
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

Association of Paediatric Chartered Physiotherapists

Newsletter No. 63

INTEGRATION

May 1992

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EDITORIAL

Jenny McKinlay, Editor

It was very welcome to hear in Mary Goy's summing up of our National Conference in Norwich reference to the 'Team Approach' of so many of our speakers. You will hear much more about that excellent conference in our August edition, but in this edition, it is encouraging to note that we have evidence of people successfully working together to further promote the type of service we all long to see. It was in Loughborough that one Workshop, when asked to debate the subject 'Health and Education - Marriage or Divorce?' concluded after much debate that 'Health and Education should live together, for the sake of the Children'!

This is not the forum to expound the merits of marriage in preference to living together, but there is surely an increasing openness and willingness by the many varied groups involved in child care to work together. Only recently the Departments of Health and Education & Science initiated a conference commissioned by VOCAL to examine the need for new opportunities in communication aids. We were represented at this conference by our Vice-Chairman Viv Williams and one of our Honorary Members, Ian McKinlay. Undoubtedly, 'communication' is something that we all need to improve greatly, even if we have no speech or language difficulties.

Communication brings us neatly to your Newsletter in which you have the opportunity of communicating with each other even through the time lapse between editions. It is for you to express your point of view and share with your peer group and, of course, the members of your team.

My thanks go to all who have contributed.

* * * * *

**COPY FOR THE AUGUST 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.

ANNUAL SUBSCRIPTIONS FOR 1992 - £15.

Ordinary Membership is open to suitable qualified members of the Chartered Society of Physiotherapy

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INTEGRATION

Geraldine Tisdall, Head of Lavinia Norfolk Unit

The Lavinia Norfolk Unit at Angmering School in West Sussex is a support facility for secondary school age students (11 to 18 years) who have a physical disability or hearing impairment.

The school is a day school for over 1,000 students and physiotherapy and hydrotherapy need to be fitted into the timetable to take account of the curriculum the students follow.

At Angmering all students are members of tutor groups and are fully part of the whole: fully "integrated" or "belonging". It is not a problem that these students need physiotherapy but it is a requirement that all professionals work with each other to ensure the optimum learning programme for each student.

Two physiotherapists work with some twenty students who have a range of needs. The biggest group at present are those who have Muscular Dystrophy, but at any one time there can be a wide range of physiotherapy needs to meet, from the daily supervision of students with Cystic Fibrosis to the monitoring of the exercise programmes of students with Cerebral Palsy.

Physiotherapists work closely with the teams of Special Support Assistants who are timetabled as physiotherapy aides, to meet all the calls on their skills and provide a superlative service to the students.

Careful timetabling of the morning-only sessions targets physiotherapy sessions when students would have PE or where time has been created by modifications to the curriculum. The close liaison and flexibility of all concerned result in the optimum use of time and students rarely have to miss lessons or parts of lessons.

Our two physiotherapists overlap on one day a week which enables them to share, exchange information and plan developments and new strategies. Both have become very much part of the multi-disciplinary team, being consulted on a range of issues from seating to hydrotherapy programmes. They plan and implement regular in-service training for Special Support Assistants; re-assess the lifting skills of all staff of the facility and make proposals to up-grade resources.

At the hub of the facility lies the physiotherapy room, an unusually shaped awkward room in which three to five students could be working on programmes of exercise to the sound of raucous music and hysterical laughter. It is a place of light and humour, pain and the pleasure of good company, good listeners, security and understanding.

In the afternoons it has a sad and waiting air: a marked contrast.

And Integration?

Integration as we have briefly seen, is the integration of all the parts into the whole. It is belonging. In this context every aspect of the whole is important to the wholeness. The work of the two physiotherapists at Angmering is deeply integrated into the life of the school as are the students whom they support so ably.

THE CHANGING ROLE OF THE PAEDIATRIC PHYSIOTHERAPIST IN MAINSTREAM SCHOOL IN NEWHAM HEALTH DISTRICT.

Christine Cole - Senior Physiotherapist

The number of children referred to the Newham Paediatric Physiotherapy Department has increased considerably in the last three years. In addition, there has been a sharp rise in the number of children with special needs who attend mainstream schools. In 1985, there were 23 children with special needs in mainstream school. By 1991, the number of children requiring physiotherapy intervention in mainstream schools was 142, as shown below. These numbers only represent the children that are seen by a physiotherapist, they are not the total numbers of children integrated.

CHILDREN RECEIVING PHYSIOTHERAPY IN MAINSTREAM SCHOOLS IN 1991

Arthritis	5
Neuromuscular Disorders	4
Spina Bifida	2
Cerebral Palsy	29
Clumsy/Co-ordination Difficulties	83
Downs Syndrome	4
Other	15

Staff ratio has not paralleled the increase, therefore, we have had to change our working practice to accommodate the increasing numbers. In this paper I have discussed our considerations for re-evaluating our methods of service delivery to one particular group of children. I have also presented a summary of a single case study carried out on a clumsy child and offered a discussion for the relevance of the results and the issues surrounding this. To summarise, I have described our strategies for the way forward.

BACKGROUND

In Newham, the Education Authority is fully committed to integrating children with special needs into the mainstream system. The Health Authority works closely with the Education Authority to implement this. The Education Authority plans to close all special schools within the next few years. This means that the 143 children who receive physiotherapy in special schools will be transferring to mainstream schools. Therefore, the growing number of children with special needs i.e. physical handicap, learning difficulties and emotional and behavioural difficulties, continues to re-define the physiotherapists working role in the mainstream schools.

The number of children who are being referred with co-ordination difficulties is of particular interest. These numbers have increased at the greatest rate and so involve a large percentage of physiotherapy time. With our continuing teaching input to relevant Health and Education personnel regarding physiotherapy intervention, referrals continue to arrive. Moreover, referrals of children with co-ordination difficulties are becoming more relevant and accurate.

THE CLUMSY CHILDREN

In 1988-90 the number of children who have co-ordination difficulties and who were receiving physiotherapy intervention in mainstream schools was 20. Of these, seven had regular, weekly treatment and 13 were seen for review and advice approximately every three weeks.

By 1989-1990, the number of children with co-ordination difficulties, and referred to physiotherapy, had grown to a total of 83. 14 of these children received individual treatment, 12 had group treatment, and 18 had a physiotherapy programme which was implemented by staff employed by the Education Authority. The other 39 children were assessed and advice was given to the parents and teaching staff. They were seen for review at intervals or when this was requested.

The numbers of referrals have continued to rise, therefore, our role as 'adviser' has become a more prominent part of our working practice than previously. However, it must be said that this role is somewhat influenced by a great increase in client numbers with resultant 'stretch' on the service. Possibly the most important skill required for this working model is the ability to assess and designate the correct mode of intervention to suit the needs of the individual. I would suggest that we are often in danger of being directed by our limited resources when making our recommendations, rather than directly meeting the child's needs, particularly when numbers increase in a short space of time. Additionally, frequently there is the issue of personal responsibility for not providing more physiotherapy treatment. But, is this in response to the child's needs or a parent/teacher 'nag'?

From personal experience I believe that these pressures often cloud our ability to be objective in the evaluation of our intervention. The 'once a week treatment syndrome' can run in to months, and sometimes years, without appropriate review. So, with a growing interest in the child with co-ordination difficulties, plus a need to achieve a standard of service to this client group, we decided to carry out a single case study on a clumsy child in a mainstream school. The child had already been selected for individual physiotherapy treatment, our intention was to ascertain how effective a boost of intensive treatment could be. It is not relevant in this article to impart the full details of the study as wider issues will be discussed, but a brief outline is given below.

SINGLE CASE STUDY

Our hypothesis was that an intensive period of treatment delivered to a clumsy child over a short period of time (2-3 weeks) is an effective method of providing physiotherapy treatment. The design of the study chosen was Single System A.B.A. The benefits of the single case study are: 1) performance acts as its own control; 2) it directs treatment to problem solving efficiently; 3) it has been proven to be an efficient method to evaluate treatment.

Following a full assessment of the child's motor abilities, a base-line was established which included five testing areas. These were: hand-eye co-ordination; bilateral activity; body awareness and proprioception; balance; motor planning and sequencing. Points were awarded on each section for achievement. A treatment programme was then devised involving sensory-motor activities which were applicable to the child's difficulties. It must be noted that during testing, treatment and re-testing stages the consistency of days between sessions did vary due

to other school commitments. This did not seem to affect the results which are shown in Figure 1.

At the end of the study we were able to show that:

- a) During base-line testing, repetition of an activity did not significantly improve sensory-motor function.
- b) Intensive treatment did significantly improve sensory-motor function and sustained the improvement.

The study provided useful information to our service in several ways. The child did indeed benefit from intensive in-put and subsequent re-tests of his motor performance at six-monthly intervals have confirmed the benefits of this improvement. The visual representation of progress made has been useful in providing data for medical and other personnel, and not least, for the child himself. Needless to say, this is becoming a very important requirement for our documentation aiming to achieve a more scientific approach to assessment and treatment. I believe that this is of paramount importance to this particular client group as we are largely dealing with non-visible disability.

RESULTS

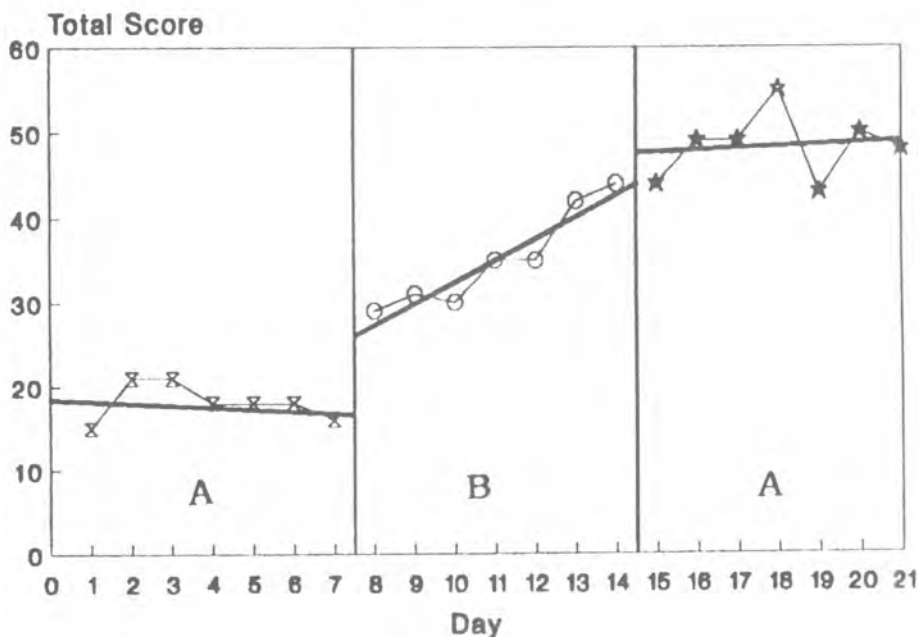


Figure 1. Line graph illustrating the change in trend across phases. In phase A (baseline), there is a decelerating trend; in phase B (treatment), an accelerating trend; and in the second A phase (baseline), an almost static trend with maintenance of improvement gained in phase B.

The most useful information derived from the study was the interest and response shown by the teaching staff at the school; being very supportive and encouraging. With our present low staff/client ratio we are obliged to work on a priority basis, so physiotherapy time to clumsy children is greatly limited. We are, therefore, unable to offer frequent intensive periods of treatment but have realised the possibility of utilising teacher's contribution to a programme of advice and activity. At school, the raised awareness of this particular child's difficulties has led to more appropriate management of his needs with 'strategies' employed to assist him when necessary. This has been a consistent response throughout schools in Newham with many of the children we are dealing with. Whilst not suggesting that this is a replacement for physiotherapy treatment, it goes some way to enabling the child to recognise and cope with his difficulties with greater possibility of achievement in the school environment.

From the results of the study we deduced that intensive physiotherapy treatment over a short period of time, using appropriate goal orientated plans, is likely to be effective for other children. The success lies in appropriate assessment and goal planning.

Including others (ie. parents, teachers and carers) in the assessment, goal planning and eventual management plan is likely to be an effective method of implementing a 'therapeutic programme' for the child. More relevantly, including others working with the child facilitates the holistic approach; thus management does not remain exclusive to the physiotherapist. This will also facilitate delivery of service to a greater number of children.

WHERE DO WE GO FROM HERE?

Our service has been working towards the implementation of school-based programmes for some time, with what we believe to be good effect. In conjunction with our occupational therapy department, we continue to provide teaching sessions to education staff about various aspects of the 'clumsy child' and the general interest has increased rapidly. We are now providing more written information for all mainstream schools.

Providing intensive physiotherapy treatment for those children requiring it is proving impossible in schools or within the limited resources of our Child Development Centre. We are now looking towards the use of alternative premises during school holidays to provide intensive boosts of treatment. We have also been obliged to further prioritise our service so that children who are not seen more regularly than 6 monthly intervals have been discharged. Letters have been sent to families and schools advising them to contact us when needs arise as we are unable to offer regular appointment times. This has relieved us of our obligation to review routinely and placed more responsibility on the families and schools to contact us when necessary.

With the introduction of P.E. to the National Curriculum, the standardised 'attainment targets' expected of the children is bound to identify a number of non-achievers. Many of these are unlikely to need physiotherapy treatment, but, if referred, could still require a time-consuming assessment. We are interested in providing information to teachers which will help to identify, clarify and eventually assist those children. We are presently negotiating a method for introducing trials to help to develop a meaningful check-list for use by Education Authority staff prior to referral. It is hoped that this will lead to all referrals to physiotherapy, by Education Authority staff, of children with co-ordination difficulties being even more relevant than they are at present.

THE ROLE OF THE PHYSIOTHERAPIST IN SPECIAL EDUCATION

“Why can’t my child walk and go to a normal school?”

Mrs. Hilary Getty, Superintendent Physiotherapist
Mitchell House School

Variation is a fundamental characteristic of living things, and people vary widely in their mental and physical abilities. A child is said to be handicapped when a disability puts him at a disadvantage in his particular environmental circumstances. “**Handicapped** - One who suffers from any disability of body, intellect or emotions” (2). Such a disability of body, intellect or personality, may adversely affect the child’s development and capacity to learn and to adjust to life. The extent of the consequent handicap will obviously depend not only on the nature of the disability, but also on what is expected of him, and on the personal qualities and abilities which help him to meet the challenge. The aspirations of the parents, the tolerance of the teachers, the rivalry of the other children, the nature of the physical surroundings and the demands made by the society in which he lives, will all influence the severity of his handicap.

The Child

Children learn what **they live**

If a child lives with criticism

He learns to condemn

If a child lives with hostility

He learns to fight

If a child lives with ridicule

He learns to be shy

If a child lives with shame

He learns to feel guilty

If a child lives with **tolerance**

He learns to be patient

If a child lives with **encouragement**

He learns to be confident

If a child lives with **praise**

He learns to appreciate

If a child lives with **fairness**

He learns justice

If a child lives with **security**

He learns to have faith

If a child lives with **approval**

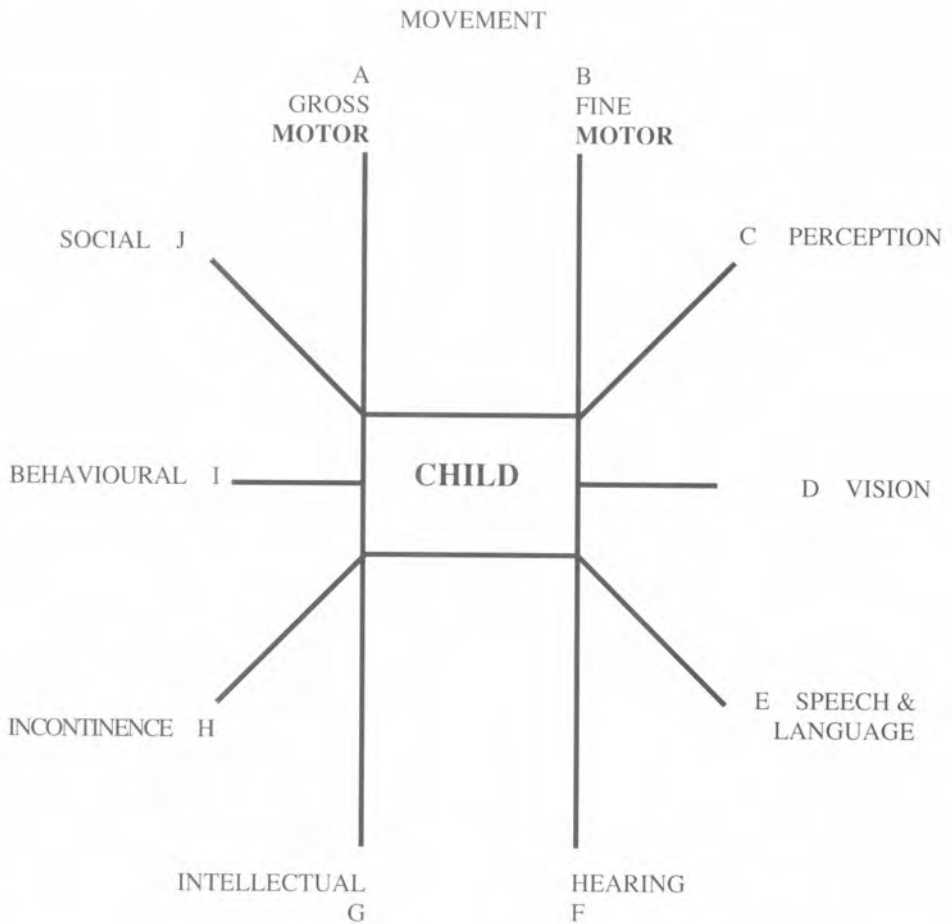
He learns to like himself

If a child lives with **acceptance and friendship**

He learns to find love in the world.

Parents Anonymous Inc USA

Diagram of Disabilities



MOVEMENT

- A. **Gross Motor Function** - is the development of sitting, crawling, standing walking.
- B. **Fine Motor Function** - is the development of the use of the hands and hand-eye co-ordination.
- C. **Perception** - is the process of organising and interpreting the sensations an individual receives from external stimuli. "If what the child perceives of the world around him is incorrect due to his brain damage, the Gross motor and Fine motor development will be delayed" (3).

- D. **Vision** - Visual stimuli develop movement. "Motor delay will occur because of visual handicap in otherwise normal children" (4).
- E. **Speech and Language** - is the ability to communicate verbally. Delay in development of language is "normal" for a child who cannot yet understand the meaning of sounds, words and conversation.
- F. **Hearing** - a hearing deficit is a barrier to communication and development, and early detection and training are of the utmost importance for language and speech development.
- G. **Intellectual** - intelligence is the ability to learn, to reason things out and to profit from experience. If a child's reasoning abilities are impaired, it will adversely affect motor development.
- H. **Incontinence** - if a child gets older and continence has not been achieved, the causes can be:
- i) neurological, as seen in a child with spina bifida, where the nerve supply to the bladder has been damaged,
 - ii) intellectual,
 - iii) behavioural.
- I. **Behaviour** - is any action of a child that can be seen.
Physiotherapists may be concerned with emotional behaviour problems which interfere with co-operation or motivation.
- J. **Social** - problems as in housing, facilities and background can cause delay in development, due to lack of opportunity for the child to develop and practise his skills.

One Handicap

Where the developmental delay is only to do with motor (movement) development, a child may achieve his milestones with treatment at the many Developmental Clinics, and transfer easily to mainstream Nursery and Primary Education. The Warnock Report 1978 recommended integrated education for all children.

Multiple Handicap

A child that has more than one handicap on the diagram of disabilities already shown may need the specialist help of a school like Mitchell House School where, from the age of 2 to 16+, his extra requirements can be met.

MITCHELL HOUSE SCHOOL

Staffing	Length of initial training
Education	
Teachers	4 years
Education Psychologist	7 years
Child Care	2 years
EHSSB	
Physiotherapists	4 years
Occupational Therapists	3 years
Speech Therapists	4 years
Nurse	3 years
Social Worker	4 years

The Consultant Paediatrician, Orthopaedic Surgeons, Orthopaedic Nursing Sister, Orthotist and Clinical Psychologist all visit the school. The total assessment treatment or habilitation and education programme for each child will depend on the team of experts.

The Integrated Education Service - from Mitchell House School was set up in 1978 as an advice service for any teacher in mainstream education who had a handicapped child in the class, and was experiencing difficulties. This scheme is also available for any children who transfer from Mitchell House School to their local Primary School.

The Physiotherapist's Role

"What makes a child move?" - a crucial question for those treating cerebral palsied children, and children with developmental motor delay. "In Paediatric circles the Physiotherapist is as much an Educator as a Habilitator and the nature and quality of the relationship of the Physiotherapist with the patient and parent probably transcends both roles! (1).

It is the physiotherapist's role to encourage and develop movement and motor exploration. As other factors have a direct effect on progress, success is only achieved through collaboration with fellow experts. a child's assets in one function may be used to develop another different and inadequate function. For example, speech may reinforce movement, motor activities may stimulate speech, movement may be used to train perception, perceptual activities and motion may develop language and so on.

A full developmental programme for each child can be achieved by interdisciplinary treatment from physiotherapists, occupational therapists, speech therapists, teachers and social workers facilitated by:

1. Staff conferences
2. Informal discussions over tea and elsewhere
3. Visits to one another's rooms for observation and treatment of each person's own patients

4. Combined treatments by different therapists, or working with teachers in the classroom or playground, with social workers or health visitors on home visits, or with nurses in hospital wards
5. Interdisciplinary group activities or therapeutic group work

Physiotherapy Treatment - cannot be seen as a half hour session a day, or three times a week. The nervous system (activating the muscles and therefore motor function) is responsive to what is happening all the time. If after a treatment session, a child is fully supported for the rest of the day, there is no activation of any postural reflexes. This makes it difficult for them to become established and prevents a child sitting and standing on his own. Deformities counteracted in a treatment session should not be accentuated by bad positions during the day and night. It is important for the whole team to recognise that correct handling and suitable equipment throughout the day is treatment as well.

Parents - the parents role is vital. "If the child is to make progress, the parents have to play an active and intelligent part in the total treatment programme" (3).

"Why can't my child walk?" - the ability to develop a child's motor development to walking is every paediatric physiotherapist's goal. The survey of children born 1976-1984 with multiple disabilities who have attended Mitchell House School shows an amulant rate of 83.2%.

Medical Conditions in the Survey

30	Cerebral Palsy
14	Spina Bifida
2	Hydrocephalus with spasticity
1	Spinal Muscular Atrophy
1	Myotonic Dystrophy
1	Bilateral dislocation of hips
3	Road Traffic Accidents
1	Alternating Hemiplegia
53	children admitted to the Unit
44	became ambulant (33 without aids and 10 with)
83.2%	ambulant
8	children transferred from the Unit and 3 children will be transferring in September 1987 to mainstream education

"Go to normal school"

Of the children of primary school age who did not transfer, all had more than one disability.

Out of the 28 children left in the survey:

17	had delay in fine motor function
11	problems with speech and language
10	perceptual difficulties
17	impaired intellectual development
3	behavioural problems
9	are incontinent
2	social problems.

Because of the extra disabilities apart from gross motor function delay, the special needs of

these children could not be catered for in mainstream education. The Special School is required to develop the child's potential abilities.

Senior School

With the older child, the multi-disciplinary team programme the education and treatment to prepare him for adult life. Social skills and independence training in all every-day activities are a part of education.

At this age, children become attracted to the idea of using a wheelchair. It often takes less effort than walking, and is quicker to get around school. At an age of self-consciousness, it is also a place to hide.

The Physiotherapists encourage the child to continue to walk. There is a dignity about being able to stand up and walk, which the adolescent often does not realise.

The survey of the Senior School does not include children who have left us for mainstream education. Contact with all children has only been kept since the IES Scheme was started in 1978.

Senior School

Out of 35 children, 26 were ambulant to a varying degree (14 without walking aids, 12 with), which equals 74.3% ambulant children.

Of the nine non-ambulant children, seven had walked, but had stopped for various reasons.

- 3 - all spina bifida patients, had increasing problems due to growth, and chose to go into a wheelchair
- 3 - whose walking ability never became functional due to the degree of their handicap, and lack of motivation
- 1 - had a deteriorating condition.

Summary

As well as intellectual and physical development, for any child to develop emotionally, he must have tolerance, encouragement, praise, fairness, security, approval and most of all, acceptance. This is even more relevant for a disabled child. It is therefore so important to assess a child accurately and to be honest with both parents and the child. All problems can be helped, all disabilities treated. Half truths or truth wrapped up in professional jargon as advice are non-productive and even unkind. They only lead to future resentment, lack of faith, even parental anger - the "nobody told us" syndrome.

Conclusion

It is a source of happiness and a privilege to be a part of a child's development and life, but doctors, nurses, therapists, social workers and others are all members of a team. The

permanent leaders are the disabled child and his family. The child belongs to the parents. The only people who can really help him are his constant companions - his father and mother and other members of his family. It is the business of the professionals to guide and encourage the mother to make the most of the child's potentialities within her home during the child's waking hours, without depriving the rest of the family of her love and attention. Our most important role must be working with the child within the family.

References

1. John Wilson PhD FRCP. *Physiotherapy Journal* (November 1976).
2. Mary Sheridan OBE MA DCH FFCM. *From Birth to Five Years*.
3. Nancie Finnie FCSP. *Handling the Young Cerebral Palsied Child at Home*.
4. Sophie Levitt BSc (Physiotherapy). *Rand Treatment of Cerebral Palsy and Motor Delay*.

We were sorry to hear of the death of Mrs. Hilary Getty on 21st December 1991. Hilary had worked at Mitchell House School since 1964 and was Superintendent there since 1979. During that time she was instrumental in bringing about many changes to provide a better service for disabled children including the Integrated Education Scheme which provides practical help and advice for disabled children in mainstream education.

While on a First Line Management Course Hilary wrote a paper on the role of the Physiotherapist in Special Education entitled "Why can't my child walk and go to normal school?" The results of a survey contained in this paper have been widely quoted to illustrate the high percentage of children who become ambulant following our system of treatment.

Hilary will be sadly missed by staff and pupils at Mitchell House School and also by her colleagues throughout the profession.

INTEGRATION IN AVON

**Carole Hurran, Supt. Physiotherapist (Community Paediatrics)
Southmead Health Services, Bristol.**

A Review of Special Educational Needs Provision in Avon was carried out in 1991 and resulted in a number of proposals which are still under discussion but aim at a set of entitlements including a commitment to high quality responsive provision which meets the needs of children and young people in the county, and informs all using the service of what they should expect. An Education/Health Review was also carried out and Southmead H.A. responded by supporting the principles of integration, support and child based action planning but pointing out the implications for input of health services and particularly for those paramedical services with small numbers of staff. The number of children in mainstream schools requiring long-term physiotherapy input has increased from 34 in 1988 to 58 in 1991 in Southmead Health District.

Claremont School continues to provide special education for physically handicapped children from 2+ to 11 years and act as a resource base for physiotherapy advice to other schools in the District and for outreach teaching and training of support staff to the Bristol area. An active integration policy has been operating at the school for many years but in the last 2 years the number of children integrating (usually part time at first) has risen from 2 per year in 1989 to 15 in 1991. The number of children coming in to the school has risen too, both at nursery age where more complex handicaps are appearing, and further up the school as pupils move out to main stream and others come in for part time extra help with learning and perceptual difficulties.

In practice parents often have to 'shop around' with help from the Educational Psychologist and Outreach Teacher for a suitable primary school with a positive attitude to integration. Staff are invited into Claremont school to observe the child and discuss problems before any formal arrangement is made. A review is then set up to discuss practicalities and agree on the number of general assistant hours required for the part time placement proposed. This has been a great problem in the past, partly because of different perceptions of how much help may be needed and also lack of funding available from the LEA which now seems to have improved. Special furniture and equipment specified when the statement is amended is provided from LEA Special Services funds (not the individual school's LMS budget) and minor modifications to toilet facilities, rails and ramps are requested but may take a long time to be completed.

Three Special Units are now attached to local Comprehensive Schools in Avon to enable more physically disabled pupils to integrate into mainstream provision with the necessary support, and this arrangement has many advantages in terms of time management for the visiting physiotherapist and facilities and expertise available for the pupils who are not isolated or seen as 'different' by their peers.

As more physically disabled children move out into mainstream, training of teachers and general assistants is a major priority and at present is arranged on an individual basis at Claremont School and at the local school involved. It is hoped to formalise training across the Districts serving the Greater Bristol area in the future and raise the profile of Paediatric Physiotherapy in assisting in the process of successful integration.

THE INTEGRATION OF PUPILS WITH PHYSICAL DISABILITIES INTO MAINSTREAM EDUCATION

"A Personal View" by Campbell Hunter, Senior Teacher, Visiting Specialist in Physical Education, Central Region Education Authority, Scotland.

As the result of presenting a combined workshop on the above topic with Adrienne Lyon, Community Paediatric Physiotherapist and Lesley Beath, Community Paediatric Occupational Therapist, I was asked by Adrienne to write this short article. I would like to stress that these are my own personal opinions and not necessarily those of my Education Authority.

Two very important Reports have been published in Scotland in the last 12 months, which will have long term effects on children with Physical Disabilities.

- A. Her Majesty's Inspector's Report entitled "The Integration of Pupils with Physical Disabilities into Mainstream Education".
- B. Curriculum and Assessment in Scotland. A Policy For The 90's - 5-14 National Guidelines. The latter will obviously have an effect on all children but since it encourages more of an experiential approach to education (a hands on approach) than ever before, it does have major implications for the handicapped child. I should like to pull both together by quoting from the postscript of the H.M.I. Report.

"Children and young persons, whether they have physical disabilities or not, should be given opportunities to develop their ability to the maximum extent, to live full and satisfying lives in the community and to interact on equal terms with their peers. These aspirations present challenges to all engaged in education; when the pupils or students have special educational needs arising from physical disabilities, the task takes on an added significance."

In order that the above statement might be implemented and in order to give these young people an equal opportunity in life, both in and after school, the school may need to implement a policy of positive discrimination, in favour of the disabled child/student.

If the disabled child is to become an accepted member of his/her local community then as far as is practicable the child should be educated in their own local school. All new and refurbished schools are now being built and planned with this policy in mind and we now have an Access Officer who will be consulted at this time. However, in order that this policy be implemented, and since most of the children are recorded or at least known to the Authorities for 3 years prior to their enrolment in compulsory education; a sum of money has been set into the annual budget to allow a rolling programme of updating to take effect.

Integration is defined as Access to ALL that is ongoing in the school. Access to the building alone produces only nominal integration and is unacceptable. Real and meaningful integration must be Social and Curricular as well as Physical. This last statement is the Pivotal Point in the report and if it is not fully implemented then we are only paying lip service to the report.

Physical access to the building is very obvious and yet there are many examples of the disabled toilet being in an outbuilding at the far end of the school grounds, etc. The not

so obvious areas of social and curricular access are possibly even more vexatious. When planning for the disabled child provision must be made for the child to develop adequate inter-personal skills, especially with their own peers. This will never be achieved if there is a "tame" adult auxiliary in attendance at all times, nor if the child spends his/her free time closeted away in the medical suite, without peer group relationships. Curricular access is even more fraught with difficulties, particularly in the secondary school. During the first 2 years of secondary education a child will be exposed to 15 different subjects, most of which will be taught in a different work space. The commuting from room to room can be very tiring, even for a normal child. For everyone's safety it may not be appropriate to have the disabled child moving around the corridors at the same time as his/her classmates. This will therefore mean leaving the class perhaps 10 minutes early every period or else arriving 10 minutes late every lesson. This will give the teacher problems of either ensuring this pupil has the missed work transmitted to them or else the rest mark time for this 10 minutes. Over a 25 period week and a 40 week school year this is a considerable amount of time. If our disabled student requires to be out of the classroom for toileting or transfer to a standing frame or for therapy for 30 minutes every day, from which subject will this be taken? Bearing in mind that the absence from the classroom will probably be at the same time each day it will cause major problems for the secondary school timetabler, unless the child is to cover a reduced timetable and if so, which subjects will be omitted? Over and above this we must not forget that some of the conditions that produce physical disabilities also generates Specific Learning Difficulties (for example cerebral palsy).

In order that each child received the best possible educational support/experience a multi-disciplinary approach is needed and this should be adopted at as early a stage as possible, i.e. paediatricians, physio, occupational and speech therapists, nursery nurses, teachers and psychologists should all be encouraged to contribute to the work with these children and their families. It must however be emphasised that parents should be consulted and where practicable the pupil also in matters relating to the educational provision.

It is considered important to the total development of young people with physical disabilities that every effort be made to integrate them in their neighbourhood schools. It is not felt suitable that some schools should be designated as being the area primary school for disabled children. However, while integration of secondary pupils is advocated wherever possible it is recognised that the size of secondary schools and the breadth of the curriculum can create difficulties not experienced in the primary sector. Even although these can be minimised by flexible attitudes and management within the schools. Nevertheless it is acknowledged that it will be a considerable time before every secondary school is able to cope with pupils with physical disabilities and meanwhile it is considered appropriate that there should be designated secondary schools serving their own areas.

In many instances these pupils will have a special duty attendant who is a vital member of the team, responsible for the pupil's education and should therefore be involved in any meetings to plan or review educational provision. In order that the special duty attendant is capable of carrying out his/her duties adequately in-service training should be provided and their duties should be decided by the multi-disciplinary team already mentioned, and should be specific to each child. The Headteacher should be fully conversant with these duties and ensure that the special duty attendant is capable and willing to carry out all these functions.

The aims for the education of children and young people with physical disabilities are the same as for all children; namely, helping them to achieve their full potential. It is however to be emphasised that the psycho-social development must not be neglected. Once it has been agreed that a pupil with physical disability should go to a particular school, the relevant school staff should have the opportunity of meeting the involved professionals for discussion. It is important that in the case of a primary school that the class teacher as well as the Headteacher be involved and that all teachers including visiting specialist staff have access to the pupils "record of need".

Most children who would fall into our group of disabled will have been identified and recorded well before they reach school age and the relevant professionals will be involved. This being the case an easy access route and the suitability of child and school will have been established. There are however 3 main hurdles that require to be negotiated by all children but the physically handicapped child will find them even more difficult to surmount.

These are:

- a) transfer from primary 7 to secondary 1
- b) transfer from secondary 2 to secondary 3 (course choice, Standard Grade)
- c) transfer from secondary 4 to secondary 5 (course choice, Highers)

In an attempt to assist in the addressing of these problem areas the Scottish Office Education Department funded a project in special educational needs entitled "Opening Doors". As a result 4 booklets have been produced:

1. Information for Schools.
2. Opening Doors - Preparing for S1.
3. Opening Doors - Preparing for S3.
4. Opening Doors - Preparing for S5.

These take the form of a pupil's diary and record all the relevant information about pupil, school, contact people, addresses. Copies of these documents should be available from H.M.S.O.

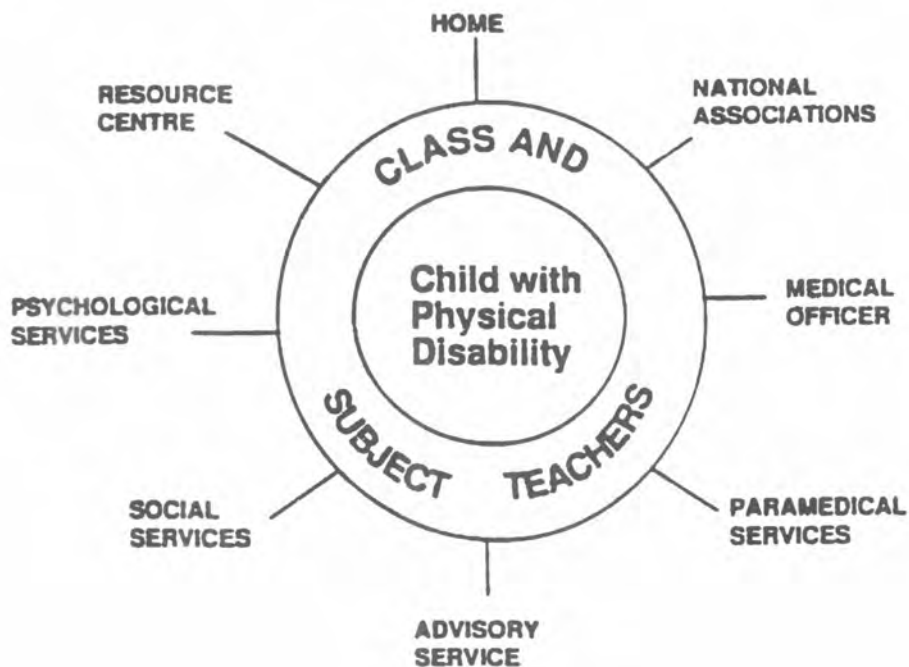
It will greatly assist our ability to cope with the problem areas if we remember 2 things:

- a) Think of them as challenges.
- b) Look through the disability and find the child.

In order to achieve this, much in-service is required for the teaching staff, many of whom have no training, knowledge or experience in the area of physical disability, and in some cases fear it. It will now be essential that a programme be introduced for all school staff and pupils on "Understanding Disability".

Many teachers view the prospect of having a pupil who is physically handicapped in their class with great reservation. This kind of feeling is quite natural if it is their first such encounter and although there may be challenges there are usually ways of surmounting them. It will help if they can remember that they are part of a team working with the pupil and that they are free

to seek support and reassurance. The teacher however occupies a central position in the team as the following diagram illustrates:



In November 1991, at our local in-service diet, in-service on the above topic was offered to 250 staff. This, for the first time gave practicing physiotherapists, occupational therapists and practicing teachers an opportunity to exchange ideas and views on this very important topic. At the end of each day appraisal forms were issued to those participating and the feedback was very, very encouraging. I would commend this exercise to those of you out in the field because an exchange of views and information can only but be more supportive to these children who need all the support we can give them.

SUMMARY OF A NORWICH STUDY INTO PHYSIOTHERAPY AND THE DISABLED CHILD IN MAINSTREAM SCHOOL

Sue Mackay

The research study was designed to investigate the physiotherapy needs of disabled children in mainstream schools. The majority of children were identified by school head teachers in response to a letter of enquiry. A combination of qualitative and quantitative approaches was used with structured interviews as well as 4 case studies.

Three separate interview schedules were developed for teachers, parents and the disabled children. Sixty-one children were included in the survey sample so that a total of 180 interviews were conducted throughout the Norwich Health Authority from January to July 1989.

Case Study Findings

The case studies revealed that environmental factors preventing equal participation of disabled children in school fell into two main areas:

- (i) Problems intrinsic to the disability eg. wheelchairs, joint deformities or muscle paralysis.
- (ii) Problems with the school environment eg. staircases, height of work surfaces or lack of adapted equipment.

In both cases these problems sometimes resulted in limited access to school life both in terms of the teaching curriculum and social interaction.

Difficulties were seen to increase in secondary schools due to poor physical access, a large campus and frequent classroom changes. Other issues raised were:

- a) How far should the curriculum be modified to suit the disabled pupil.
- b) To what extent can the school be adapted to enable complete access.
- c) The question of accident liability when school personnel carry or work with a disabled pupil.
- d) Delays in providing resources.
- e) Adequate welfare assistance to aid participation.

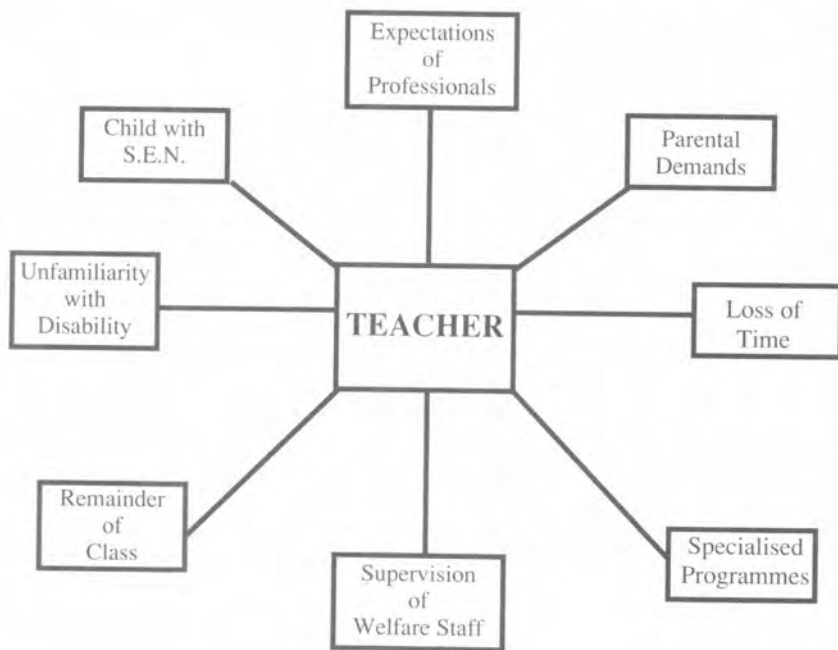
Generally the children managed everyday functional activities well at school. Practical lessons like craft, PE, science or home economics posed most problems, especially where equipment had not been adapted and often help was needed from peers or school staff. Problems were alleviated by providing extra help to complete tasks or setting more individual tasks. Frequently it was learning problems rather than physical ones that caused most concern.

The physiotherapy input in these schools varied from no contact in one school to the involvement of three different physiotherapists in another. Specialist paediatric support was frequently not available and mothers often had to fulfil the role of the therapist in assessing the school environment, advising staff, obtaining equipment and communicating between school and medical services.

Observations during the case studies highlighted the sources of pressure for teachers working with special educational needs pupils and some of the difficulties of implementing physiotherapy advice in school, for example:

- (i) Finding time within the school day.
- (ii) Demands of the other children.
- (iii) Supervising welfare staff.
- (iv) Possible withdrawal for therapy regimes.
- (v) Specialised programmes.
- (vi) Expectations of parents and professionals.

Figure 1. Sources of Pressure on Teachers Working with Special Needs Pupils.



The interactions between disabled children and their peers was very good. The children were not observed to seek extra attention and teachers did not appear to treat them differently either. Parents were sometimes forced to make more demands on staff because of their child's special needs. This could be a cause of concern especially where teachers were not used to parents being in their classroom instead of at the school gate.

5.1 - Level of Support

A third of schools in the study were visited but 72% had not been visited in the last year. 64% of parents said their child had been seen by a physiotherapist. Opinion on the adequacy of physiotherapy support was varied but 50% of the school staff visited and 40% of the parents felt that it was inadequate.

Findings indicated that the level of client satisfaction and the divergence of opinion on its adequacy could not be explained by identifying common factors amongst subjects. Each case needed to be assessed separately.

Over half the sample were estimated by the researcher as needing a physiotherapist once a term or less as the majority were not severely disabled. However there were still indications of a substantial shortfall in the number of visits clients received.

Possible factors influencing the number of visits were examined and it was found that children in the oldest age band, attending high schools were less likely to be visited. There was a trend towards the more severely disabled being visited more frequently, although no statistically significant association was found. The type of disability did not appear to influence the number of visits.

Eighty percent of schools had not tried to obtain physiotherapy support. In most cases staff were not sufficiently aware of the role of physiotherapy in supporting a disabled child in school and therefore did not initiate contact.

Six schools had tried unsuccessfully to obtain physiotherapy support and it became apparent that although a statement of educational need may include physiotherapy, it is not always provided as physiotherapy manpower levels cannot meet this need.

School doctors and nurses are the most common agencies that school staff would contact if they require physiotherapy. It was noted that some doctors have been unable to obtain physiotherapy support in the past and that the referral system was not effective.

5.2 - Choice of location

Children are most often seen at hospital as 88% of the sample had been seen there. Forty-three percent were seen at home and 36% at school.

If given the choice of where to see a physiotherapist, 70% of school staff said that they preferred school. Staff teaching younger age groups were the most likely to choose school and health centres were a more popular choice in secondary schools.

The information collected suggests that a child's physical therapy has less priority in secondary education, so that the current practice of visiting younger school children more often would seem to be appropriate.

Parents were more divided in their choice of where to see a physiotherapist but by a slight majority, school was also the preferred location for 28% of parents. Frequently their choice did not match where they were actually seen by a physiotherapist.

The findings indicated that most staff and parents would prefer therapy to take place at school. However, this was not the case for children and for a substantial number of parents. It is evident that the location needs to be negotiated in individual situations. It would be

preferable though for physiotherapy services to achieve greater agreement between client choice and location of therapy where possible.

5.3 - Experiences of Physiotherapy in School

When asked to comment on which aspects of the physiotherapy service had worked well before in school, both staff and parents listed advice and physiotherapy exercises as being the most useful. School staff also mentioned that information on the disability, reassurance and improved communication were other useful aspects.

The area of advice was valued most by staff in primary education and information on the disability was found particularly useful by staff working with cerebral palsy children.

Both staff and parents found that the major problem associated with physiotherapy in school was lack of adequate support. Some staff also felt that the amount of time spent carrying out physiotherapy regimes or with visiting professionals also caused problems.

Only 18% of the children remembered doing physiotherapy exercises at school and seven of these eleven children said that they liked or did not mind having physiotherapy at school. Children who had not experienced it in school were divided on how they would feel about doing special exercises, with half stating that they did not like the idea.

It was suggested that a choice in the location of physiotherapy should be available so that children's views could be taken into account.

5.4 - Perceived Needs for Physiotherapy Services in School

To ascertain which are the most appropriate forms of support, school staff were asked to rate the usefulness of 15 different physiotherapy services. Advice on PE was rated the most useful service as staff felt they needed guidance on how to adapt PE and sports to allow disabled children to participate more fully.

Staff also welcomed a physiotherapy service that could assess a child's motor abilities and advise accordingly on the range of suitable activities. Personal contact and feedback were also highly rated as lack of communication was one of the major concerns to emerge. It was suggested that 'one-off' assessments in cases of mild motor problems, where the school could contact the physiotherapy service directly would be useful.

Generally, training of school staff by the physiotherapist was rated more highly than the physiotherapist carrying out treatment in school. However not all staff, particularly those in high schools, felt that teachers should be involved with physiotherapy training and they preferred any training to be focused on the welfare assistant.

The item of 'general support' was rated more highly than the more technically-based services of advice on handling, equipment, adaptations and independence training. Teachers needed this support most when a disabled child first started school but frequently paramedical services could not provide it.

Overall the factors of severity of disability and age of children did not appear to affect how useful school staff rated the physiotherapy services to be.

Parents were asked to rate the usefulness of nine different physiotherapy services. They valued being shown how to help their child with physical activities most and had rated it above treatment given by the physiotherapist.

Assessing the school's facilities and advising on adaptations or activities had been another highly rated item as well as training of school staff in how to handle their child. General support and personal contact had been rated above the item of obtaining mobility aids and equipment as most of the children were mildly disabled and unlikely to need specialised equipment whereas general support could be appreciated by everyone. Where equipment was needed, some parents and staff noted that there was an unacceptably long delay in providing it.

Sixty-four percent of parents had ranked more information on their child's condition as either very useful or useful and lack of information was the most common complaint of parents in this survey. It was suggested that an information pack providing written information on the disability and an overview of services would be useful and should be made available to parents from the beginning.

Many parents expressed the need for an aids centre where equipment and toys could be loaned and a variety of different items could be available for trial.

As with the staff interviews, the age of children or the severity of their disability did not appear to affect their rating of services. Therapy was important to parents of both mildly and severely affected children and to those with either older or young children.

5.5 - Difficulties Found in Mainstream

Sixty percent of school staff reported that the integration of a disabled child in their school had not created additional difficulties. The major difficulty found by staff was due to lack of resources in the form of environmental adaptations or welfare and teaching support.

Twenty-eight percent of staff found that the need to arrange different programmes created difficulties. This occurred particularly in PE, practical subjects or when a disabled child had additional learning difficulties.

Some also felt that a disabled child required extra attention and the need to be aware of possible risks or give special help caused additional strain. Other difficulties were created by a lack of outside support and advice. The severity and type of disability did not appear to increase the number of difficulties noted by staff but the greater proportion of them were found by those teaching the 8-12 year age band.

Children were asked if their disability had caused them any difficulties at school and were prompted in the following areas: schoolwork, mobility, PE, lunchtime and playground.

PE and games caused the greatest difficulty with 84% of children noting a problem. Participation was limited either because children could not perform activities in the same way or there was a risk of injury. Some schools managed to adapt lessons to include their disabled pupils but overall, imaginative, alternative activities were not generally created. The findings indicated that the number of children finding difficulties increased with age and severity of the disability.

Fifty percent of the children found difficulties with schoolwork and these were mainly due to handwriting. Other problems were encountered in practical subjects, where a combination

of poor fine motor skills and lack of adaptations caused limited access to these subjects.

Going upstairs was the most frequent cause of mobility problems and was noted by 15 of the 23 children who had difficulties in this area. Many schools did not have sufficient lifts and ramps. As might be expected, the number of mobility problems increased with the severity of the disability.

Difficulties in the playground were felt more by children in primary schools where playing games outside was more common. Sometimes their disability appeared to limit socialization and some parents felt children were unnecessarily restricted from playground activities because of potential risks. The number of children noting difficulties in the playground tended to rise with the severity of the disability.

Fourteen of the children noted difficulties at lunchtime and these were mostly due to problems cutting up food or carrying a tray. Twenty-six of the children were aware of restrictions in their ability to participate fully in school activities, mostly those related to PE or the playground. These restrictions were found to increase with the severity of the disability.

Children were questioned on whether they felt people understood their difficulties at school. The findings were that 87% of the sample felt that the medical professionals understood and 77% felt the school staff did too. However only a half of them felt their peers understood their difficulties. It was apparent that some form of disability awareness training was needed in schools where disabled children were integrated.

Recommendations

- 1) A system to review and update the number of disabled children in mainstream schools is needed. The ideal would be a computerised register for the district that could be assessed by key agencies.
- 2) The level of physiotherapy support to mainstream schools should be increased.
- 3) It is proposed that the paediatric service to children in mainstream schools should be community rather than hospital based.
- 4) Awareness of therapy services should be raised and a clear referral system to obtain this support needs to be established.
- 5) Flexibility in the location and timing of physiotherapy visits to suit individual needs would be helpful with the options of either treatment or advice when necessary.
- 6) Where resources are limited, therapy input is more effectively targeted in primary education.
- 7) Improved coordination and communication at all levels is needed so that schools receive regular feedback and information concerning their disabled pupils.
- 8) Time allocated to observation of the child functioning within the school environment would be extremely beneficial.
- 9) Within the paediatric department, expert advice on PE for disabled children in mainstream schools should be developed so that the department can act as a resource for schools.
- 10) School staff would find physiotherapy services such as advice, assessment and monitoring helpful even in cases where active treatment may not be necessary.

- 11) In-service training for school staff, based on a collaborative approach is essential for managing the child's physiotherapy needs.
- 12) Parents need more comprehensive information about their own child's condition, the disability and all the available services from the beginning. Additional written explanations and counselling would facilitate understanding and retention of that information.
- 13) An equipment centre where aids, toys, specialised furniture or wheelchairs could be loaned, tried out, or exchanged on a second hand basis would provide an invaluable resource for parents.
- 14) Strategies to combat the delay in providing equipment in schools are needed as well as clarification on which items are to be funded by Education or Health.
- 15) Statements should recommend specifically which resources a child needs whether in terms of equipment, welfare assistance or the amount of outside support.
- 16) Disability awareness programmes are needed in schools where children are integrated and physiotherapists could play an important part in this training.

N.B. For a copy of the full report, please write to:

The Secretary

Centre for Health Policy Research

School of Economic and Social Studies

University of East Anglia, Norwich, NR4 7TJ.

Cost £5.50

WOULD YOU BE A SCHOOL GOVERNOR?

Many Governors terms of office will come to an end this Summer and although many will seek re-election, County Councils are already making recruitment arrangements for September '92.

Would you be a Governor?

The last four years has seen many milestones, new responsibilities for governors, the implementation of Local Management of Schools, and the National Curriculum, are only a sample of issues dealt with.

Few Governors have a working knowledge of child development, or any experience of the management of Education prior to election, let alone knowing what provisions should be available when a child has special needs.

Therapists, particularly those working in the Paediatric sector have a great deal of experience to offer, not only in terms of PE and the curriculum, but because we provide an important link between families and schools. This experience enables us to make valuable contributions to the issues Governors have to address.

There still seems to be concern in schools regarding the intake of children with special needs, particularly with resources for learning support, welfare help, and literacy tuition.

Being part of the management of a school enables one to form good working relationships and use our personal skills to increase public understanding of the needs disabled children have.

I firmly believe that the only way to improve communications and understanding between Health and Education is to be involved in a practical way. Being a Governor does just this, and is therefore the best way to improve opportunities for all children.

If you are interested, look out further information from your Local Education Authority, and watch for the Department of Education and Science's national media campaign. You could also contact any Governors in your local schools and confirm your interest.

REMAP G.B. TECHNICAL EQUIPMENT FOR DISABLED PEOPLE

From time to time therapists encounter problems for which there is no suitable aid on the market. Although it may be possible to visualise something which would benefit the client, it can be difficult, if not impossible, to get it made because commercial firms are generally unwilling to make "one off" items or even to modify standard equipment. Technicians in the N.H.S. and the Social Services are rarely able to help and in these circumstances the "gap" in the supply of aids can only be bridged by voluntary help. We believe that most MCSP's are already aware of Remap G.B. but for the benefit of those who are not, Remap is a voluntary organisation of professional engineers and technicians guided by therapists and doctors who design and make all types of aids where nothing suitable is available from any other source of supply. These aids are usually provided free of charge because our members work for nothing and make considerable use of scrap or "scrounged" materials. Remap's 2000 or so volunteers are organised into 92 local groups, called panels, stretching from Aberdeen in the North to Bodmin in the West. Remap makes aids for all age groups and it may be of particular interest to members of the Association to learn that nearly 20 per cent of all our referrals are for children and these come mainly from therapists and teachers working in the so called "special schools". Apart from teaching aids and incentive toys there is a great demand for specialised furniture, mobility and exercise equipment and also for modifications to existing equipment. Children's equipment often presents an especial challenge for children are frequently too young to explain what they can or cannot do. The advice and guidance of the responsible therapist or teacher is vital in directing the engineer towards a result which will develop the ability of the child; and with much time and patience remarkable success is often achieved. It may be that a hard pressed therapist faced with a problem for which there does not appear to be any possible solution will decide that nothing can be done to benefit the client. But our members thrive upon difficult problems and no matter how difficult the case may appear to be, it is always worthwhile giving Remap an opportunity to consider it. After all, an organisation that has enabled a one armed child to play a recorder is not likely to give up easily.

Tricycle (Marlborough panel). *The 4-year old boy suffers from spastic diplegia. The high back with side extensions prevents his falling off. The axle was widened to give greater stability. A pommel bar at the front of the seat and larger handgrips made him much more secure. Velcro was used for toe-straps. All this was done by apprentices of the Royal College of Military Science, Shrivenham, Swindon.*

This is the first contribution of the newly-formed Marlborough panel and is especially welcomed.



Remap's success depends upon close co-operation with the professionals working with people with disabilities and all therapists are invited to make and to maintain contacts with their local panels. If you wish to learn more about Remap or to contact your local panel and do not know its address, please write or telephone Remap's National Organiser:-

John Wright at "Hazeldene"
Ightham
Sevenoaks
Kent TN15 9AP Telephone (0732) 883818

The Remap Year Book is another source of information. This pocket sized book tells all you would wish to know about Remap and gives addresses and telephone numbers of all panels. It also contains scores of photographs and descriptions of some of the more interesting aids made during the past year. The Year Book for 1992 will be out shortly and although this is priced at £3.00, in view of the close ties between Remap and therapy professions we are offering free copies to all therapists. To obtain a copy write to Remap's National Organiser at the address given above, enclosing a cheque or postal order for 70p made out to Remap G.B. to cover cost of postage and packing.

* * * * *

BOOK REVIEW

'Switch to Play' - National Toy Libraries Association

This specialised booklet explains different aspects of the use of switches by children with special needs. It includes the appropriate selection of switches and toys plus how to adapt battery operated toys. Case histories are cited and the adaption of computers, electric wheelchairs and communication aids is also discussed. Many sources of information are given in this very useful publication, which is intended primarily for parents and toy librarians. Any professional involved with children who have special needs would find this publication very helpful.

* * * * *

LETTER TO THE EDITOR

Dear Mrs. McKinlay

In the February newsletter I read with interest the article entitled a 'physiotherapist's views of the David Hart Child's orthotic walker'.

I joined the Orthotic Research and Locomotor Assessment Unit (ORLAU) at the Robert Jones & Agnes Hunt Orthopaedic Hospital, Oswestry as a research physiotherapist in September 1991, following many years as a community paediatric physiotherapist and would like to enter the debate on the use of orthoses in cerebral palsy.

As therapists we need to decide what particular therapeutic benefit which we wish the orthosis to provide and this, as always, must depend on assessment and analysis of the patients individual needs and will inevitably involve some compromise.

In providing support we are facilitating co-ordination of limb movements but we are demanding less postural control from the child, in providing weight relief we are reducing the physiological work needed to move but providing less stress on joints and bones.

In fixing the hands on a rollator, abnormal movement patterns are reduced but infants do not normally use their hands for support and forward propulsion when learning to walk.

There is always the dilemma of when it is appropriate to provide a compensatory device and when functional training can be expected to produce functional gains.

I believe that therapists may be interested to read of the work which has been undertaken since 1985 here at ORLAU using designs loosely based on the parawalker for use with cerebral palsy children. (The parawalker was originally designed for use by patients with spina bifida or with spinal injuries).

Children with cerebral palsy vary greatly, and have individual orthotic requirements. This has led to the development of a series of orthotic features; but within each orthosis adjustment can be made for the individual at fitting and at a later date alterations can easily be made following progress.

The Locomotor Guidance Orthosis has been used for athetoid children to provide postural stability in walking when used with an ORLAU rollator. It is possible to adjust the orthosis to limit the range of hip flexion so damping the 'athetoid dance'. The rigidity of the orthosis prevents adduction and rotation at hips. Currently a reciprocating mechanism is being tested and when developed may add to the versatility of the orthosis, so that reciprocation can be imposed, erect posture maintained, and flexor collapse prevented. It will be possible to disengage the reciprocating mechanism to sit in the orthosis.

Orthoses are being developed for use with the spastic cerebral palsied child; including a less extensive bracing system for use with diplegic children.

Consideration is also being given to using alternative means of providing external stability and a commercially available posterior supportive walker is being evaluated for use with the locomotor guidance orthosis.

In our work we are monitoring the patients range of movements, strength and functional ability with and without the orthosis to evaluate the benefits or detrimental effects of the usage of the orthosis.

Children may be accepted into the research and development programme for these orthoses following a medical referral to the Medical Director of ORLAU, Mr. J.H. Patrick FRCS. I endeavour to communicate with children's therapists by telephone and written reports and they are of course welcome to attend the Unit or contact me with queries.

At ORLAU the technical developments necessary to provide an orthosis for use with

athetoid patients is nearing completion. This will mean that an orthotically controlled walking pattern can be provided for an athetoid child, and this walking pattern will not depend on the ability of the person assisting the child and may in some cases give some independent mobility although a severely affected child is unlikely to be able to doff and don such an orthosis.

The ORLAU approach to research and development of this and other orthoses before general release means that we are working towards the day when specialist centres can be trained to supply, repair and adjust these orthoses on a relatively local basis. Publicity, outside of the medical domain, is avoided by ORLAU so as not to raise expectations before treatment systems are available. The research and development work of ORLAU is funded through a Department of Health research contract.

In outlining some of the work at ORLAU I hope that other therapists will be stimulated to think about the value of such devices for cerebral palsied children and I would welcome inquiries about our work from interested therapists.

Yours sincerely
 Sybil E. Farmer
 Research Physiotherapist

HERE AND THERE

DETAILS OF NATIONAL COMMITTEE MEMBERS:

	Elected	Re-Elected	Retires
Jill Brownson (Chairman)	1986	1990	1994
Michele Lee (Nat. Comm. Member)	1987	1991	1995
Viv Williams (Vice Chairman)	1987	1991	1995
Jenny McKinlay (Editor)	1987	1991	1995
Fiona Corkhill (Secretary)	1991		
Ann Shanks (Nat. Comm. Member)	1991		
Lyn Weeks (Treasurer)	1992		
Lyn Wakely (Nat. Comm. Member)	1992		
Angela Glyn-Davies (Nat. Comm. Member)	1992		
Jeanne Lamond -	Co-opted as Membership Secretary		
Caroline Dunn -	Co-opted as P.R.O.		

* Our new re-printed booklet is now available:

“SERIAL SPLINTING IN HEMIPLEGIC CEREBRAL PALSY”

By Margaret Jones, Grad Dip Phys. M.C.S.P.

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* A New book for Therapy Managers

CALCULATING STAFFING LEVELS IN PHYSIOTHERAPY SERVICES

by Joyce Williams

A handbook on how to calculate staffing levels in therapy services is published. It is aimed at physiotherapists but the principles will apply to other therapy professions.

The book provides the basic tools for attaching numbers to workloads and working out the staff required. It gives formulae for describing the various professional tasks of a therapist and the hours used on each.

Tables show the effect of varying staffing levels on caseloads, frequency and intensity of treatment. Underlying the system is the concept of the input hours required for the different types of physiotherapy case episodes. This is linked to the input hours available from one whole time therapist in a variety of working situations. Skill mix, the need for clerks and the use of helpers are covered as is the question of time used for supervision and teaching the monitoring of at risk cases, for ward rounds, for research and for the clinical and administrative management of the service.

Although the book consists mainly of worked examples, there is no prescription of norms or ideal staffing levels. It describes how to calculate in practical terms the work which can be dealt with at different levels of input. Users can then substitute their own figures and make their own local decisions as to the appropriateness of the input level for the type of work to be done and the outcome required. A final chapter deals with the ethical and legal issues connected with a therapists duty of care to provide an appropriate level of input into a case once accepted.

The handbook is published by Pampas Publishing, 10 Spinneyfield, Rotherham S60 3HW at £7.50 including postage. Cheques with orders.

*

ARE YOU ALL PREPARED

For the National Paediatric Physiotherapy Day
on **19th May?**

ARE YOU GOING

To the One Day Conference in Birmingham
on **20th May?**

* **The South African Neurodevelopmental Therapy Association (SANDTA)** have noted that some members have been using the letters NDT after their names and qualifications on letterheads and cards.

The Association have drawn attention to the constitution of SANDTA that "Members may call themselves a member of SANDTA, but no letters may be used behind his/her name and such membership shall not imply additional qualifications nor may it be used to imply this in any manner whatsoever."

* **The Australian Physiotherapy Association** has produced an Independent Learning Package on 'Motor Co-ordination Difficulties' (MCD) The Author and Presenter is Mrs. Pauline Watter, who is known throughout Australia and New Zealand for her work in this area of physiotherapy. She has also had papers on this subject delivered at WCPT Conferences.

The package consists of an hour long videotape and an accompanying 'how to assess' booklet. The videotape shows assessments of 2 children with different presentations. The booklet consists of a 27 page assessment guide, which includes some treatment suggestions for the 2 children shown.

Cost - A\$170.00 which includes postage and packing.

All enquiries can be directed to Edith McPhee, Distance Education Officer,
Australian Physiotherapy Association, P.O. Box 435, TOOWONG, Qld. 4066, Australia.

REGIONAL REPORTS

South West

Carol Hurrant, 23 Bayswater Ave. Westbury Park, Bristol BS7 7NU

The spring study day on Paediatric Seating Problems held at Odstock Hospital was well attended and a very worthwhile and interesting day. 19 members attended the AGM.

The Autumn study day on Counselling is being planned in Dorchester. Dorchester have started a Cystic Fibrosis clinic, and are having a one year trial of using physiotherapy helpers in special schools. Odstock are also involved in a 'Skill mix' study.

In Bristol, the local Spastics Society is starting a campaign called Action for Cerebral Palsy to develop respite care facilities and start a school for parents. This has enormous implications for existing services, but may slow the current exodus of children to Budapest in the future.

Bristol's local girl Georgina Moore who has severe Arthrogyrosis, has won the logo competition for National Paediatric Physiotherapy Day. We hope you all like the logo and Cheltenham are planning a children's party for 19th May at Battle Assessment Centre. Portsmouth hope to be giving talks in schools and putting on exhibitions in libraries. Bath will be having an open Day at the Mary Dorrien Unit and West Dorset also celebrate their 20th Anniversary of Paediatric Services and are preparing a brochure to mark the occasion.

South East

Terri Fearn, 38 Woodland Close, Peacehaven, E. Sussex BN10 7SF

Our study day in March was well attended. The subject was 'Conductive Education', and we had some very good speakers who gave us a lot of insight into their work and experiences.

In June, we are holding a study day on Muscular Dystrophy. a programme and application form is enclosed for S.E. Regional members.

Our autumn study day will be a research update on Cystic Fibrosis. Please continue to inform the committee on any subjects you would like covered in future study days.

London

Rowenna Hughes, Sheldon Children's Centre, St. Giles Road SE5 7RN

Karen Burchett resigned as a member of the committee at the last meeting. Karen has been a committee member for many years and we would like to thank her for her hard work and support for the London Branch at all times. After well attended study meetings in the last half of 1991, we were hopeful that this would continue. Unfortunately we had to cancel the study day on 'Sports Injuries' due to lack of applicants. This was disappointing not only for the applicants but also for the committee who had worked extremely hard to arrange an excellent programme.

A repeat of the 'Inhibitory Casting' day is being planned and we are hoping this will be a success as it was over subscribed the last time it was held. It was encouraging to see that the London Branch was well represented at the Conference held at the University of East Anglia, Norwich.

East Anglia

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

March 26th-28th 1992 represented the culmination of all the planning and hard work of your committee for the National Conference 'Forward with Europe 1992' held at the University of East Anglia, Norwich. In spite of all anxieties the conference was well supported by over 250 delegates and lecturers. Look out for reports of the programme in the August Newsletter. The AGM for the East Anglia Branch was held at the Conference. Several members were due to resign after their four years of office, others were re-elected for their second two years. Since the committee has grown to support all the requirements of conference, it was felt that no new members were needed at this point. The Committee will be convening at an early date to plan the 1992/93 programme.

Trent

Jenny Gill, 42 Britannia Ave., Arnold Rd., Nottingham NG6 0EB

Our Regional AGM was held in Nottingham on 11th March. A buffet supper, kindly sponsored by Gilbert & Mellish, was followed by the business meeting and a very topical presentation by Sheila Landamore about the Children Act.

An inaugural regional news-sheet was sent out with the February edition of the national Newsletter. Hopefully this will be a regular feature. Ideas and comments would be welcomed.

On Friday 19th June an Introductory Sensory Integration Study Day will be held at Rauceby Hospital, Sleaford. Jenny French will be lecturing. The fee is £20 to include tea, coffee and a buffet lunch. For more details and an application form, please contact: Lynda Hayes, Community Personnel, Rauceby Hospital, Sleaford, Lincolnshire. Tel: 0529 8241.

West Midlands

Carol Forster, Physiotherapy Dept., The Children's Hospital, Ladywood Middleway, Ladywood, Birmingham B16 8ET

We are now half way through what is proving to be a very successful Orthopaedic Course - two evenings remain;

May 6th - Mr. G. Thompson - 'The Spine'

June 3rd - Mr. Sterling - 'Hips'

Please come to Victoria School, Bell Hill, Northfield for 6.30, you will be most welcome.

Thursday 25th June at Dudley Road Post Graduate Centre - an interesting day on the 'Multi disciplinary management of the older profoundly handicapped child'. Speakers include a: Seating Specialist, Physiotherapist, Occupational Therapist, Speech Therapist and a Teacher.

Cost £25.00, Contact Sally Braithwaite, 531 Church Road, Yardley, B33 8PG for further details.

Looking forward to September we are organising an update on Neuro-anatomy and Physiology to run over three Wednesday evenings - September, October and November. More details later.

What are we doing for the Paediatric Physiotherapy Day on 19th May? So far, we have various events in Birmingham which include a competition for the best picture or short story about a child's experience of physiotherapy to be featured in the local press, BBC coverage on local news, a display in a new local Health Centre and shopping centre displays - plenty of balloons, posters, leaflets, T. Shirts from Lyn Duxbury at CSP to advertise paediatric physiotherapy. Our W. Midlands membership now stands at 101 - please let me know of any local events or concerns.

Wales

Barbara Bowen, Children's Assessment Centre, East Glamorgan Hospital, Church Village, Nr. Pontypridd, Mid Glamorgan

Our last meeting was on 24th Feb. at the Rhymney Valley Childrens Centre, where the Centre's Director Mike Bray gave a comprehensive overview of the Children Act with particular emphasis on children with disability. This was followed by the AGM where a new group of very enthusiastic officers and committee were elected.

Following discussion at the AGM an open meeting was held on 10th March at Llandough, Childrens Centre, Penarth, to discuss the provision of wheelchairs and specialist seating. Consequently letters were sent to the powers that be, and we look forward to their reply. If anyone has any burning issues on the subject, please contact me.

The committee held its first meeting on 24th March and our programme for 1992 was outlined as follows:

7th & 8th May - Symposium on Counselling Skills for Physiotherapists and other Professionals working with Children, held at Hensol Conference Centre, Mid Glamorgan.

June - a date to be confirmed - a day of physiotherapy presentations of unusual conditions. Anyone is welcome to present their atypical cases.

Long presentations are not necessary, anything from 2 to 20 minutes.

Other suggestions for courses were 'Assessment and Treatment of children with Cerebral Palsy', 'Sensory Integration', 'Assertiveness Training', 'Paediatric Cardiac Surgery', Juvenile Rheumatoid Arthritis and a local Road Show of Equipment for children.

Any other ideas and suggestions of venues? We do not want to hold all meetings and courses in and around Cardiff - it's over to you North, West, East and Mid Wales!

North West

Alex Winney, 14 Langley Rd. Bebington, Wirral, Merseyside L63 9HW

The AGM held on Sat. March 14th with a study morning following it was very well attended, in fact about forty people came with twenty non-members joining the study morning later.

The course to be held in Oswestry in May is now fully subscribed. If enough interest is shown, it may be possible to run it again at a later date. Plans for an Autumn Study Day to be held on the Wirral are well in hand; the subject is to be on 'Visual Handicap'. Information and application forms will be sent out later in the year.

Other ideas for possible Study Day/Mornings were the 'Children Act' and 'Child Abuse'. If you have any ideas for future courses please let any of the North West Committee know and we will try to implement them.

North East

Carrie Jackson, 4 Abbotsway, Muncaster Gate, York YO3 9LB

A very successful study day and AGM were held on March 9th at North Tees General Hospital on 'Paediatric Respiratory Care in Hospital and Community'.

Our thanks go to our two excellent speakers, Sue Miller from Newcastle's Royal Victoria Hospital and Chris Passingham from Leeds General Infirmary, and to the hard working committee members, especially Liz Hardy and Sheila White, for making this such a successful day.

The day was sponsored for the first time and we are very grateful to Allen & Hanbury, ASTRA and SORSKY for their support.

The AGM was well attended by all the members present and we were pleased to welcome two new committee members, Faye Dobinson and June Garner. Our next study will be in York in the summer and will be on Sensory Integration - More details soon.

Scotland

Lyn Cambell, 19 Craigmount Ave North, Edinburgh EH12 8DH

Our AGM was held in Stirling on 29th Feb. in conjunction with a study day entitled 'Standing on my own two feet'. It was well attended and gave delegates material for further discussion.

Preparations continue for the 1993, 8 week Bobath Course to be held in Edinburgh, and discussions have been held with the Bobath Centre, The Scottish Office and others over the possibility of creating our own Bobath Centre for Scotland.

We hope to hold two further Study Days this year and details will be circulated once they have been finalised.

N. Ireland

Ruth Graham, 75 Ravenhill Gdns., Belfast BT6 8EQ.

