removal of ETTs - this providing a clearly defined period in which all infant's respiratory requirements were similar and procedures could follow an identical management procedure.

Methods of measuring amounts of secretion, transcutaneous monitoring etc. are then described.

The authors ends the article by stating the study clearly demonstrated that in pre-term infants, increased amounts of secretions were associated with lower O₂ levels and increased frequency of hypoxic episodes - removal of large amount of secretions were associated with improved oxygenation.

* * * * *

Title: Implications of Mainstream Classrooms for Adolescents with Spina Bifida

Authors: Jan Lord, Nicole Varzos et al.
Dept. of Paediatric Rehabilitation, Oakland, U.S.A.

Source: Developmental Medicine and Child Neurology 1990, Vol. 32, pp 20-29.

Children with spina bifida represent the second largest group of students with orthopaedic handicaps in mainstream schools in the U.S.A., - they are placed thus because they have normal or near normal intelligence. It is expected this placement should prevent the pattern

of inadequate development of academics and social skills during childhood which in adolescence can precipitate further deterioration and lead to significant depression.

Little is known about the educational and social effects of mainstream placement and there has been little evaluation effectiveness in these subjects.

33 adolescents with spina bifida who attended tertiary clinics participated in this study. The Peabody Picture Vocabulary list, the UCLA loneliness scale were administered to the children and their NTAs completed. Personality Inventory for Children.

Those adolescents placed in mainstream education had the most normal scores for academics and social skills while those placed in mixed and special education had the lowest. Adolescents placed in mixed i.e. a combination at mainstream and special education reported the least loneliness, enjoying meeting others with disabilities.

This study suggests that mainstream education, although recommended generally, and popular with parents can be associated with a greater degree of loneliness than expected.

* * * * *

Title: Rehabilitation of Children and Infants with Osteogenesis Imperfecta
A program for ambulation

Author: Lynn H. Gerber - et al.
National Institutes of Health, Bethesda, Maryland, U.S.A.

Source: Clinical Orthopaedics and Related Research No. 251, Feb. 1990.

Management of Children with osteogenesis imperfecta has usually followed one of two approaches:

1. Excessive protection because of frequent fractures.
2. Attempting to achieve some form of protection by surgical rodding.

This programme described in this article was devised to gain maximum function while minimising the risk of fractures. It evolved over 8 years of clinical involvement with such children and is based on the theory that standing and walking are desirable and attainable goals.

All children seen were evaluated by a team of paediatrics and health professionals.

Those under four years who had sufficient head control in sitting and were able to pull themselves by standing were fitted with lightweight full length calipers, those unable to get in to standing but fitted other criteria were given standing calipers. Those who did not fulfil any criteria were provided with a moulded supportive seat.

Individualised specific exercise programmes were devised for each patient muscle strengthening exercises focussing on weak muscles, usually hip extensors and abductors. Swimming was advocated to improve endurance. Calipers were removed for non weight bearing exercises and swimming.

Initiation of standing and progression to walking followed a standard approach - in many cases calipers were discarded but by no means always.

Twelve children were evaluated using this programme - only one being able to pull to standing prior to their evaluation. All children were enrolled in mainstream schools and all eventually walked. If any fractured they were treated with skeletal traction and/or plaster casting. Plates and rods were removed where possible. All the children had leg length discrepancies and hyperextensibility of joints was common, mostly in knees, ankles and elbows.

The authors feel the programme consisted of three main components - early intervention, strengthening of hip extensors and suitable calipers. All the children attend mainstream school, fractures are not eliminated but remain at an acceptable level. They feel that such a programme has enabled these children to reach a high level of function.

* * * * *

LETTERS TO THE EDITOR

Dear Editor

Following the review by Mrs. C. Dunn (No. 58, Feb. '91) of my letter to you regarding seating for the young Cerebral Palsied Child, there were several questions raised to which I would appreciate the opportunity to reply.

Firstly, concerning the selection of children to the study groups. All children were to be diagnosed as having cerebral palsy with significant delay in development and who had not previously been issued with individually prescribed seating. Careful attention was paid in trying to match children in both groups, especially as to their additional handicaps such as visual impairment and epilepsy. It was recognised this was a difficult undertaking as each child having cerebral palsy has individual manifestations of the condition. However, as the majority of the children in the older group had been known to the researcher from an early age and had been regularly assessed for their developmental activity, when selecting children to the younger group it was possible to identify children whose development was comparable at a corresponding age to the older ones. Therefore I feel Mrs. Dunn was incorrect in her assumption that the older children were more severely handicapped. It is unfortunate that she did not perhaps take the opportunity to familiarize herself with the results of the theses as a whole, before reviewing the results I enclosed within my previous letter to you.

I have been fortunate enough to be accepted to present my work at WCPT this summer. If any members who attend wish to question me further, I would be most willing to discuss the results with them.

Sincerely,
Jill Simpson

Dear Mrs. McKinlay,

For many years therapists have struggled to inform the medical profession that we must not simply accept the disability of the child with cerebral palsy. As any Bobath trained therapist knows, (and indeed many others) it is possible to help most children with cerebral palsy to improve function. This is done through technique of handling which inhibit abnormal motor patterns and facilitate more normal ones. I therefore read with dismay Dr. Croft's precis in the November 1990 Newsletter. It is surely an obvious conclusion that C.P. children who cannot chew should be given the appropriate food to prevent frustration or distress from choking. However, in order to promote better chewing, it is vital to introduce some more solid food at an early age. This is done with careful control of the child's head, trunk and jaw to avoid choking. Gradually, the amount of solids is increased as the child learns to cope.

Dr. Croft does not mention whether the children in his study were given any such control, and thus his results are very misleading.

Sincerely,

Gillian Stern
Sr. Physiotherapist, Bobath Centre

* * * * *

Dear Editor,

It was with great interest that I read the first part of Dr. Ian McKinlay's article: 'Therapy for Cerebral Palsy' in the February Newsletter.

I would like to express my thanks to Dr. McKinlay, particularly for the last two paragraphs - 'Doctors Attitudes' and 'Magical Treatment'. I found it gratifying to see in print, acknowledgement of the 'emotional and behavioural consequences of the child's disability' with which we are so often confronted during the fulfilment of our more easily recognisable role.

Without warning, the Paediatric Physiotherapist may become the 'listener' to the parents outpouring of grief, in various guises. Each encounter is different and the Physiotherapist can only hope that she handles every one of these encounters to the parents advantage. Dr. McKinlay's understanding of the parents grief and their handling of it, together with his call to address the process of grief was refreshing.

Faithfully,
Judy Hemming-Allen,
Supt. Physiotherapist
Sandwell Health Authority

COURSES

CASTLE PRIORY COLLEGE

For details and application, contact Castle Priory College, Wallingford, Oxfordshire OX10 OHE. Tel: (0491) 37551/26350.

27/29 10 - 12 May 1991

The Hand as a Guide to Learning

- designed for all those working with young children who have cerebral palsy or a similar disability.

27/41 28 May 1991

Parents, Families and Professionals

- a one day seminar concerned with the development of joint initiatives and ways of working together. Families, staff and clients welcomed. Further details available including low cost fees.

27/56 11 - 14 June 1991

Halliwick Swimming Method Parts A and B

- full further details indicate 'parts' components.

27/65 22 June 1991

Inner Rhythm

- a programme on 'Dance for the Hearing Impaired', developing an awareness of inner rhythm. For teachers and carers of the deaf, dance teachers and trainee dance teachers.

27/70 24 - 26 June 1991

Organisation of Learning Environments for Profoundly Handicapped Children.

- a workshop based on programmes inspired by the work of the Peto Institute. For teachers, therapists and others.

27/89 12 - 14 July 1991

The Portage Teaching Materials

- an introductory course led by Mollie Whiulte, National Portage Association. Institute of Child Health

INSTITUTE OF CHILD HEALTH

For application form and further information, contact Mrs. Anne Crowley, Teaching co-Ordinator, Institute of Child Health, 30 Guildford Street, London WC1N 1EH.

44 13 - 17 May 1991

Assessment and Management of Young Children with Severe Visual Disabilities

- Severe disability is considered from developmental, family, medical and educational viewpoints. Assessment techniques which provide a basis for developmental and visual intervention in the early months and years are discussed and demonstrated for children both with and without additional disabilities.

ISSUES IN THE TRAINING OF POSTURAL CONTROL

14 - 16 July 1991

Venue - Addenbrooke's Hospital, Cambridge.

A meeting will be held in Cambridge under the auspices of the Eastern Motor Group to provide an opportunity for clinicians, therapists and behavioural scientists to exchange information in the important area of training postural control. It is intended that there will be an emphasis on rehabilitation of neurological patients, both adults and children. The conference will include formal papers and poster presentation as well as allowing informal small group discussion, exhibiting of videos and equipment concerned with the training of postural control. Attendance will be limited to 50 and the meeting charge is expected to be in the region of £40.

Those interested in presenting a paper or poster, in showing a video or demonstration equipment or, simply, wishing to attend, please contact: Paulette van Vliet, School of Physiotherapy, Coventry Polytechnic, Priory St., Coventry CV1 5FB. Tel: (0203) 838347.

CALL FOR PAPERS - University of Dublin, Trinity College

26 - 28 February 1992

'Quantity of Quality of Physiotherapy by the year 2000'

Trinity College School of Physiotherapy and the Irish Society of Chartered Physiotherapists are hosting an international conference in celebration of the quatercentenary of Trinity College. The Scientific Programme Committee invites you to submit abstracts for consideration - maximum presentation time twenty minutes. Abstracts should be typed in English and should be no more than 300 words. Poster presentation is also welcomed. Last date for abstract submission is 1st October 1991. Programme topics will include new research and observations from clinical practice: Electrotherapy, Ergonomics, Respiratory Therapy, Paediatrics, Neurology. Papers welcomed on topics not covered by the above.

For more details, and submission of abstracts, contact Quatercentenary Committee, School of Physiotherapy, Trinity College, PO Box 814, James's Street, Dublin 8, Ireland.

RNIB SHORT COURSES

For further details, contact RNIB NMC, 1 The Square, 111 Broad Street, Birmingham B15 1AS. Tel: 021 643 9912.

No. 916 6 June 1991

Introduction to Visual Disability

- A one day course focusing on the psychological and practical consequences of visual disability. The day will include instruction on and experience in guiding a blind person. This course is particularly suitable for social work assistants, social workers, home helps, nurses, volunteers, care staff, and others who have limited experience in visual disability.

REGIONAL REPORTS

Trent

Jenny Gill, Child Development Centre, City Hospital, Hucknall Road, Nottingham NG5 1PB

The Annual General Meeting of the Trent branch was held as usual at the Nottingham School of Physiotherapy on 13 March. A buffet supper was kindly sponsored by Gilbert and Mellish and was followed by a lively talk, along with a very amusing set of slides, given by Dr. Leon Polnay about the role of the Community Paediatrician.

A study day "Children and the Human Sandwich factor" to be held in Nottingham during April is drawing an encouraging number of applicants. Membership numbers within Trent Region are down this year and so plans are underway to have a 'recruitment drive'. Hopefully this will include reminders to recently lapsed members as well as drawing in totally new members to the A.P.C.P.

West Midlands

Carol Foster, Physiotherapy Dept., The Childrens Hospital, Ladywood Middleway, Ladywood, Birmingham B16 8ET.

This past year has been a difficult time for the Committee of the W. Midlands. There have been problems with our Secretary, Hazel Wotherspoon who had to retire due to the advent of a companion for her small adopted son (congratulations Hazel!), and also cancellations due to lack of support for two courses, one a Downs' Day, the other a Single Case Methodology day. This was most disappointing. However, on the bright side, the A.G.M. was held on 18 March at Sandwell Postgraduate Centre, and we had a good turn out of 35-40 physios. A new committee was elected with some new keen members, plus Mrs. Judy Hemming-Allen as Chairman. Mrs. Liz Bubb as Secretary and Mrs. Rachel Nerrick as Treasurer being the main officers. Opinions for venues, times, places and content of future courses was enthusiastically discussed and we hope to offer a varied programme with something to suit all during the coming twelve months. Dr. T. Southwood, Paediatric Rheumatologist BCH added to the evening with a thought-provoking talk on Juvenile Arthritis. We are all looking forward to this new year and ask please for your support.

Wales

New Reg. Rep: Barbara Bowen, Supt. Physio, Child Assessment Unit, East Glamorgan Hospital, Church Village, Nr. Pontypridd, Mid Glamorgan.

Retiring Lyn Horrocks writes:- "Barbara Bowen has worked in special schools for several years and took up her present appointment about a year ago. She is treating mainly pre-school children, but is also responsible for physiotherapy on SCBU and clinics at the hospital. She went on the eight week Bobath course when it was held in Cardiff last summer, and also attended Jenny French's three day course on sensory intergration later in the year. She maintains interest in acute physiotherapy with weekends on-calls and is involved with the organisation of the 1991 conference in Cardiff. I hope she enjoys her time as rep. for Wales as much as I have."

- North West** **Miss Alex Winney, 14 Langley Rd., Spital, Bebington, Merseyside L63 9HW.**
 Our thanks to Lyn Wakley who is stepping down as Regional Rep., but continues as the Chairman of the North West Committee.
 The recent A.G.M. - Study morning on Saturday March 2nd with David Scrutton as Guest Speaker proved extremely successful albeit too short!
 An 'Orthopaedic' Study Day is planned for October, probably to be held somewhere in Manchester - more details nearer the time.
 Other ideas for courses or study days would really be welcomed by the Committee.
- North East** **(Reg. Rep. pro-tem) C. Jackson, 4 Abbotsway, York YO3 9LB.**
 Judith Baigent has retired after 4 years - our thanks for all her help and hard work.
 A most interesting Study Day on Legal Aspects of Community Paediatric Physiotherapy was held in Gateshead on March 9th. Our thanks go to Penny Robinson of the C.S.P. and Sandra Holt for giving up their Saturday to give such a stimulating day.
 The branch AGM was held on the same day and we hope to have an even more geographically representative committee as a result. A programme for the next year is to be planned at the next committee meeting in April.
- South West** **Mrs. Carole Hurran, 23 Bayswater Ave., Westbury Park, Bristol BS6 7NU.**
 The committee held a successful meeting at Odstock Hospital on 1st February and welcomed Linden Clark from Gloucester and Tess James from Dorchester.
 Poole are organising a very interesting Day Course on Gait Analysis and Walking Problems on Friday 3 May when the Regional AGM will also be held. Hope to see lots of you there!
 At least 3 children from Bristol are being assessed for the new David Hart Walker-Trainer at the present time. We will report back on how they get on and would like to hear from anyone else with a child using one.
- South East** **Miss Terri Fearn, 38 Woodlands Close, Peacehaven, E. Sussex BN10 7SF.**
 Our Study Day on 'Arthrogyrosis and Advances in Orthopaedics' for March 16th had to unfortunately be cancelled due to lack of response. It seems there was a lot on in March, and many diaries were full. After the course had been cancelled, it was discovered that 10 people or so had intended to apply but had not got round to doing so! We hope to run a similar day later this year.
 We hope to get more response for the day on June 15th when the programme will include 'Behaviour Modification, Counselling and Portage'. A programme and application form is enclosed for S.E. members. Our A.G.M. will also be on this day. Please apply well in advance.
 If there are subjects you feel would be useful for study days, please let me know. Also, we try to hold these at different centres around the region. If you would like to have one held at your local centre, again, let me know.

We would also be pleased to hear of anyone interested in joining the committee.

London

Mrs. Rowenna Hughes, Sheldon Centre, St. Giles Road, London SE5 7RN.

The programme for 1991 consists of three events:

May - Inhibitory Casting - see April Journal. This is a Practical Workshop, and numbers are limited.

November 7th - Evening Lecture: 'Development of Hand Function' - Sheila Eden. Venue to be confirmed.

Saturday 14th September: 'Deformity' Study Day, Venue to be confirmed. Speakers to include an Orthopaedic Surgeon and Physiotherapist, and Occupational Therapist and Orthotist.

East Anglia

Mrs. Jackie Reynolds, Church Farm House, Ormsby, St. Michael NR29 3LN.

An interesting study day was held at Watford General Hospital on 6th March on Gait Analysis in Spastic Diplegia. The speakers, from Oswestry, were Mr. Patrick, Orthopaedic Surgeon, and Vicky Draycott,

Physiotherapist who works with the children following their multistructural surgery. The day stimulated many questions and was well attended by 60 people. Our A.G.M. was held at lunchtime. Four committee members retired and we extend thanks to them for all their work. Angela Glyn Davies needs special thanks for her work as Secretary. Liz Waugh has agreed to take on this role. Chris Burnett was co-opted to remain as Treasurer for the next year. Elaine Curtis, Elizabeth Sykes, Susan Whitby and Judy Greenwood are welcomed on to the committee.

The Conference Committee has been hard at work planning the 1992 conference which will be held at the University of East Anglia in Norwich on March 26th - 28th. The theme will be 'Forward with Europe' and will be looking specifically at the management of the neurologically impaired child. This is taking most of the time and energy of the committee this year. It is hoped that we may hold a 'Five Minute Day' over the summer giving an opportunity for regional members to present short topics, treatment notes or items of interest. Please contact me if you would like to participate. A Study Day is planned for September or October.

N. Ireland

Miss Ruth Graham, 75 Ravenhill Gdns., Belfast BT6 8GQ.

A very informative and well attended gait analysis study day was held in February, with a team of speakers from Dublin and Belfast.

Two courses are planned for May. The first of these is 'Problem Solving in Cerebral Palsy' on the 10th and 11th at Musgrane Park. The speaker will be Colin Stevens from the Bobath Centre.

The second course is a two day counselling course to be held in the Management Development Centre in Lurgan on 30th & 31st May. Geoff Magee - a professional counsellor - will conduct the course.

Please let the committee know of topics which would be of interest for talks, study days and courses for the year 1991/92

Scotland

Mrs. Ann Harden, 56 Juntly Court, Lnagside, Glasgow G41 2DH.

