ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS

NEWSLETTER

Association of Paediatric Chartered Physiotherapists

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Officers of the Association

Chairman
Mrs. Jill Brownson
23 Vallence Road,
Hove
E. Sussex BN3 2DA

Vice Chairman
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Milton Road
Harpenden, Herts AL5 5LQ

P.R.O.
Mrs. C.L. Dunn
The Haven
Knightwick Rd.
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

Jackie Reynolds, East Anglia Regional Rep. and Supt. Physiotherapist, James Paget Hospital, Great Yarmouth

The APCP National Conference held in Norwich in March this year opened the door to links with our professional colleagues in Europe. It was refreshing to welcome speakers and delegates from overseas and to find them eager to participate in our conference and to share ideas and experiences. We do need to discover more about physiotherapy for children throughout the European Community and to look at the way in which services are delivered in those countries. We are in the midst of a period of change in the organisation and delivery of services in the NHS and there may be much for us to learn.

Through the contacts created as a result of the 1992 conference there is a real opportunity to establish more formal links with the European Physiotherapy colleagues, to encourage further reciprocal participation in conferences and to share information by exchange of newsletter and articles. Facilities for translation are now more readily available but there must be people in our own association with some linguistic talents and the capacity and desire to extend their abilities.

The next decade will bring new opportunities to work in Europe and to welcome European Physiotherapists to this country. Let us be ready to meet the challenge.

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COPY FOR THE NOVEMBER NEWSLETTER MUST BE WITH THE EDITOR BY 1st OCTOBER

ANNUAL SUBSCRIPTIONS FOR 1992 - £15.

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

Associate membership is open to suitably qualified professionals working in the field of paediatrics. New applicants require to be proposed and seconded by full members of the Association.

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FORWARD WITH EUROPE

University of East Anglia, 26th - 28th March 1992

The Unified Approach at Brookfield House School

Maria Ash and Ann Shanks, Superintendent Physiotherapists,
(Job shared at Brookfield House School)

The "Unified Approach" is based on the integration of British education and therapy. It is a holistic approach to the total management of motor-impaired children.

The Unified Approach is concerned with using the already existing expertise of the relevant education and therapy professions, combining their specialist knowledge, and integrating this knowledge into a motor programme, which is based on functional performance.

It is more than a multi-disciplinary approach. All persons involved with the child deal with the total input to that child, therefore, there is a unity of approach which provides the holistic element. Parental involvement is paramount as the child's needs continue throughout the whole day.

Background History

In the past children in special schools were scheduled for short limited bursts of therapy being provided by the individual therapists in isolation. This involved the child being removed from the classroom setting and little or no carry over of treatment principles during the school day.

Parental expectations have risen sharply and most are now rightly demanding and seeking an intensive approach. This is supported by the media. The Unified Approach was developed in order to meet this need.

Essential Features of this Approach

A. Parental Involvement

A high initial input is required to educate the parents in the establishment of correct habits and patterns for the child and the recognition of counter-productive activities, which may lead to deterioration of the condition. Correct full time handling of the child at all times is therefore paramount from the outset.

a) Parental involvement must be a shared and two way process.

c) They should also be made aware of the expectations and current limitations of their child.

d) They must be given clear and positive help and support, in order to inspire their own confidence.

This close working with the parent or carer must begin with the pre-school child either at a Children's Centre or in the community. It must then be continued when the child attends either mainstream or special school nursery. The Unified Approach has been developed to meet the need of children with moderate to severe physical impairment who attend Brookfield House School. (A school for physically handicapped pupils).

B. Team Approach

A team approach is mandatory in the special school setting.

a) All members of the team should be able to carry out all the procedures, under the supervision and direction of the key professional. they should therefore,also participate in teaching the other team members.

b) Input should not be seen as therapy or teaching alone, but should be fully integrated and become a part of the child's way of life and continue throughout the whole school day.

c) All those involved with the child must adopt a positive, honest and realistic approach. They must all be aware of the expectations of the child and have the same aims.

d) Those dealing with the child must be able to adapt to the changing needs of the child and be prepared to alter their views accordingly.

e) The core curriculum of the Approach is based on living skills and is structured to incorporate the National Curriculum This system was initiated in 1986 and since then has been continually developed and successfully applied in the nursery unit and infant classes at Brookfield House School.

The United Approach offers the following advantages:

1. A system which integrates therapy with conceptual and linguistic areas of learning in the classroom.
2. An eclectic approach to treatment. In order to be able to offer eclectic therapy and to be able to choose the most appropriate treatment for a particular child, the therapist must have a thorough understanding of many available approaches. The Bobath Neuro-developmental treatment provides the most comprehensive base into which other approaches can be integrated and we have combined this theory base with the best principles of Conductive Education to form the Unified Approach. Unified not only by combining Education with Therapy but also combining the best principles from many therapy approaches.
3. The therapy input used is a medical one so that all of a child's physical needs come under the care of a team of therapists who have the same philosophy.
   Post-operative and chest care is provided by the same team of therapists who also assess and order orthotics, walking and mobility aids.
4. The expertise of the differing professionals are essential for assessment, planning and training in their field of speciality. They become the lead professional for their speciality area sharing their knowledge with the other team members.
5. The assessments and subsequent aims and objectives formulated by each discipline are combined to form the joint education and therapy programme, tailor made for each child.
6. The programme is implemented at the school by all staff throughout the day. This maximises the use of scarce resources.
7. The input from each of the different professional components supports and reinforces that provided by each individual professional so that the child is the recipient of on-going care and management which is consistent and relevant to need.
8. This approach is not limited to children with Cerebral Palsy and can be adapted with minimum disturbance to the motor programme to meet the individual needs of any child.
9. Emphasis on treatment or on education can be modified according to the individual and changing needs of the child.
10. The use of skill mix ensures that there is maximum and efficient use of resources.
11. The therapy input is complementary to and is supported by the Consultant Paediatricians who are finally responsible for the Health requirements of the child.

12. This approach combines what seem to be the most beneficial and relevant components of the various available methods of management.

One of the primary aims of the Unified Approach is to evaluate and action research the project.

Benefits to children

1. Treatment and therapy is part of their everyday education.
2. They have an expectation that they follow the programme whoever is managing it.
3. The children know that they are expected to be as independent as possible.
4. They learn to be supportive of and are stimulated by each other.
5. Their time at school is used to maximum advantage.
6. The children are self motivated, willing to join in activities and have fun.
7. The children are valued what ever level of independence they are able to achieve.
8. By maximising their independence as early as possible they will be integrated into mainstream school if appropriate.

SIXTEEN KEY POINTS

1. Takes place in L.E.A. Schools
2. Existing Professionals
   - Teachers
   - Physiotherapists
   - Occupational Therapists
   - Speech Therapists
3. Involves
   - Classroom assistants
   - Parents
   - Nursery nurse
   - Volunteers
4. Holistic Approach to Total Management.
5. Assessment, aims and objectives by each profession.
6. Combine to form: Individual Joint Programmes.
7. Realistic long and short term goals.
8. School day incorporates.
   - Motor
   - Cognitive learning
   - Learning
   - Speech
   - Social
9. Management programme throughout the day.
10. Therapy in classrooms.
11. All staff involved in therapy.
12. Staff training.
13. Individual therapy in groups.
14. Therapy "a way of life".
15. Therapists part of health care team.
16. Eclectic therapy:
    Best principles from many approaches.

Caseload Weightings, Costings and Outcomes:

Joyce Gemmell, Centralised and Child Health Services Manager, Ransom Hospital, Notts.

This paper described the way in which caseloads can be linked with costings and outcomes to give information which is valuable for clinical management and planning purposes. The system of simple caseload weighting was devised in 1986 as a means of coping with the speaker's brand new caseload, costings were added as part of a business plan in 1989, and outcomes have been developed from work started by the Research Group in Mansfield in 1980. Definitions of paediatric caseloads and workloads have been adapted from work done by Joyce Williams.

It is clear that physiotherapy work consists of a wide range of activities which are not just "hands on" treatment. There is also responsibility for a wider range of potential patients than would be indicated by a current caseload.

The system of weighting a caseload as "high, medium and low" in terms of number of face to face contacts over a defined period is simple and capable of adaptation to the individual needs of the therapist or speciality. For example a community paediatric physiotherapist could define "high" as weekly treatment over a period of 4 months, whereas a physiotherapist working on an orthopaedic ward may define "high" as twice daily treatment and calculate workload over a weekly or monthly period. Its uses include allocation of workloads, and supporting a case of need for increased staffing, in conjunction with time measurements obtained from Korner activity surveys, and actual workload statistics.

In conclusion there are 3 factors interlinked in this control system. Workload and work rate can be measured and costed. it is essential that they are supported by outcome measurements to establish quality of and effectiveness of intervention. they are an essential part of managing today's health service, but the information obtained is also a valuable clinical tool and should always be accompanied by clinical interpretation.

Additional Information:

There is a day course available in Mansfield on Friday October 9th. Introduction to TELER - presentation of work on multidisciplinary and single profession outcome measures followed by speciality discussion groups. Cost £50 per person or £33 when more than one person from a department attends. Telephone Joyce Gemmell 0623 22515 Ext. 4651 for information and application form.

It is intended that this day will be followed by an in-depth study day offering a complete working package.

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Sensory Integration Therapy

Jenny French, Community Services Manager, Child Health, Chesterfield.
Bette Berents, Physiotherapist in Special Education, Copenhagen

Expanding the Theory of Sensory Defensiveness

Introduction

Sensory Integration Therapy is just one treatment option for therapists working with 'Clumsy" children. (Baker 81), (Laszlo and Bairstow 85), (Russell 89), (Sherbourne 90).

Definition of Sensory Integration

A process that occurs primarily within the brain stem as a response from stimulation of sensory nerve endings. The information from the various stimuli is cordinated, filtered and interpreted to meet the individuals needs to perceive and act in response to his environment.

DR. A. JEAN AYRES.

Dr. A. Jean Ayres pioneered this area of therapy. She was trained both as an OT and a Psychologist and worked initially with children and adults and realised that often the symptoms they presented with, like poor coordination and instability of the hips and shoulder girdles, were not the reason they were referred for therapy. They were more often referred because of learning dificulties in the classroom, poor attention span and perceptual or behavioural problems. She focused her attention on children which we refer to as 'clumsy' and determined to improve assessment and treatment methods to help them.

A thorough understanding of how the brain processes sensations and how the child responds to different sensory input enabled her to develop the Southern California Sensory Integration Test, and the Sensory Integration and Praxis Test. (Ayres 72) (Ayres 78).

Bearing in mind that theories of brain function are still changing, and new knowledge is added nearly daily to existing foundations, the Ayres theories of sensory integration continues developing in the light of new research.

AYRES HYPOTHESES

Learning is a function of the brain and as new learning occurs changes will occur in the nervous system. Influencing stimuli include vestibular, proprioceptive and tactile input which are critical to learning. Integration and organisation of these stimuli are basic for cortical learning and are closely related to emotional stability and the childs ability to organise sensory information to make appropriate environmental demands. Thus impaired sensory integration may reflect a deviation in neural processing and interfere with a childs learning and his ability to organise and respond appropriately to certain stimuli. Ayres believed that by improving sensory integration for this group of children a positive effect could be achieved. Many children however, may have global delay, or cortical impairment and although the principles of sensory integration may be used to help the child, such intervention will not be curative.

CHARACTERISTICS OF SENSORY INTEGRATION PROCEEDURES.

This form of intervention relies on the therapists ability to control specific sensory input. The therapist creates an environment for the child in which he actively expolores, experimenting for himself and guided by the therapist, to enable him to make an appropriate adaptive response. An understanding of Ayres theories is paramount in understanding SI (See Chart from Sensory Integration and the Child).

The combined result of a well integrated system is praxis *ie* motor planning. The ability the child develops to think about, inwardly plan and execute a well controlled, environmentally appropriate response to any stimulation.

THE VESTIBULAR SYSTEM

This system controls the movement of the body and postural control against gravity. A well stimulated vestibular system will lead to good perceptuo-motor development. The vestibular system comprises the vestibular nucleus and the 8th cranial nerve, situated in the brain stem, and the auditory apparatus, the semi circular canals and the otolith organ. (Ottenbacher 78), (Weeks 79), (Kelly 89), (Keshner 89).

THE PROPRIOCEPTIVE SYSTEM

This system registers postition and movement of joints and postures providing information about postition of body in space and environmental relationships. The significance of the system for sensory integration is that it maintains the body at a particular postural level of tone in readiness to respond to any change in movement. (Ayres 72), (Sherbourne 90).

THE TACTILE SYSTEMS

Touch and pressure stimuli are constantly being received by the nerve endings in the skin (Meisner corpuscles, Merkel receptors etc.) and information is fed to the brain stem where integration and organisation occurs.

This system is commonly overlooked during assessment but in fact impairment of the tactile system can explain many of the difficulties these children encounter. The system is closely linked with the limbic system and emotional stability. In simple overview the system can be looked at in 2 parts the primitive protective system, which is divided into 2 sections, and the discriminative system An imbalance between the two parts of the protective system can cause problems for the 'clumsy' child. This theory was based on theories of pain prior to 1964. Since then the theories of tactile defensiveness have been further developed by (Melzak and Wall 65), (Montgomery and Richter 77), (Ayres 79), (Bauer 77), (Dunn 80), (Wilbarger 71 and 84).

French J, Berents B, (1992)

SENSORY DEFENSIVENESS APPLICATIONS TO CLINICAL PRACTICE.

DEFINITIONS AND KEY CONCEPTS.

Sensory Defensiveness is a constellation of symptoms that are the result of adversive or defensive reactions to non-noxious stimuli across one or more sensory modalities. It is an over reaction of our normal protective senses. Individuals with sensory defensiveness have their own response style. There may be patterns of avoidance, sensory seeking, fear, anxiety or even aggression.

Social and Emotional Disorders Related to Sensory Defensiveness are a pattern of learned behaviours that create habits and interaction styles that are protective and defensive in nature. These stress and anxiety reactions can continue after the primary symptoms of sensory defensiveness are no longer present.

Types of Sensory Defensiveness:

Tactile Defensiveness is an over reaction to touch experiences. This may result in avoiding touch from others, dislike of crowds, irritation when having their hair washed or cut, avoidance of certain types of clothing, and many other similar ractions to touching or being touched. Tactile defensiveness was first described by A. Jean Ayres in a California study of hyperactive children. The behaviour patterns observed during somatosensory testing were distinctive and led to many studies in occupational therapy clinical practice that further elaborated this syndrome.

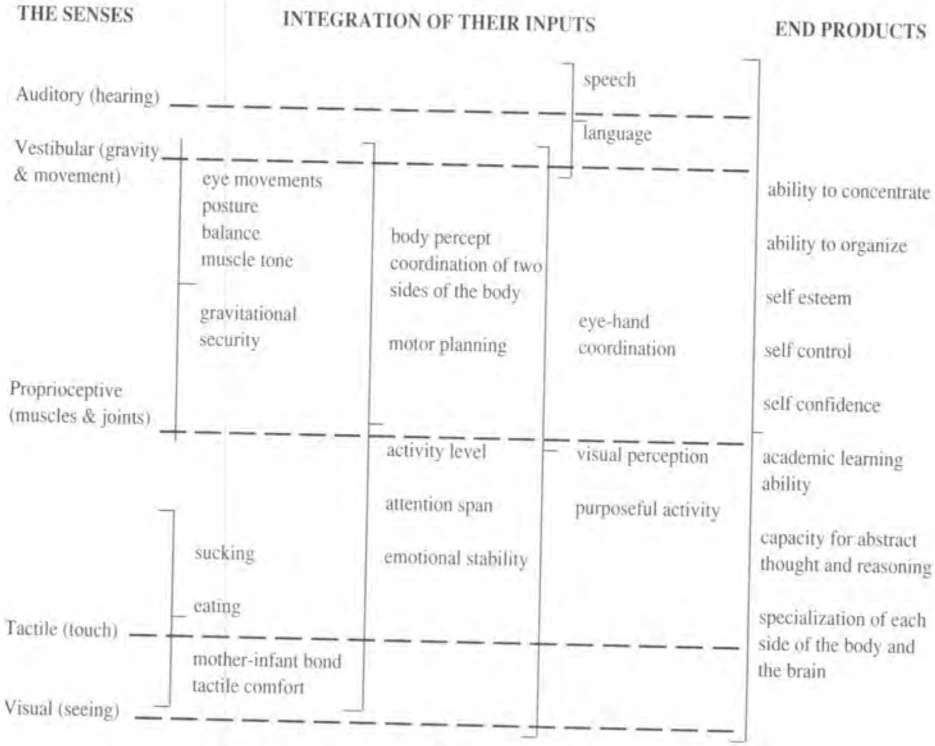
Oral Defensiveness is an avoidance of certain textures of food and irritation with activities using the mouth in general. The patterns of avoidance is unique to each individual. Some avoid soft slimy foods, others, rough texture etc.

Gravitational and Postural Insecurity is an overacting or a fearfulness of movement or change in posture. Some individuals are alarmed when walking down open stairs, riding on escalators etc.. There may be a dislike of swings and carnival rides.

Auditory Defensiveness in an over sinsitivity to light, visual distractability, and often gaze avoidance.

Other sensitivities can include heightened smell and taste and proprioceptive system irritability.

Wilbarger & Wilbarger 1988
Santa Barbara, CA



The senses, Integration fo Their Inputs and Their End Products.

Early Intervention - is it really valuable?

Dr. C. M. Verity, Paediatric Neurologist, Addenbrookes Hospital, Cambridge.

This review concentrates on the use of physical therapy for the treatment of children with cerebral palsy. It starts with a discussion of two papers that have evaluated physical therapy for children with motor handicap (Harris 1987, Tirosh and Rabino 1989). Harris found 8 studies published since 1973 that were worthy of comment - some found that physical therapy had been helpful, some did not. Tirosh and Rabino identified 9 papers that had evaluated physiotherapy for children with cerebral palsy. 6 had positive results, 3 did not. Tirosh and Rabino assessed the studies and gave a maximum score of 14 for the way in which each study had been planned and carried out. The 3 studies that found no positive result from physiotherapy were among the 4 with the highest scores. Thus both reviews found only a small number of studies that had addressed the problem of physical therapy for children with motor problems, there were mixed results and few had been carried out sufficiently carefully to yield a reliable result.

The next part of the talk deals with the paper that had the highest score in Tirosh and Rabino's review. This was an examination of the effects of physical therapy in infants with spastic diplegia, published by Palmer et al in 1988. They found no evidence that neurodevelopmental therapy as used in their study was better than infant stimulation. There were problems with the study and the authors called for the need to perform bigger studies, possibly using a number of different centres.

It is difficult to evaluate the effects of early intervention. This is discussed by Rosenbaum et al in an article in Physical Therapy in 1990. The challenge is to develop an evaluative measure capable of measuring a change that has been brought about by therapy. One approach that has been used is to analyze movement. The analysis of gait in specialised laboratories has provided a means of doing this. A paper by Fetters in Physical Therapy reports on the use of this approach to measure movement in the upper limb after neurodevelopmental therapy. The report claims that the use of kinematics enables therapists to evaluate the short term effect of therapy. The author suggests that in the future subjects may be grouped according to movement variables, rather than according to the description of their disability.

An alternative approach is to use a single subject and to evaluate the response in that subject to different types of treatment. An example of this is given in a paper by Goodisman in Physical Therapy in 1982.

The conclusion is that we do not have good evidence that early physical therapy is helpful for children with cerebral palsy. A number of studies have been done, but many of these have not been well designed. Even those that have been well designed can be criticised. There are new approaches, such as gait analysis and the study of single subjects, which may provide a means of evaluating early intervention more accurately.

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Palmer F.B. et al. "The Effects of Physical Therapy on Cerebral Palsy. A Controlled Trial in Infants with Spastic Diplegia" N. Engl J Med 1988; Vol 318: 803-8

Rosenbaum P.L. et al. "Issues in Measuring Change in Motor Function in Children with Cerebral Palsy" Physical Therapy 1990 Vol 70: 125-131

Tirosh E and Rabino S. "Physiotherapy for Children with Cerebral Palsy. Evidence for its Efficacy" American Journal of Diseases of Children. 1989 Vol 143 552-555

Suggested Reading

Gait Analysis in Cerebral Palsy - J R Gage. Clinics in Developmental Medicine No 121 1991 MacKeith Press Oxford, New York.

The Effectiveness of Early Intervention for At-Risk and Handicapped Children. Edited by Michael J. Guralnik and Forest C. Bennett. Academic Press 1987 London.

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The following articles are the synopses and interpretations of conference lectures as seen by members of the East Anglia Region.

Epilepsy

Dr. S. Green, Sr. Lecturer in Paediatrics and Child Health, Birmingham Children's Hospital.

Synopsis by Frances Thomas Davies, High Wycombe Community Team for People with Learning Disabilities.

Dr. Green gave a very comprehensive lecture on epilepsy

Prevalence 7/1000 births or 1% In **Cerebral Palsy** this rises to 35% of all children.

Physios working with children with cerebral palsy have more experience of observing seizures than the average GP.

What is a seizure?

It is the occasional excessive disorderly discharge of nervous tissue in the brain.
Frebile convulsions and jerks.
Not all epilepsy is convulsive.

Cerebral Palsy

Spastic diplegia) not often seen
Athetoids) not often seen
Spastic tetraparesis sometimes
Hemiplegia - most common

If the cause is:

a) genetic - seldom have fits
b) Due to birth asphyxia - sometimes
c) Post natal - most likely 35% have fits

Classification of fits

Generalised

Tonic Clonic - this is a grand mal. The patient is not aware. There is a danger of asphyxia.

Myclonic

Spasms jerks - common in young children

Partial caused by damage to one side of brain causes jerking on one side of the body affecting, first the face, then arm and leg and may become generalised.

Complex

Temperal lobe seizure. May be frightening - causes a distortion of reality or a noise may be preceeded by an aura, a smell, difficulty of language, then abnormal movement. More than one type of fit may be present making classification difficult.

Diagnosis

It is unlikely that the child will fit when with the doctor therefore he is reliant on the parent, teacher, and physiotherapist to give the history. Videos may be used.

On Examination.

Epilepsy does not show, only the cerebral palsy. Symptoms can be confusing, eg., children with bad dystonia - spasms, may be due to Cerebral Palsy or epilepsy.

Ataxia - falls could be due to ataxia or epilepsy.

Investigation:

EEG monitoring combined with video can be used, by pressing the button when an episode starts. Sensors can be used to track the child round the room but this is very costly.

Patterns: Details of seizures should be kept.

1) Duration - seizures can last from seconds - minutes
More than 30 mins - status epilepticus and emergency services must be called.
2) Frequency - Varies from 100 or more a day to 2-3 per year
3) Cluster - six weeks free, then 2-3 days of fitting
4) Build up - a few days before the seizure - the child's behaviour becomes "different". He is alright again after the fit.
5) Cyclical - nocturnal menstural

Trigger - Noise - especially in hemiparesis
Touch
Light sensitivity - rare in Cerebral Palsy
Emotion - sometimes the child gets pleasure from seizures especially in temperal lobe attacks.

The Management of Seizures at School

Teachers are terrified to integrate children with epilepsy in their classes. Therefore, they have to be educated in the management of these children in the following way.

1) An explanation of epilepsy
2) Emergency action, how and when to use rectal diazipan. Instruction to the school.
3) Medication, drugs, their dose and side effects should be explained.
4) Liaison with the paediatrician and GP and all relevant information passed to the school nurse and the therapist.

Ideally, the clinics should be moved from the hospital base and held in the school. The school must put the child first and not the epilepsy. Children seldom have seizures while carrying out an activity they enjoy such as swimming. They are more likely to have a fit before or afterwards.

Emotion can play an important part in causing seizures, or they can be self induced. It is possible to talk a child out of a fit, by diverting their attention. Sometimes drugs are given to inhibit the triggers.

Behaviour - Teachers and parents should be aware that bad behaviour, lack of concentration, and failure, can be caused by unrecognised non convulsive seizures.

Surgery. This may be necessary in massive lesions that give rise to almost continual fitting.

Epilepsy Surgery in Children

Dr. J. M. Oxbury, Consultant Neurologist and Clinical Lecturer in Neurology, Oxford District H.A. and University.

Synopsis by Jo Humins, Supt. Physiotherapist for Learning Disabilities

Dr. Oxbury began by emphasising that he was part of a multidisciplinary team.

The team consists of:-Neurosurgeon
Neurologist and paediatric Neurologist
Neurophysiologist
Neuropsychologist
Neuropsychiatrist
Physiotherapist
Counselling Psychologist
Neuropathologist - for quality and monitoring

The surgery is curative of epilepsy in 40-50% of cases. Although seen mainly as a treatment for adults, children have been operated on since 1930. The optimum age for surgery is under 16 years.

Number of surgery in the last 5 years, globally.

Temperal Lobe excisions - 2578	
	68% seizure free post-op.
	24% improved post-op.
Hemispherectomy -	188
	67% seizure free post-op
	21% improved post-op

There are about 150 ops per year in the U.K.

Principles for surgery.

Epilepsy must be disabling
uncontrolled
unlikely to remit spontaneously.

It will be arising from focal pathology, and that pathology will be known.

The types of unwanted side effects will be predictable.

The patient will be given the choice and enabled to balance the "pros and cons"

Conditions which respond well to Temporal Lobe surgery.

1. Alien tissue - malformation or slow growing tumor
2. Sclerotic hippocampus.

Questions to be asked - Is it surgically treatable?
Is there any radiological abnormality in the temporal lobe?

Has the child suffered any prolonged convulsions in early childhood? - likely to be hippocampus.

Investigations.
MRI scan
EEG
Neuropsychology

The EEG is continuous for between 5 and 7 days and costs around £5000.

In Oxford there have been 100 children operated on in the past 20 years.

Disabilities following surgery.

Poor memory
Hemionopia
Language disorder
Depression
Mental retardation

Hemispherectomy.

18 Children have had hemispherectomies in Oxford since 1983. Pre-operatively these children will have had the following problems:-

Hemiplegia
Mental retardation
Severe epilepsy, often with more than 1000 seizures per year.

86% of the children were seizure free after 5 years post-op.

50% were seizure free 2 years post-op. This is a group of children who were very severely disabled before surgery.

Conditions leading to Hemispherectomy.

1. Congenital hemiplegia with epilepsy.
2. Rasmussens syndrome.
3. Sturge-Webber syndrome.
4. Neuronal migration abnormality.
5. Hemiconvulsions > hemiplegia > Epilepsy syndrome.
6. History of pre- or peri- natal abnormality.

Conclusion.

Surgery can be a major effective method of treating epilepsy provided the principles are adhered to.

It can be curative in 50% of cases.

Childhood is the ideal time to treat.

Lastly, the most important thing is to have a good cohesive team.

Psychological Outcome following surgery in children.

Mrs. S. Oxbury, Consultant Clinical Psychologist, Head of Dept. of Clinical NeuroPsychology, Radcliffe Infirmary, Oxford.

Synopses by Anglia Harbours, NHS Trust, Gt. Yarmouth

Outcome of surgery.

1. Reduced seizure frequency.
2. Unwanted side effects
3. Quality of life change, ie school, employment, domestic, interpersonal and family.

Role of the neuropsychologist.

To assess prior to surgery.
To follow up after surgery.

Neuropsychology Assessment

1. General Intelligence.
2. Memory - verbal
   - non-verbal
3. Language function
4. Educational attainment.

The assessment is used as a basis for advice on patterns of abilities and/or special needs. It is continued with lengthy follow-up.

Programme of assessment.

1. Prior to surgery full assessment

Post-op

2. 3-6 weeks	brief assessment
3. 6 months	full assessment
4. 2 years	full assessment
5. 5 years	full assessment

Children can also be seen whenever needed e.g. before G.C.S.E.'s

Temporal Surgery

I.Q.

No change 6 months post-op, little change 5 years post-op.

Memory

There is a decrease in verbal memory in children post **left** temporal lobectomy. There is no drop in verbal memory in children post **right** temporal lobectomy. The decrease is greater in children who had a good pre-operative verbal memory.

The deficit remains permanently.

This must be fully explained to parents and schools. Help can be given in the following ways:-

Child should be well organised.
Encouraged to write notes.
Ancillary helpers in school.

Problems with exams, will do better with continual assessment. The memory loss should be no barrier to success.

There has been no change in non-verbal memory shown.

Language Function.

There may be some problems following left temporal lobectomy at 6 weeks, but these will have recovered to the pre-op level by 6 months.

Psychological factors.

Pre-op may show - Poor school attendance
Poor self image
Lack of friends
"Epileptic Personality"
Psychiatric disorders

All are markedly improved post-op but may need long term follow-up.

Parents and children must have realistic expectations of surgery, it will cure the epilepsy but it will not change their lives.

Good family support is needed, and goals must be stated on all sides.

Hemispherectomy.

Virtually all children improved their I.Q. over 5 years but none attained over 80.

Often the children were functioning pre-operatively on only one hemisphere.

Family life carried the burden of caring for a chronically ill child.

There may have been a large proportion of aggression or "slug-like" behaviour.

Post-operatively, parents report having a different child. The change can be seen within 2 weeks.

This leads to the possibility of a more normal family life. The child will still be severely disabled but will have fewer seizures and will therefore be manageable and sociable.

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An Evaluation of the Multi-disciplinary Approach to Integration.

Part 1.

Jeanne Lacey, Angela Jacklin.

Jeanne Lacey is a Senior Community Physiotherapist based at the Royal Alexandra Children's Hospital, Brighton and has worked at Patcham House School since 1979.

Angela Jacklin taught at Patcham House School from 1980-87 and is now Lecturer in Primary and Special Education at the University of Sussex.

In the wake of the 1981 Education Act, both teachers and medical staff at the Patcham House School in East Sussex have followed a positive policy of integration. In this article we describe the way the school's methods of integration developed, and the outcomes of evaluation and research. The school provides for up to 60 pupils with physical disabilities across the ordinary intelligence range, although some pupils have perceptual and spatial impairments and associated learning difficulties.

1. STAGES OF DEVELOPMENT

The inter-disciplinary ethos of the school was an important factor in determining our approach to integration.

1.1 The Simple Transfer (1983/84)

During this first phase children were chosen for integration solely in terms of their physical ability. They were given no medical or extra educational support in the mainstream school and their progress was not followed up after the first term. It was assumed that if the pupils were able to cope on equal terms physically with their mainstream peers they would have few problems.

Four children who had only slight physical disabilities and were working well at Patcham House were integrated into their local schools. This was a simple transfer arranged in the same way as pupil transfers between mainstream schools. During the next two years Patcham House staff discovered informally that all the children were experiencing problems. One pupil, integrated into a secondary school, truanted, became a non-attender and was in trouble with the police. This was in vivid contrast with the way the child had been respected and had been active and enthusiastic when attending the special school.

1.2. Moving Out (1984 onwards)

Disturbed by the outcomes of these placements we developed and refined our methods of preparing pupils. We broadened our approach to integration to encompass the special school as a whole as well as the individual child. We realised as a special school we had a responsibility to become less isolated. We began to "move out" by building links with mainstream schools and the wider community.

We progressed from using facilities such as the swimming pool at one local secondary school to making contact with some other mainstream staff in local schools, in order to enable the children to benefit from the school's expertise in activities such as working with computers and learning canoeing. At that time none of these schools had experience of pupils with physical disabilities but were anxious to learn and take on the responsibility. Physiotherapists, teachers and welfare staff were all involved to ensure the success of these activities.

Other ways to break down the isolation of the school were initiated. We took part in local fund raising events and community festivals such as the Brighton Festival. Pupils joined mainstream schools for chess club sessions and matches and the annual primary schools' Music and Drama Festivals. Equality of participation was always the aim.

Three positive benefits emerged during this phase. Firstly, we had successfully included pupils with severe physical disabilities in mainstream activities. Secondly, the majority of mainstream staff were able to take on the implications of the child's physical disability, overcome their anxiety and felt it had been a rewarding experience. Thirdly, chidren whom we were planning to integrate were included in these groups; these were initial steps towards the goal of full individual integration.

1.3 Encouraging Personal Relationships.

During this phase we moved beyond simple contact between children from special and mainstream schools towards structured opportunities for building relationships.

At the primary level children took part in exchange visits several times a term with mainstream classes. Individual children, classes and teachers from both schools worked together. This was significant progress towards preparing children and their receiving schools for integration.

The classes as a whole benefitted. 1. Flexible organisation allowed for co-operative working between able-bodied and physically disabled children who came to know each other better. 2. It is important for children to accept their physical disability in an able-bodied peer group. One child with severe facial disfigurement was placed within a carefully chosen group and became confident enough to cope with other people's reactions to her appearance. 3. Mainstream children commented that they had learned how to relate to their special school peers irrespective of disability. 4. All teaching staff felt that they had increased both knowledge and skills as a result of the exchanges.

As part of the class visit the children we intended to integrate were given the added experience of working in larger groups, supervised only by mainstream teacher and experience a low teacher-pupil ratio. After this regular individual visits were arranged for these children.

1.4 The Procedures for Integration

This phase overlapped with the previous one.

1.4.1. Choosing the child became our first consideration. A multi-disciplinary team from health and education was involved. It comprised the head, class teacher, school medical officer, physiotherapist and welfare assistant. Additional members varied according to the special needs of the child. The team worked from the premise that physical disability need not be a handicap if resources are available to provide access to the curriculum. However in the Brighton area of East Sussex, because of the nature of the local school buildings, many, even primary schools, having more than one storey, physical access always had to be a consideration.

Whether or not medical support and therapy could or needed to be provided was an important issue in selection but the physical ability of the child became one of many other criteria discussed. One such criteria was the child's maturity in taking responsibility for the management of their own disability, for example, children with spina bifida coping with their own toileting needs and skin care. Intellectual ability, emotional and behavioural problems and social skills were also considered. The opinion of the child was a major consideration; all the children wanted to attend mainstream. On these criteria children integrated proved to be our 'best' pupils, achieving well academically and prominent in social and extra -curricular activities. All pupils were counselled by key members of the multi-disciplinary team, usually the class teacher or physiotherapist.

1.4.2 Parental support was crucial and parents were fully consulted. Some of the impetus for integration came from the parents themselves. The majority needed reassurance and expressed reservations about allowing their child to leave a secure environment. Informal meetings were arranged to enable parents to discuss these issues among themselves. A major concern was the lack of physiotherapy cover once the child left Patcham House.

1.4.3 Preparation of the mainstream schools. Written reports, case conferences and reciprocal visits were arranged between the mainstream staff and the teaching , medical and welfare staff from Patcham House School. The physiotherapy report was detailed. The format was based on Guidelines on Advice to Teachers from C.S.P. publication on the 1981 Education Act (Eckersley, et al). A teacher who is well informed is more confident and better equiped to meet the special educational needs of the 'whole' child. Mainstream staff visited to observe children in the classroom, playground and having therapy. The physiotherapist visited the mainstream schools to advise on access and the implications of the medical condition for classroom and school management and to teach treatment techniques to welfare staff if necessary. The welfare staff at the special school passed on their expertise to their counterparts in mainstream. After placement, teaching, medical and welfare staff from the special school offered continuing support.

1.4.4 Promoting Integration.

At primary level part-time integration was introduced and depending on how the child was coping, the time spent at mainstream was gradually increased until the child was full-time. During this changeover time, the child discussed problems with his or her class teacher, physiotherapist and friends from the special school.

At secondary level the pupils attended approximately half the week at mainstream schools and half the week at Patcham House. Because of the size and complexity of secondary schools, we felt this model provided pupils with continuing support from the special school and at the same time enabled them to benefit from a wider curriculum and broader social contacts in the mainsteam. All pupils held their own academically at their mainstream school. However all but one of these placements failed. This was both a surprise and a disappointment and prompted a more careful evaluation.

2. EVALUATIONS AND FINDINGS

2.1 An Initial Evaluation

This evaluation was carried out by examining the progress of the 13 children who had been transferred from Patcham House into mainstream school during the four phases of development. The following table summarises the outcomes.

Type of Placement	*Number of Children*	*Maintained Placements*	*Failed to Maintain.*
Pri. Full Time	4	4	0
Sec. Part Time	3	0	3
Sec. Full Time	6	6	0

The evaluation showed that approximately three quarters of the children maintained their placements and these children had been full time at primary or secondary schools. The children who returned to Patcham House had been attending mainstream schools only part time.

'Maintenance' of a place at mainstream school must not be confused with successful integration. The apparently successful picture portrayed by the table concealed the fact that successful placements were sometimes achieved only after more than one attempt. Truanting and periods of suspension which had been a feature of our 'simple' transfers still occurred.

2.2 Further Evaluation (1986/87)

Our need to find out the reasons for the failures and to assess the relative importance of the factors which made for successful integration led to a school-based evaluation, with interviews recorded on video. Our priority was to gain insight into the puils' perspectives and their experience of integration.

We interviewed two primary and six secondary pupils, some successfully, some unsuccessfully integrated. We also sought the views of 16 year olds who had gone on into sixth form colleges or further education as well as selected parents. The main findings are summarised below.

All pupils appreciated the supportive "family" environment of the special school but wanted to continue in the mainstream. Those whose initial placements had failed were prepared to try again. Children who had previously experienced only special education found the change to mainstream school most difficult and those integrated at secondary level experienced most problems. All had been able to cope with the academic work.

All pupils experienced teasing. The majority said that they were able to cope, although it emerged that constant teasing led to one part time pupil to truant from secondary school. Ancillary staff were supportive at these times and for two children their help had been crucial. Instructed to give physiotherapy they saw the child daily and were able to step in, indirectly, to help the child with teasing and other problems. Direct intervention from staff was felt by the pupils to be counter-productive. It alienated the disabled child from other members of the group and could lead to further teasing and isolation. Support had to be given discreetly.

Establishing friendships was difficult. After seven to nine years at the special school, some pupils said that they did not know what mainstream children were like. Only the pupil integrated into sixth form was enthusiastic about her new friendships. The secondary pupils said that transfers other than at eleven, and non-local or part time placements made making friends more difficult. Pupils felt the part time placements failed because they were never able to 'get in' with other pupils. Most importantly, they felt they did not belong to either the mainstream or the special school.

With paramedical and ancillary help all children were able to cope with the physical aspects of their medical conditions although logistics in some secondary schools did cause problems. Stairs and similar obstacles, carrying books, quick change-overs and long distances between classes were common difficulties.

The parents were selected to represent the range of opinion, for and against integration at Patcham House. Some parents felt that there should be no segregation for pupils with physical disabilities and that all schools should be designed and adapted for their use. They believed segregation led to teasing, isolation and the inability to cope with the realities of life.

In contrast, parents of children who had been casualties of the mainstream system explained how their children, withdrawn and non-attenders at mainstream school, had become self-confident, happy, sociable and more competent in their work at Patcham House. Parents of mainstream children, who had been temporarily at the special school, for example following a road traffic accident, and then re-integrated, were grateful for this time. Their children had gained confidence, improved physically and caught up academically.

Parents were also concerned that mainstream staff did not always understand disability and could be over-protective, that provision of a broad curriculum was useless if the child was unhappy, truanted and was unable to learn. They believed the children needed professional counselling before and after integration and the parents themselves missed the close contact with staff at Patcham House, especially the physiotherapist with whom they could discuss their child's condition.

2.3 Outcome

The evaluation revealed that the child's social and emotional adjustment to integration presented problems. To find out what elements were missing from our provision, we needed to explore the children's perspectives more fully. We began to realise that while there was an integrated team of ancillaries, teachers and therapists working closely together in the special school, with links developed between education, health and social services, we had neglected the importance of maintaining this integrated support network after integration. We needed to investigate how it could be maintained. At this time, an opportunity to study for an M.A. at the University of Sussex (1987-88) enabled these concerns to be the focus of two small scale research projects.

Conclusion.

The research provided essential insights into the factors necessary for maintaining a successful support network. The findings illuminated the problems of integration from the perspective of the child, especially the cultural dichotomy between mainstream and special education.

An understanding of these factors is important for any one working with the complex and ongoing problems of integrating the physically disabled child.

The research will be the subject of a following article.

* * * * * * * * * * * * *

APPRECIATION

MARY CLEGG

Mary was elected to the National Committee in 1983. Almost immediately, she became a member of the Post Registration Education Committee and has chaired this committee for the past six years. She became Vice Chairman of APCP in 1987 and served in this capacity for three years. She was elected Chairman in 1990, a position which she held until April 1992.

As a member of the Post Registration Education Committee, Mary was a co-author of the APCP 1991 Education Act booklet. In addition, she took over the running of the Introduction to Paediatrics Course at that time validated by CSP. Mary was instrumental in moving this course into Birmingham Polytechnic (now known as the University of Central England in Birmingham) where it is about to start its second year as part of the CATS scheme.

Mary has worked hard to promote the Association, giving a lot of her time to this cause. She has always been supportive to other committee members and has been very reliable.

Mary's contribution to the Committee over the past nine years has been much valued. We would like to record our grateful thanks for all of her hard work.

Sandra Holt.

MICHELLE LEE

Following the A.G.M. at Norwich in March, Michelle has stepped down as Secretary, her place being taken by Fiona Corkhill. Michelle first came on the committee in 1986, her first post being that of Publications Officer. More recently as Secretary, Michelle has been enthusiastic, energetic and efficient. Members of the Committee and Editorial Board will also remember her for the wonderful working lunches (at little or no cost) she organised in the Board Room at the A.M.I. Portland Hospital whilst she was Superintendent Physiotherapist there. We were treated and felt like royalty by our excellent host.

Fortunately Michelle will remain on the Committee as she still has much to offer the Association. I am sure all members of the A.P.C.P. will joint the Committee and me in thanking Michell for her hard work.

Thank you Michelle for a job well done.

Viv Williams.

There are many more thanks to give to those who have served so willingly on the National Committee, (and/or its many Sub-committees) and it is difficult to name them all. There is much time and effort given on a voluntary basis to this Association, and it is pertinent that they should know that their labours have been greatly appreciated. Thank you all.

Editor.

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CHAIRMAN'S REPORT A.G.M. OF THE APCP - MARCH 28th 1992

This Conference represents the 19th AGM of the Association and I welcome you all. The A.P.C.P. continues to grow as we enter a new era and go forward with Europe.

Unfortunately, Julia Bottomley's workshop was cancelled or those who attended would have a greater understanding of what this means, but greater opportunities for all must surely be challenging and exciting. It is up to us to make it happen as we would wish, the Association will work towards this aim.

Much has happened again over the past year, and again we will soon be feeling the impact of Legislative Changes, as the implication of The Children Act which became Law on 14th October, 1991, begin to take effect.

Adjustments will have to be made, and our resources juggled with to help make it all happen and work. Communication with our colleagues and families has always been a prime factor in the work we do, but perhaps never more so than now. Communication, understanding and making sure we maintain our desired values and standards, must be the way forward.

Every year now, at the Chartered Society Conference, we as an Association, have the opportunity to put forward motions for debate at the Delegates' Conference. It has been shown that the ensuing discussions and debate have a very real effect on the ways forward for the Profession. Only last year a motion for change in the proposed Advanced Diploma in Physiotherapy Studies was put forward. The result is a change in the outcomes of the study pathways offered, allowing greater flexibility in the awards offered. We have another opportunity this year to take motions forward, which could effect change. If you have any burning issues please let our Secretary know, but within the next three weeks as we do have a deadline to meet.

Your National Committee and its various Departments have worked hard for you this year. As you are no doubt aware, the Committee meets 4 times a year and a great deal of work has to take place between these meetings. Our PRO, Caroline Dunn, will be giving her Report of the work done by the team of Regional Reps. The Regional Reps are your links to the National Committee and the way information is fed in from the regions. Again, the whole team has worked hard and our thanks go to them and Caroline.

The Post Reg Education team have combined to work furthering our educational knowledge and opportunities. A full report will be following, but as a member of that team, I would like to add my personal thanks to yours, for all the work they put in.

The Editorial Board and in particular our Editor Jenny McKinlay have produced four extremely high value copies of our Newsletter over the past year. To produce such a publication requires dedication and I know that during the days before copy is finally sent to the publishers, there is much burning of the midnight oil by Jenny and her team. Jenny has been our Editor for 4 years and the August Newsletter will be her last, I am sure you will wish to thank her for all her efforts.

I am very pleased to say that under Carol Foster's guidance and enthusiasm, the 2nd editions of the Booklets are now beginning to get off the ground. Carol reported at our meeting here, that there had been a hot line between her office and Australia in the effort to get the Serial Splinting published for this Conference. Others are now well on the way, including new titles. Thank you Carol and good luck with the new ones.

Some of you may have noticed the small changes to the Membership renewal forms this year. "Needs must change", and Jeanne Lamond our Membership Secretary continues to keep an eye on what is happening. I am sure that hardly a day passes without the postman dropping something through her letter-box.

Many is the time I have required information about the Membership and Jeanne can always supply the answers - thank you Jeanne for your continuing excellent work.

Money can often be an area of problem and debate, but I must report that we as an Association do not have those concerns due to the very professional advice of our Treasurer, Lyn Weekes. I have wondered many times Lyn, how you have coped this year, with being not only National Treasurer, but also Treasurer for this Conference. However you have, and thank you for your advice and hard work.

I hope you think this AGM is running as smoothly as I feel it is! This is one of the many onerous tasks of our Secretary Michelle Lee. Being Secretary requires great organisational skills and often instant action to deal with a request. You also have to round up people and remind them what to do and when.

During my two years in office, Michelle has been my right hand, smoothing the way to running the Association. She also stands down from office this year, although not from the Committee, we all thank you Michelle for the hard work.

I am sure you are all aware the CSP are highlighting Physiotherapy in Paediatrics this year during two days in May. The PRO Dept in particular Lyn Duxbury and Jane Morrison who were running their stand, have worked very hard to produce publicity material for it. Thanks go to all other Depts at the Chartered Society of Physiotherapy for their continued support for the Association.

To end, I as your Chairman for the past two years give you all my thanks for your support and backing.

It has been an enormous privilege to be Chairman, and a very humbling one.

This is a great Association. I thank my Committee, and I thank you all, and look forward to continued friendship through occasions such as this.

MARY CLEGG, M.C.S.P., S.R.P

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Letter to all members

6th July 1992

Dear Membership,

I wish to express my thanks to you all for the support and friendship I have received during ten years of service on the National Committee. The last two years were as your Chairman, a position I felt very privileged to hold.

The Association goes from strength to strength and has National recognition as representing your views.

I look forward to watching, with interest, the continuing development of the A.P.C.P. and to maintaining contact with the many friends I have made.

Mary Clegg.

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

POST REGISTRATION EDUCATION REPORT 1991-1992

The past year has begun to show the fruits of the course planning which the committee has been doing over the past months.

The Validated Course is now well and truly established at Birmingham Polytechnic, with the first 14 students all through their part 1 of this year's course. They take their final oral in June. Our thanks go to the Health Sciences Department for the welcome and support which the Course has received. A mention must also go to the very large School of Nursing Studies there, for their interest and input into the Course. Our thanks also go to Sarah Beeston, Principle of the Physiotherapy Division at East London Polytechnic, who kindly agreed to be the external examiner.

The registry office is a vital link to the smooth running of the course and must also be included in this list of thanks, as must all of those who have any part, however large or small, because without them there would be no course.

To supplement this news there is the exciting development of the MSc in Paediatric Physiotherapy or Occupational Therapy, at East London Polytechnic, which is due to start in September this year. The existing MSc Physiotherapy Course, still in its first year, is a modular system. Two new Paediatric modules have been developed to fit in with the existing Course; the other seven modules can be easily adapted to fit into a Paediatric framework. The Course development team is very grateful to those Paediatric Physiotherapists and Occupational Therapists who have given very useful feedback and advice on the proposed content at various stages in the development of the modules. The Course will be two years part- time, one afternoon and evening per week. The four modules to be undertaken during the first year will be compulsory; there will be a choice of modules to be undertaken during the second year. This will allow the individual to identify their own objectives within the modules. In addition to this, each student will undertake a research project which will stem from his or her own practice within the field of paediatrics. Special thanks must go to Sarah Beeston, Principal of the Physiotherapy Division at the Polytechnic of East London; without her help, advice and encouragement, and her hard work in producing the documentation for the validation panel, the project would never have got off the ground.

Currently, committe members are busy in two other main areas:-

A document on Standards of care in Paediatric Practice will shortly be available. This will be a twin document to the Good Practice Guide-lines document, and will be in line with others being produced in areas of specific physiotherapy practice. We hope this publication will help you with writing and auditing your own standards. The committee is also producing a booklet about the Children Act and Caroline Dunn has been co-opted to help with this. It will be out later in the year.

Access to records became Law on 1st November 1991, and the Professional Affairs department at the CSP have produced a very useful leaflet to help with this - available from the department for anyone who wants to know more.

We get quite a number of enquiry letters asking about different issues. This is very gratifying - we help if we can - don't be afraid to write.

Finally, our thanks to all committee members for their help and hard work. Meetings have not been easy this year, and much of the work is done on the telephone and by letter.

As always our thanks go to the CSP for the advice and support given.

NATIONAL PAEDIATRIC PHYSIOTHERAPY DAY
19th May 1992

The Paediatric physiotherapists report from Aberdeen.

The Physiotherapists from the Royal Aberdeen Children's Hospital, the Raeden Centre and Schools got together to have a joint Open Day in the Children's Hospital. We had much needed and appreciated help from our colleagues from Aberdeen maternity Hospital without whom our aerobic sessions would not have occurred.

We had a display stand in one of the local shopping malls on the Monday and Tuesday to which we had very favourable comments as one of our mum's stood and listened to what passers-by had to say. This stand illustrated the 3 main areas of work which we represent. The day itself was spent with our main displays in the Children's Hospital. Each area had display boards for photographs and information relative to their specific area and a small display of specialist equipment. A lot of effort was put into these to give those attending a good insight in to our specific areas of work.

The day officially started at 11.00 a.m. with Bob Sessions - the male lead in "42nd Street" which was on at the theatre - officiating at our Balloon Launch. Once the 100 balloons were launched it was back inside for a vigorous work-out with our colleagues from A.M.H. leading the proceedings and our very special guest 'Joggy Bear' lending a paw or two. Not only did 'Joggy Bear' participate in the aerobics, but he also visited some of the children on the wards and in clinics, spreading the word a little further. There were a number of aerobic sessions throughout the day as well as competitions and word-searches. How many words can you make out of PHYSIOTHERAPY?

"Joggy Bear during Aerobic Session having a 'Bear Hug'"

The day was well attended by children and teachers from special and mainstream schools, our colleagues from the adult services, Doctors, Nurses, O.T.'s, Dentists and even members of the Trust Board, as well as the all important general public. We had media coverage on the local radio stations, in the local press and on National Television. After a rather hectic and tiring day, we have hopefully made more of the general public aware of the range of services available to children in Hospital, Child Development Centres, and in mainstream or special school.

We have had very positive comments from all those people who attended so feel that the day was very worthwhile. Roll on the next day but maybe give us a little more time to recover from this one.

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Miss Bennett reports from Trengweath School, Plymouth.

The event that took place was a 'cycle ride'. Children of all ages and varying degrees of handicap, both from the school itself, as well as children from the community that attended for physiotherapy had the opportunity to participate. The cycle ride took place in a local park throughout the day, starting at 10.30 in the morning. Mr. Ian Stirling, a TV presenter was there to start the first children off on their way, together with staff, parents and friends.

It was a glorious day; the sun was shining and everyone thoroughly enjoyed themselves, especially the children. A cake sale and trampolining challenge were other activities taking place during the day which were a great success too.

It was a lovely opportunity to organise such an event as this is where children, parents, family and friends could get together for that special day and have some fun as well as an opportunity to help raise funds for equipment needed for children here at Trengweath.

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Judy Brock reports from Birmingham.

19th May, 1992, was the first National Paediatric Physiotherapy Day. Paediatric Physiotherapists throughout the country highlighted the day by exhibitions, in shopping centres, health centres, etc., of the variety of places in which they work with children.

In North Birmingham, I arranged to take some of our children and their parents to be interviewed by Gordon Astley on his mid-morning programme for Radio West Midlands. On this particular day they were doing an outside broadcast from the newly opened Wing Yip supermarket.

The whole event turned out to be great fun for us all. Whilst still being able to talk about a variety of issues such as the importance of working as a team with the parents and child and the value of Rear Posture Walkers, the message of our role in helping to turn disability into ability came over well.

Several of the children had written stories about their physiotherapists and one of the children was asked to read hers, which was fortunately complimentary. Another little girl was delighted that she could say on radio that I was bossy and a bully, much to the delight of the interviewer! She also brought a tear to many an eye by demonstrating that she was now able to walk 37 steps independently.

We were fortunate to be given about fifteen minutes of air time, certainly more than I had anticipated. The final highlight of the broadcast, after playing my request for "Boots" with Nancy & Frank Sinatra, was when Mr. Wing, who had already been most generous with his drinks and Chinese tastes, presented all the children with packs of chopsticks - how about that for practicing motor skills.

My thanks go to Gordon Astley and Radio West Midlands for giving me so much time to highlight our day but mainly to my children who once again proved how wonderful they are.

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Community Physiotherapists report from Rotherham

In order to promote the day, the Rotherham team of community paediatric physiotherapists held a practical exhibition in the Rotherham arts centre.

The individual sections, ie Paediatric Assessment Unit, Newman School for the physically handicapped, special schools for learning difficulties and mainstream schools were represented, with practical demonstrations of Bobath, management of muscular dystrophy and sensory integration therapy. There was a photographic stand, together with displays of the different aspects of paediatric physiotherapy and orthotics. Also present were trade stands displaying therapeutic toys, sensory integration equipment, wheelchairs and standing frames.

Many thanks to those parents who brought their children so that we could demonstrate 'live', and to the children too, who, in the main, took to the limelight, and behaved perfectly. Thanks too, to the companies who brought their products and especial thanks to the arts Officers who arranged the free use of the room, thus giving us a unique opportunity to 'go public'.

There was a steady stream of visitors, with a large influx at lunchtime, keeping us very busy explaining all the different techniques applied to the differing conditions. We had aimed to invite professionals associated with our work, and were pleased to see consultants, clinical medical officers, educational psychologists, occupational therapists and teachers. We also had pupils from local comprehensive schools who were interested in physiotherapy as a career, and student nurses, (oh, and the boss turned up as well). Radio Sheffield were interested in the story, but were unable to come on the day, but they did come to Newman School on the Thursday before and interviewed Judy Dalton, who talked to them about the physiotherapy service, all its different parts, introducing some children, visitors from mainstream schools and one or two from Newman. The interview lasted about half an hour, and we experienced technical difficulties, as the signal faded once inside the building. We had to come back outside into the blazing sunshine and show how adaptable physiotherapy can be, working in the most strange circumstances - you know about school staffrooms, medical rooms, staff toilets etc. The presenter, Rony Robinson, told us he had expected a rather sombre interview, and was pleasantly surprised at the good nature of the children he met and of the enthusiasm with which we worked.

In conclusion, National Paediatric Physiotherapy Day was celebrated in Rotherham in a lively colourful fashion, with the help of balloons and leaflets, the parents, children and the physiotherapists who worked hard to produce this interesting and informative exhibition.

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Lord Mayor and Lady Mayoress with staff.

Viv Williams reports from South Wales.

The Paediatric physiotherapists in South Glamorgan organised a series of events to publicise their National Day on Tuesday 19th May 1992. The T-Shirts sold by the C.S.P. were worn with pride.

The Physiotherapists working at Preswylfa Nursery Assessment Unit had a sponsored bicycle race with a cake stall and publicity stand to raise money for specially adapted bicycle. It was a wonderful sight to see all the toddlers cycling around the school yard. The weather was sweltering hot and much orange squash was the order of the day.

Pentwyn Special School had a publicity stand in the local health centre. Another special school joined with the physiotherapists on the childrens wards at University Hospital of Wales and provided an interesting display showing their contrasting specialties. Money collected was for a prone board for a Romanian boy to take home with him.

A mainstream infants school with a special class was visited by a group of physiotherapists who took along aids, wheelchairs and crutches for the children to try out. The most popular being the obstacle races in the wheelchairs. It was so successful that a return visit has been requested for the older children.

The staff at the Childrens centre set up a display of our favourite ranges of childrens shoes. There was great excitement when physiotherapists visited shops and gave informal advice and consultations. The second venue was at Childrens World who were very happy to allow us to use the entrance to their store. Boots of Nottingham, their head office, sent out a national press release . A publicity stand showing the work in the community with pre-school children attracted great interest or was it the yellow balloons with the Community logo on that we were giving away. (Sadly the C.S.P. had run out of the special balloons.)

Great excitement built up as the V.I.P.'s from the community unit arrived to greet the Lord Mayor and Lady Mayoress - an enjoyable time was had by all as babies were patted, balloons popped and photographs taken. The day attracted publicity from local radio as well as local and national press.

Thank you to everyone who helped or just came along to make the day successful.

ABSTRACTS

Title:	THE DEVELOPMENT OF CRAWLING BETWEEN 18 MONTHS AND FOUR YEARS
Author:	B.C.L. Touwen M. S. Hempe. L. C. Westra University of Groningen, Netherlands
Source:	Developmental Medicine & Child Neurology, May 1992, Vol. 34/No. 5 pp. 410-416

The development of crawling in infants has been described by many authors, but rarely has attention been paid to changes that occur in crawling patterns in children who are able to walk independently.

In this study, video recordings were made of six groups of fifty children aged $1^1/_2$, 2, $2^1/_2$, 3, $3^1/_2$ and 4 years old. These children would have been walking independently for at least three months - the videos lasted at least fifteen seconds.

The aspects of crawling were divided into categories:

- quantitative, including shoulder abduction, trunk rotation, head motility and initiation of movement;
- qualitative, consisting of variability of movement, speed and stride length, adaptiveness of trunk movement, fluency of movement, ability to turn and change direction smoothly.

Inspection of the data showed the major changes occurred in all variables between the ages of 2 and 3 years. During this period, the inefficient stiff primary crawling of the young toddler developed into the smooth elegant sequence of the pre-school child, with the accompanying ability to select proper strategies and programmes.

Basic sensorimotor abilities such as rotation and lateroflexion were present from early months, but if not used selectively in later years, could indicate abnormal development, possibly being the first signs of clumsiness.

The presented research forms part of a comprehensive neurological examination, aiming to detect minor symptoms. It is suggested that the results of this study could be of value in detecting problems in some future language and cognitive problems.

Gillian Riley.

Title: INDEPENDENCE FOR THE PHYSICALLY DISABLED
Author: Neil Gordon, Wilmslow, England
Source: Child Care, Health and Development, Vol. 18, No. 2 Mar/Apr 92, pp 97-104

When and how to develop independence in any child is always a difficult task for families and one which is considerably greater for parents of children with physical impairment. Too much protection restricts opportunities for further experimentation and learning, too little can lead to frequent failure and diminishing confidence.

Behaviour depends to a great extent on personality. Most children crave independence, but in cases where physical impairment is present, much depends on the degree of disability. With encouragement, it is amazing what these children can achieve. Depression and anxiety is often not recognised in them and therefore overlooked, but are factors which must be taken into account. The main source of teachers, carers and friends are also of major importance.

The day to day strains on parents, which can be so heavy in the early stages, can lead to later problems in taking into account the necessary changes in growth and development of the older child.

The stress placed on self reliance in Conductive Education is commendable but applicable only to a small group of selected children. In any method of treatment, there is always a need to concentrate on fostering the child's strengths as well as helping the difficulties. Acquiring daily living skills could be as important as gaining academic qualifications to those children. In a recent review of the health and social needs of physically impaired children and young adults, it was found that insufficient advice was given on education, training and employment. Also that in many mainstream schools, there were insufficient facilities to cater for special needs.

Those children who have had positive attitudes instilled in them by parents and others demonstrated increased self esteem and the confidence to seize opportunities as they appear. New programmes will need to be developed and these children given the opportunity to discuss their problems and their need for emotional support, requiring less pressure from an educational point of view.

Gillian Riley.

COURSES

Counselling Workshop

Venue: Children's Centre, Damers Road, Dorchester, Dorset.
Date: Friday 6th November 1992
Tutor: Sheila Murray
Fee: £12 APCP Members
£15 Non Members
To include Tea and Coffee
Closing Date: 30th September

This workshop is aimed directly at the needs of Paediatric Physiotherapists. For further information and application form please apply to:- Margaret Homes, Supt. Physiotherapist, Children's Physiotherapy, Children's Centre, Damers Rd., Dorchester, Dorset. ST1 2LB

CHILDREN AND SPORT - One Day Symposium

Date: Thurs 22nd October 1992 9.30 - 5.00
Venue: East Midlands Conference Centre, University of Nottingham.
Fee: £35 including lunch and refreshments.

Programme content:

The exercise physiology of children - Prof. Craig Sharp
Growing pains and the athletic child - Prof. A. Wallace
Sport and the child with a disability - Mr. D. Williamson
Activity patterns - children and exercise - Mr. N. Armstrong
The growing child in competitive sport - Dr. S. Rowley
Nutrition and the young athlete - Jane Griffin
Sport and the child with diabetes - Prof. R. Tattersall

Further details and cheques should be made payable to University of Nottingham and sent to: Mrs. Diane Roberts, Course Co-ordinator, Department of Orthopaedics and Accident Surgery, Queen's Medical Centre, Nottingham, NG7 2UH. Tel: 0602 709407. Fax: 0602 423656

Introduction to TELER - Presentation of work on multidisciplinary and single professional outcome measures followed by speciality discussion groups.

Date: Fri 9th October
Fee: £50 per person, £33 when more than 1 from a dept.

Information from Joyce Gemmell on 0623 22515 Extn. 4651

Castle Priory College
Wallingford, Oxfordshire, OX10 0HE
Tel: (0491) 37551/26350

The Basic Motor pattern and Cerebral Palsy
Date: 11 - 13 September 1992
Tutor: Ester Cotton
Fee: £162.80 Course No. 28/139

The Children Act and Special Education Needs - an Up-Date
Date: 1st October 1992
Tutor: SENIC
Fee: £39.60 Course No. 28/164

An Introduction to Conductive Education
Date: 23-25 October 1992
Tutor: Olive Surtees & Maureen Lilley
Fee: £162.80 Course No. 28/190

HERE AND THERE

What is a Primary Ciliary Dyskinesia?

"In this syndrome, patients have upper and lower respiratory problems, need daily chest physiotherapy and may have hearing problems."

In the summer of 1990 the PCD Family Support Group was formed with the encouragement of Professor John Warner who was then at the Royal Brompton and National Heart Hospital, London, Professor Bob Williamson, Geneticist at St. Mary's Hospital Medical School and Professor Peter Cole at the National Heart and Lung Institute London.

PCD, previously known as Immobile Cilia Syndrome, was first described in association with Kartagener's syndrome. For further information about this syndrome, contact the co-ordinator of the PCD Family Support Group, enclosing a s.a.e. to Mrs. Carol D. Polak, MCSP, 67 Evendons Lane, Wokingham, Berks. RG11 4AD.

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Would anyone like a 6 month rotation to Australia with a physiotherapist from there? For further details, contact the Editor.

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There is a paediatric physiotherapist returning to England from Canada in September and is looking for work on her return. Anyone interested, contact the Editor.

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Howie Cycles are undergoing considerable developments and have a video available, on loan or for sale. For further details contact Andrew Howie, Howie Cycles, 113 Main Street, Auchinleck, Scotland. KA18 2AF

THE HOWIE THERAPY TRICYCLE Model "DOVE"

Aquashield is a re-usable orthopaedic caste protector and cover. Reasonably priced, it enables the wearer to bath or shower with their cast or wound dressing in a water tight cover.

They are obtainable in different sizes - full leg, half leg etc. from:

Springbank Medical Ltd.,
Springbank House,
14 Turners Drive
Thatcham,
Berks RG13 4QB Tel: 0635 71043

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National Conference 1993 will take place at Bath.

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Conference 1994 is booked at Chester College.

REGIONAL REPORTS

South West **Carol Hurran, 23 Bayswater Avenue, Westbury Park, Bristol BS7 7NU**

Bristol held a workshop on 'Tone' in May and will be meeting again on the 9th July for an Introduction to the Bobath Concept by Jane Pyman.

Dorchester will be running a Counselling Workshop on Friday 6th November, specially for Paediatric Physiotherapists. Further details from Margaret Homes, Supt. Physiotherapist, Childrens Centre, Damers Road, Dorchester.

National Paediatric Physiotherapy Day went well in Bristol with displays and a Hot Air Balloon Picnic for the children of Claremont School which received some worthwhile press coverage. It also made a very memorable day for staff and children, who were taken up 50 feet in the tethered balloon in perfect weather.

South East **Terri Fearn, 38 Woodland Copse, Peacehaven, E. Sussex BN10 7SF**

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

Our membership now stands at 111 and we were fortunate to be able to appoint new members into the committee.

Our recent meeting had to be cancelled due to lack of support and so the committee decided to hold a further workshop as the previous one had been successful. The subject will be "Techniques and Technology" and there will be 4 areas of interest: a) Cystic Fibrosis, b) Neonates, c) Asthma and d) current respiratory technology.

Venue: Great Ormond Street, Date: 12th September.

For more details and application forms please contact Kate Lough, MCSP, 42 Gloucester Road, Acton, London W3 8PD.

Any suggestions for further meetings will be very welcome.

East Anglia **Jackie Reynolds, Church Farm House, Ormsby St. Michael, NR2 3LN**

The Committee has been stunned into silence following all the activity of the last two years, planning, preparing and organising the 1992 Conference in Norwich. The success of the event was undoubtedly due to the committment of Mary Goy, Angela Glyn Davies and Lyn Weekes, who took on the strategic organisation, but they were backed by a strong committee who all worked incredibly hard. We have all needed some "time out" but it is now time to get things moving.

A workshop on Vibracoustics is planned for September 12th to be led by Lyn Weekes. This will be held in Great Yarmouth and we hope it will be a successful day.

Many events took place through the region on National Paediatric Physiotherapy Day with Exhibitions, open days and other news-catching events. Many areas targetted the Primary Health Care Teams, teachers and other professionals.

Trent. **Jenny Gill, 42 Britannia Ave., Arnold Road, Nottingham.**

Membership in the region currently stands at 65: the local committee are trying to chase up recently lapsed members. Please try to recruit new members in your area!

News of two courses in the area:-

A Study Day/Workshop in Sheffield on 24th Oct: "The Evaluation and measurement of windswept deformity" Speakers are Liz Goldsmith MCSP and Julie Clarke MCSP and the cost is £20 to members, £25 Non-Members. Places limited to 16. For details contact Miss Julie Rooke, Ryegate Children's Centre, Sheffield. Tel: 0742 670237.

For details of other course on 9th October, see under "Courses". Details from Joyce Gemmel, Ransom Hospital, Mansfield, Tel: 0623 22515 Etxn. 4651.

West Midlands **Carol Foster, Physiotherapy Department, The Childrens Hospital, Ladywood Middleway, Ladywood, Birmingham, B16 9ET.**

The branch has now concluded the very successful Orthopaedic Course with the final evening given by Mr. Sterling FRCS on 'Hips' on June 3rd. Each of the four evenings was well attended, thanks are extended to all who assisted in running the course and especially to Victoria School who allowed us their studio.

June 25th saw a day course at Dudley Road, Post Graduate Centre on the "Multi-disciplinary Management of the Older Profoundly Handicapped Child". This too was well attended by a multi-disciplinary audience. Thanks to Sally Braithwaite who organised it.

The series of evening lectures proved successful and we shall be running an update on "Neuro Anatomy and Neuro Physiology" at Morris House School of Physiotherapy, Queen Elizabeth Medical Centre on:

Wed. 16th September
Wed. 21st October
Wed. 18th November 1992
6.30 p.m. coffee for 7.00 lecture.

In 1993 we are planning two evening lectures on:
i) Neuro Muscular Condition and ii) Genetics.

Further details will appear in the November newsletter.

Please read elsewhere news of the National Paediatric Physiotherapy Day.

Wales: **Barbara Bowen, Children's Assessment Unit, East Glamorgan Hospital, Church Village, Nr. Pontypridd, Mid. Glamorgan.**

We held a 2 day Symposium on counselling skills in May. This was very well received with request for follow up study days.

In June we held a "Sharing Day", members were invited to share their knowledge of unusual conditions with informal presentations, at Creigiany-Parc, Spastic Society School. This again was so successful that we are planning a similar day in the future.

On July 18th we have a study day on an Introduction to Sensory Integration. All study days have, in the main been attended by the same faithful few. We have kept fees to a minimum, FELLY BLE RYDYCH CHIT?!

I appeal again for request for topics and likely venues. The Welsh Group can only be as strong as the commitment of the membership.

North West: **Alex Winney, 14 Langley Road, Bebington, Wirral, Merseyside. L63 9HW**

The ORLAU Study Day held at Oswestry in May on 'The Assessment and Orthotic Treatment of Walking Handicap in Children' proved to be extremely popular and very successful. If people are interested in having another day organised please could they contact anyone on the committee. Our thanks to the ORLAU team for a really stimulating day and a wonderful lunch!

Application forms for the study day in October on Visual Handicap will be with this Newsletter or will be mailed separately.

The 1994 National Conference Committee have now had two meetings and the Venue has been booked and a provisional programme out-lined. We may require further help nearer the time. Hope you all have a wonderful summer.

North East: **Carrie Jackson, 4 Abbots Way, Moncaster Gate, York, YO3 9LB**

A study day on "Management of the Talipes Foot" was held in Leeds on July 3rd. Our speakers were Orthopaedic Surgeon, Mr. Chris Tulloch and Sen. Physiotherapist, Liz Hardy; it was a good day for acquiring New Skills, and discovering old ones. The "Sensory Integration" day is planned for Sat. Sept. 12th in York. Early application is advisable as places will be limited.

Scotland: **Lyn Campbell, 19 Craidmount Ave. Nirth, Edinburgh EH12 8DH**

N. Ireland: **Mrs. E. Harty, Physiotherapy Department, South Tyrone Hospital, Dungannon, N. Ireland.**