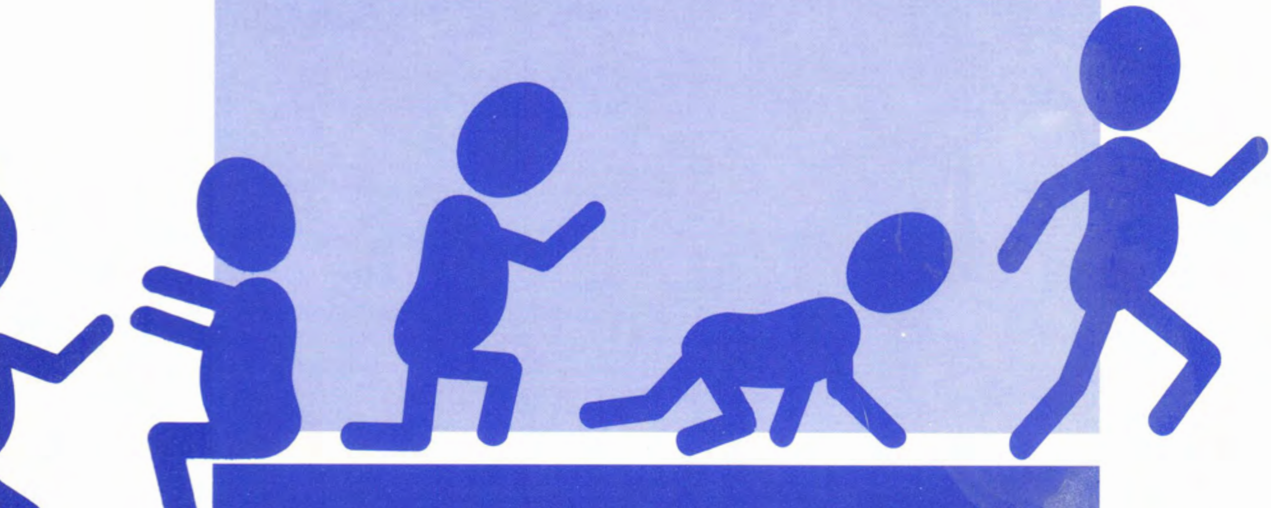
ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

JOURNAL



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OVERSEAS EDITION

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LIN WAKLEY
Editor

It was with some trepidation but a sense of challenge that I agreed to become the new editor of the Journal. Jeanne Lacey has worked so hard over the past two years to launch the 'new look' Journal my main hope is that I am able to continue to maintain her high standard. I would like to take this opportunity to thank Jeanne for all the time and effort she has given up on our behalf.

This is the Overseas Edition and we were pleased to receive five very interesting articles from paediatric physiotherapists who work or recently have been working abroad. Several of the articles illustrate how much British paediatric physiotherapists have to offer in the way of treatment and training to the emerging third world countries.

I have also included a report from a north west region study day. I hope this is one of the first of many such reports. I have always seen the Journal as a forum for the exchange of ideas and experiences and I am sure there is plenty happening in the regions which would be of interest to everybody. It does not have to be a long article or report, a short chatty news item can be just as interesting.

I would like to finish by wishing you all A HAPPY NEW YEAR!

COPY FOR THE MAY 1995 JOURNAL
MUST BE WITH THE EDITOR BY
APRIL 1st 1995

The Board reserves the right to edit material submitted

LETTER TO THE EDITOR

24.11.94
The Editor A.P.C.P. Journal,
Mrs. Jeanne Lacey,
43, Withdean Road,
Brighton,
East Sussex.

Joanne Simpson M.C.S.P.
Senior Physiotherapist,
Child Development Unit,
Halifax General Hospital,
HX3 0PW.

Dear Editor,

With the implementation of the manual handling regulations, I am trying to gather information on handling within the paediatric setting, especially special schools and child development units.

Recognised handling techniques are difficult to carry out within these areas and it is often necessary to move children into equipment (e.g. standing frames) by lifting them. Staff working with children are expected to carry out many repetitive high risk manouvers within each working day.

I would be grateful to hear from anyone who is in the process of devising a protocol covering these problems and to share ideas on the format of risk assessments.

Thank you very much for your help.

Yours sincerely.

Joanne Simpson M.C.S.P.

Lyn Hemmings, MCSP

Senior Physiotherapist
Southmead Health Services
N.H.S. Trust
Claremont School, Bristol.

TRAVELS TO SIBERIA WITH STEEPER ORTHOPAEDIC LTD.

In September 1994 I was offered the chance to travel to Siberia for two weeks with an orthotist from Steeper Orthopaedic Ltd. to assess and treat children being seen at two separate clinics. Having accepted the challenge and arranged my working and family life accordingly, I flew three thousand miles to north west Siberia.

The first week was spent at a general hospital in Strezhevoy where I assessed and treated 42 children and 1 adult. It was Steepers third visit to this clinic so some of the children were being fitted with gaiters, A.F.O.'s callipers, heel cups, insoles or Piedro boots as previously ordered. Some were also receiving walking aids. Others were there to be cast or measured for orthoses or equipment.

Each child I saw had a full physiotherapy assessment and then I gave advice to the parents on stretching, positioning, carrying and use of orthotics and equipment. All communication was through an excellent interpreter who is also Director of the Russian area of Steepers. However, having to wait for interpretation of every sentence did ensure that I used my eyes and hands to their fullest extent to confirm or repudiate a diagnosis which was often very vague, i.e. birth injury. Also advice to parents was concise and always demonstrated for them to try understand my instruction.

People came to watch

While we worked many people came in to watch. Doctors and manual therapists were frequent visitors although we were often too busy to look up and see who was there. The facilities we had in the clinic room were the bare minimum - 2 chairs, a table, a low couch and water brought in bowls, occasionally warm, frequently cold. Examining and casting in these surroundings was often difficult and frequently back-breaking. Each working day varied in length and activity. On the first day we arrived at 1.00 pm after travelling all night and we then worked until 8.00 pm. Towards the end of the week we worked only two or three hours and spent the rest of the time waiting around for patients to arrive. As there is no appointment system patients turn up when they want and will wait as long as it takes to be seen.

At Strezhevoy as in most towns our visit and the supply of all the orthotics and equipment was paid for by the mining company for whom the people of the town worked. The hospital was also in the process of buying some medical rehabilitation equipment through Steepers. I was required to give a lecture to doctors and therapists on physiotherapy for cerebral palsy. This lecture took 3 hours and was fairly basic, concentrating mainly on stretching, positioning, manual handling and use of orthoses and equipment. As the treatment of choice for C.P. in Siberia seemed to be drugs, massage and electrotherapy I am sure my work appeared to them to be very different. I hope however that with constant repetition and example they understood my methods of treatment.

Russian Hospitality

Such was the importance of our visit that we were featured on local television and in the local newspaper. Every night our hosts, doctors at the hospital, invited us out to someone's house for dinner. Vodka flowed and we got used to eating Russian bread, pickled vegetables, soup and dumplings. According to Russian customs you cannot refuse to eat or drink anything or else you risk offending your hosts, so we were polite and frequently full! During the evenings business was often discussed and one night contracts were being arranged at 4.00 am. - very different to England. As recreation we were taken drift net fishing for sturgeon by a patient (an amputee) and the chief doctor. They also took us hunting for water rats in an ex-army tank! We survived two sessions at a bagna (sauna) but did not survive eating the local delicacy of raw (still wriggling) fish!

The Steeper's Team - September 1994 at the ferry on the River Ob.
Lyn is second on the right.

During the second week we moved on to the Children's Charity Hospital at Nizhnevartovsk. This hospital has only been open 3 years and is at present only offering daycare but it is run by a Director who is forward thinking enough to have a 12 year plan of renovation and expansion. He already has 3 main areas of work - oncology, cerebral palsy and alcohol and drugs abuse. He had asked Steepers to visit to assess some children so that he could find out the cost of providing equipment and orthotics for them. I spent two days assessing 28 children, most of whom had cerebral palsy, and offering advice on treatment to parents and medical staff.

Close to dispair

It was at this hospital that I came closest to despair. I was shown a 6 month old baby with bilateral club feet. When asked how I would treat him I said that I would strap his feet. The only problem was they had no strapping materials, no Elastoplast, not even any sellotape. Their method of treatment was Faradism to the dorsiflexors and evertors. I could do nothing! I did not dare use plaster of paris because of lack of aftercare and if we had cast for splints the child would have outgrown them before we returned again in 4 months time. However next time Steepers visit they will be taking with them some orthopaedic felt, strapping tape and elastic bands to help those children born in future with club feet. I also saw a child with Osteogenesis imperfecta and a teenager with Spina bifida and severe contractures, both of whom we could not really help. We offered to order wheelchairs for them, but because of the local environment (there are no proper pavements, everyone lives in flats usually without lifts and there is no such thing as disabled access) people do not want to use wheelchairs. At these times I felt really inadequate but on the whole we were able to offer advice and orthotics and equipment that would enhance the lives of the children.

The challenge

The whole trip was a challenge both to my professional skills and to my physical and mental stamina. Assessing and treating 70 children in 8 days, teaching, travelling for 5 days and averaging 20 hours awake every day for a fortnight certainly taxes you to the limit. However at the end of the trip I felt that I had made a worthwhile contribution to the lives of many children and helped to further the knowledge of therapists in Siberia. I also felt that I had developed further as a physiotherapist and for this I must pay tribute to the very professional and supportive team from Steepers, especially Dave Munn (orthotist) who was always at hand to offer advice and assistance. I look forward to returning to Siberia in the near future. We have so much to offer to a country that has so little.

Terry Pountney,
MCSP

A SHORT STAY IN THE BLACK FOREST

September 11th 1994 found me kissing my husband and children goodbye and boarding a flight to Zurich. I was off to Waldshut Tiengen in Germany to fulfil my European placement for the MA Health Education (Europe) which I am studying for at the University of Brighton. The course requires that we visit and observe our field of work in a European setting. We had to use the information as part of our research and include this in our dissertation.

Thoughts of research and dissertations were furthest from my mind on the flight, more pressing was my lack of German and the thought of leaving my family for three weeks. My hosts were to be the Muller-Lupps. Monika is a paediatric physiotherapist who I had met once in England. She kindly offered to let me stay with them and arrange a programme for me. We had numerous friendly phone calls prior to the visit including requests for peanut butter and English marmalade!!

I landed at Zurich to find two friendly faces ready to drive me to their home. I was made very welcome with English tea and a delightful room. The next morning was a gentle introduction to Waldshut-Tiengen, a picturesque town on the southern edge of the Black Forest. We sampled the first of many "kaffee und kuken" breaks - this was not a placement on which to worry about the waistline! My head was spinning by the end of the day with schedules to organise and people to meet. At 4pm I was whisked off to what was to become a regular Monday afternoon pursuit - French conversation! At least I felt equal terms in language terms!

The programme organised for me was very exciting with visits to a multidisciplinary centre, (where Monika worked), private paediatric physiotherapists, a school for physically handicapped children, a children's doctor and Zurich children's hospital.

The system for prescribing physiotherapy for children is very different in Germany. In each small town there is a specialist children's doctor working alongside all types of specialist doctors and general practitioners. A person can choose which doctor to visit and a swipe card is used to identify them and their basic details. They can attend as many doctors as they wish, and as often, without any referral. This system has been in existence for a year and the doctors are not happy with it - there is no past medical history available and it is proving expensive. The children's doctor will examine the child and prescribe a number of physiotherapy sessions, usually Bobath or Vojta and suggest an appropriate physiotherapist, either a private practitioner or one based at the centre. Physiotherapy fees are covered on their health (known as social) insurance to which the vast majority of people subscribe, for half hour sessions.

The shortness of the sessions has resulted in prescriptive treatments which are very clinically orientated.

My first few days were spent in Monika's centre with the team consisting of a physiotherapist, occupational therapist, psychologist, speech therapist, social worker and "Heilpadagogin" who was a teacher of social skills. The centre was purpose built with each worker having their own room. They provide a joint assessment service and then refer the child for treatment with the appropriate therapist.

The next two days I spent with a private physiotherapist who practised Vojta therapy. This was fascinating. He treated a wide range of conditions spina bifida, hemiplegia, arthrogryposis, sensorimotor problem, all using the method of triggering reflex pattern of movement. The children found the treatment very distressing but Atsi assured me it did not hurt and was beneficial. I came home determined to investigate the method further in the English literature.

The following week I spent at a school for children with physical handicaps. Again the facilities were superb right down to the swimming pool with adjustable depth base. I worked with the physiotherapist, occupational therapist and teachers. My initial impression was how able a lot of the children were. I soon discovered that special needs teaching in mainstream school was very limited and that children with dyspraxia and other minor abnormalities also attended here. Parental involvement in the school was limited. This could be due to the community service programme for young men of which they had a number in the school. However, I felt and some teachers agreed that there was a lack of support for the parents and little carry over of work achieved in school into home life. I never met a physiotherapist in Germany who had been on a home visit!

One afternoon was spent with the children's doctor. They provided an open access service for children with any condition. They did all the standard GP work - immunisations, cough and colds, skin problems etc. alongside children with chronic illnesses and disabilities. This service I found excellent, children were seen by doctors who were knowledgeable about children and only extremely complicated cases needed referral to hospital. The system of developmental checks up to the age of nine showed a good pick up rate for children with minor developmental/ coordination problems., They knew the children well because of these visits and were therefore able to detect abnormalities.

My final visit was to Zurich Childrens Hospital. I spent the morning in the outpatient's clinic where children were treated in individual rooms by Bobath and Vojta trained therapists. The children with specific motor learning difficulties were seen by a specially trained teacher who had had four years training in this speciality. The afternoon was spent in the neonatal and ITU units. The physiotherapists had a high treatment and educational profile. Currently they were aiming to normalise the environment for the children by altering their sensory input of smell, sound and touch.

The professional aspects of my visit were many and interesting. In some ways I felt reassured about our practise in England. Generally we provide a much more holistic and gentler attitude to the children and families but our facilities are far inferior to those in Germany. The physiotherapists I met were all highly skilled and were rewarded financially for this training. I know they too felt constrained by the half hour sessions of therapy and lack of opportunity to go beyond clinical input. The system however does not favour these ways but offers choice to families and there are few waiting lists. The private practitioner method does not encourage multidisciplinary working and I felt sometimes there was conflict in the parents mind as to whose advice to follow. I am looking forward to analyzing my research in this area.

The social aspects of my visit surpassed anything I'd imagined. Herbert and Monika were music lovers and walkers - my two favourite pastimes. We saw the Magic Flute at the magnificent Zurich opera house, we walked in the Black Forest and Switzerland and we had many hours of discussion about our different lifestyles and work. The hospitality that was shown to me was wonderful everywhere I went and the communication in broken German and English was not a barrier.

The trip was an experience not to be missed. I am thankful to everyone who made it possible, particularly Monika and Herbert and my long suffering husband who had to cope with an outbreak of mumps while I was away! The visit has broadened my clinical practise and made me realise what is good and bad about our practise at home and fresh ways to try to improve things. I feel much closer to our European neighbours and hope that many of my new colleagues will visit England. Finally, I thoroughly recommend an exchange to anyone who feels a little stale, it certainly boosts the morale.

Margaret Cameron M.C.S.P.

Margaret Cameron is currently Trent Regional Rep.. She currently works as Senior I at the Children's Centre, City Hospital, Nottingham.

AN INDIAN EXPERIENCE

In May 1990 I travelled to India to commence six months voluntary work in the southern city of Bangalore. This was a venture into the unknown in many aspects; I had never even visited a developing country let alone lived or worked in one. I was also leaving a junior post in the UK to go as sole physiotherapist at the Association of the Physically Handicapped (APH). My new role would involve provision of a physiotherapy service for over 100 physically disabled children attending the Shradanjali school, and others in the local community, in addition to training four local girls to be physiotherapy assistants.

My initial impressions of India revolved around the sheer number of people everywhere, the noise level and the colourful diversity of the clothing. Bangalore itself is one of the most westernised cities in India; with its high altitude it is blessed with a less humid climate than its neighbour Madras and was very popular with the British colonial powers. Modern Bangalore displays reminders of its colonial past alongside modern industrial and administrative buildings. However like all large cities it has several large slum areas where living conditions are basic and many of the population are still illiterate.

The Association of the Physically Handicapped had been founded by a dynamic Indian lady, herself disabled by polio many years earlier. From small origins it had grown to encompass various light workshops, offering employment and training for adults with disability, a school and an orthotics workshop and outreach teams to work in local slums headed by APH social workers. Having unsuccessfully tried to recruit a local physiotherapist APH sought the assistance of the Cambridge based charity Action Health 2000.

I was the fourth British therapist to go on a voluntary basis to the centre for a six month period. My predecessors had worked hard to establish a physiotherapy department. A small thatched hut served admirably as an office and provided shelter from the searing midday heat or the sudden heavy monsoon showers. An outdoor, semi-covered area had been allocated as our treatment area. The sheltered portion was concrete and this was covered with bamboo mats for floor work. A set of parallel bars and some steps for gait training had been erected and a small concrete hydrotherapy pool formed the centrepiece of our area.

The Shradhanjali Integrated School offered a basic education in English to approx. 120 children with physical disabilities, some siblings and children of staff employed at the centre. Of the children with disabilities 80% were affected by polio, still very prevalent within slum areas due to poor sanitation and lack of immunisation facilities. The polio virus most commonly affects children between 8 months and 5 years, producing mild flu-like symptoms which last up to three days. The majority of children recover but one third of children are more severely affected and the anterior horn cells are damaged resulting in weakness or paralysis of muscles. The extent of the paralysis varies greatly in both severity and distribution, with muscles in the lower limbs being most often affected. Once the acute phase is over the spread of the paralysis halts and some improvement may occur during the first 18 months but after this any residual weakness is likely to be permanent. Most children attending the school were mobile with callipers and/or crutches. Some with more severe degrees of involvement used wheelchairs in school and were carried at other times by their parents. The majority of children seen could be managed by conservative physiotherapy measures; stretches, exercises, appropriate orthotics and gait re-education. Some presented with fixed contractures or bony deformity and were referred to a local orthopaedic surgeon before returning to the centre for rehabilitation.

Other children within the school had spina bifida, congentil limb deformities, muscular dystrophy and cerebral palsy of mild/moderate severity. The school catered only for those with normal intellectual ability, however it maintained close links throughout the city with other institutions who offered alternative facilities. The Spastic Society of India ran a school for children with cerebral palsy and was well staffed by physiotherapists and O.T.s. They use Vojta techniques of treatment learned in the Vojta Institute in Hydrabad in the neighbouring state of Andhra Pradesh. Other centres offered specialised facilities for those with visual impairment or learning difficulties. As in many developing countries there were several modern hospitals in Bangalore with top class facilities whilst in slum areas people lack basic health needs such as clean water, sanitation and a good diet.

The prevalence of disability in developing countries has been estimated as 2% of the population (Werner, 1988). The causes are multifactorial including living conditions, poor health care and illiteracy. Cultural traditions in the south of India meant that consanguineous marriages were common; in the Hindu community between uncle and niece, and amongst Muslims between first cousins. Girls were often married just after puberty and were expected to bear many children with little or no obstetric care. I also saw the results of poor or absent medical care highlighted by two examples; a 3 year old girl with spina bifida with gluteal pressure sores so deep you could see her ischial bones and a 10 year old boy with burnt out JCA whose legs were almost fused in a cross legged position. In many areas the notion still persisted that a disabled child was a punishment from the gods and was passively accepted. Some expected to receive a western "miracle cure", but it was rewarding to see how hard many parents worked with their child when they realised that they could do something positive to help.

Two of the trainees outside the Physio hut

Work at the centre was certainly varied and interesting. In addition to the clinical aspect a part of each day was devoted to education of other APH staff.Primarily this involved training the team of 4 local girls to be physiotherapy aides.Subjects included basic anatomy and physiology, knowledge of the common conditions they were encountering and their basic management. The aim was to enable the trainees to carry out a basic assessment and to know which appliances and exercises were appropriate. Initially I felt quite daunted by this task but encouraged by their eagerness to learn I soon grew to enjoy these sessions. During my time I draughted a proposed 2 year training plan for future trainees in six month modules. I acknowledge that auxiliary staff do not replace the need for a qualified physiotherapist, however the sheer numbers necessitated more than one pair of hands to cope. The local girls also acted as excellent interpreters (between 4 of them they spoke 6 languages in addition to English) and understood the local custom and practice.

Amongst the APH staff I had regular liaison with the social workers who were based at the centre but ran outreach schemes in 5 of the largest slums. They visited families with disabled children, offering assistance with education, employment and rehabilitation. In addition they ran courses in each area on basic health care and recruited local women as key workers for their own community. The social workers organised clinics each month in their area which I would visit to assess or review children there who did not come to the APH centre. These clinics were quite an experience, with large numbers of local residents turning out to see this westerner at work. Families would regularly invite me into their home for a cup of sweet, milky tea and a snack. Many of the homes consisted of a single room which housed up to 10 people. Frequently there was little furniture but invariably a chair was procured from a neighbour for me to sit on. Many children had not encountered a westerner before and I certainly provided considerable novelty value!

Living and working in India brought its share of frustrations. The pace of life is considerably slower and 'tomorrow' does not necessarily mean the following day! Where I worked it usually meant next week, next month or sometime in the future! This attitude was epitomised by the orthotic workshop, which, in spite of a large staff, rarely completed anything on time. Indian bureaucracy is notorious and a simple task, for example, booking a train ticket is surrounded by such considerable red tape that it can take a whole day. As with any large organisation APH had its share of internal politics and interpersonal rivalries which at times made working conditions hard.

On a domestic note I was provided with board and lodgings by APH and lived in a small concrete house with a local family and several chickens. We had no water supply in the house, this was collected daily from the corner pump, and the electricity supply was intermittent. The lady of the house was very caring and took me under her wing, treating me as a member of the family. Although I had my own room I had very little privacy, which I missed. During my time I developed lasting friendships with local people. However I did appreciate the company of an English physiotherapy student who came on a month's elective placement during my stay. My sister came out for a holiday and we did some travelling in north India taking in Delhi and the Taj Mahal before relaxing in Goa. My few weeks travelling brought home to me the insight into Indian life and

Some of the children

culture obtained by living and working within a community rather than merely passing through on a tourist trail.

From a professional perspective I learnt a vast amount during my 6 months both in terms of clinical and managerial skills. The scale of the workload emphasised the need to prioritise, to delegate and supervise the work of others. Although I missed having the support of professional colleagues I gradually grew in confidence to recognise the scope of my own abilities and limitations. An excellent opportunity was provided for me to develop teaching skills and the ability to negotiate firmly with other departments, especially orthotics. Finally I learned to be resourceful, adapting treatment ideas and equipment to suit the cultural and physical environment.

On a personal level working in India was a very enriching experience, it broadened my horizons and put many things I had previously taken for granted into perspective. Although at times I was homesick, ill and longed to soak in a bath, in hindsight I feel it was very worthwhile and am glad to have had the opportunity to work overseas.

REFERENCE

Werner, David (1988). Disabled Village Children. The Hesperian Foundation, California.

Dawn Brodie

MCSP.
Currently working part time in a new private paediatric therapy centre in Dubai

PAEDIATRIC PHYSIOTHERAPY IN OMAN

Physiotherapy where? I hear you ask, and that was exactly our response when we heard that my then fiancee, was going to be transferred from Australia to Oman - our next stop was to browse through the atlas to identify the precise location of the country where we were both due to spend the next four years of our life.

Oman is a beautiful coastal country lying on the Arabian sea and is bordered by Yemen, Saudi Arabia and the United Arab Emirates. It is a strongly Muslim country where English is the second language. The head of the state is H.M. Sultan Qaboos bin Said, who succeeded his father in 1970 and his accession led to a drive to transform the Sultanate into a progressive modern state, using revenue provided from oil exports. Starting from virtually nothing, a university, nursing and physiotherapy schools, as well as other essential services necessary in developing the basic infra-structure of a modern state, have been developed in the last 23 years. For example, the number of hospitals in the country has increased from 2 to over 50 in this relatively short length of time.

Several programmes have been set up to address some of the more major causes of disability. Trachoma used to be a common cause of blindness, particularly within the rural areas of Northern Oman where it was identified as causing blindness in approximately 3% of the population [1]. The Ministry of Health realised the seriousness of the problem and established a prevention of blindness programme, where the population was educated on the causes, prevention and advised on how to treat the symptoms. In addition, school and community screening was introduced. Immunisation programmes have also been set up, so that infants are now inoculated prior to their first birthday to protect them from six major diseases, including polio, tuberculosis and measles. An estimated 85% of the child population is now covered by this inoculation programme[1]. Birth registrations in hospitals and clinics is encouraged so that each child's medical progress can be maintained, and since 1990 each child has been provided with his own health card.

At present the exact numbers of disabled children in Oman are not known, but based on surveys from other countries, it is estimated that 3 - 8% of persons are disabled [2]. Applying this to Oman, this would mean that there are up to 72,000 children under the age of 16 years with some sort of disability, and with 60,000 live births per year, this number is constantly increasing. The knowledge of patterns of disability are scarce, however, physical handicap, intellectual impairment, multiple handicap and blindness are identified as priorities for care. Professionals estimate that over 5% of disabilities in Oman are birth related and many families have more than one disabled child. 10% of babies born in the country are of low birth weight and many of them have associated disabilities [3].

Of the children with some sort of impairment, it has been estimated that about 1,000 are undergoing regular treatment. The first countrywide census is due to be carried out in December 1993, and from this it is hoped that more precise figures can be obtained. The development of neuro paediatric Physiotherapy services is still in the early stages. At present there are less than 25 rehabilitation experts in the country, all located in Muscat[3]. A few children are seen in the Physiotherapy Departments of the local hospitals, and the staff from these departments are involved in visiting families in remote areas, either by car or airplane. Community centres are gradually being set up by various Ministries and volunteer organisations in both the interior and capital area. This is essential, as families in more remote parts would otherwise have to travel for many hours to receive services for their children.

As with most undergraduate Physiotherapy courses, the Omani course includes relatively little neuro paediatrics. Thus paediatric Physiotherapy staff rotations are at present being set up in the Muscat region, between two of the hospitals and The Special Programme for Handicapped Children which is based at the Omani Women's Association. With this experience, the Omani Physiotherapists are gaining a broad knowledge of paediatric care, which is essential prior to their moving out into the remote community locations in the next year, where the majority of Physiotherapists will be working in isolation. In addition, an informal group for Professionals Interested in Paediatrics has been set up, so that knowledge can be more easily dissipated. This week, for example, we discussed amongst other aspects of paediatric care, what equipment could be made in Oman, and the possibility of some of our adult disabled being involved in making even basic items which would otherwise take many months to be brought into the country, after the funds had been finally obtained. The group also provides a support group for professionals, many of whom work in isolation, even in the capital area.

The author's particular involvement is with two community organisations: The Special Programme for Handicapped Children at the Omani Women's Association and The Association for the Handicapped Child. These centres have an intake of children from a large area in and around Muscat. At present these groups have a very mixed paediatric population with any type of physical or intellectual problem and a broad spread in age. The majority have intellectual impairments, but there are a large number with physical and sensory problems, particularly children with the athetoid/spastic type of cerebral palsy, and those who have hearing impairments. Both of these organisations are run primarily by very dedicated volunteers, with a few professionals providing appropriate advice on the specific programmes that the children require.

At present there are moves for the children from these two centres to be divided according to their particular areas of need. This would lead to a more efficient and coordinated approach to the provision of services and as a result, eliminate many of the organisational difficulties that arise from time to time.

The Special Programme for Handicapped Children at the Omani Women's Association was set up about six years ago, initially as a play group and to provide respite care for the families. It is now organised on an educational basis with 45 children, aged from 8 - 22 years, attending the centre four mornings a week. The children are divided up into three main groups, primarily according to their level of intellect. The programme tries to cover the basic level of knowledge that these children need for their every day life, thus following World Health Organisation recommendations. This includes a basic understanding of health, hygiene, safety and nutrition, as well as the development of independent daily living activities that extend from dressing to gardening and from crossing roads to tidying their own classrooms. The children also attend study, music and movement, art and craft sessions, as well as hydrotherapy or swimming sessions, depending on their needs. In addition, those children requiring specific therapy receive them in class, individual and/or group sessions. A group for families with young disabled children is held following the afternoon siesta, one afternoon a week.

The Association for the Handicapped Child was only recently established. Here about 18 children attend on a regular basis, during two afternoons a week. The influx of children requiring services is rapidly expanding as more families hear of the possibilities to provide help for their children. Thus, this Association will soon be running morning sessions as well, but there are still many children waiting for a place to attend one day.


Dawn with Rakaiya who was referred for ankle massage!

Being presented with children who are sometimes nine or ten years of age and yet have never been treated, apart from being given the local remedies of wassam (burning) or medicinal lead, can be both an education and a challenge. One child was carried into our centre, with her body stiff as a board from the spasticity that she had. The request was to "do something, perhaps massage her ankles." A year later it is a delight to see this same intelligent nine year old writing, sitting, standing and more recently taking her first steps, quite a change from the girl that was brought in.

As the number of volunteers attending on a daily basis is difficult to predict, there is a great opportunity to use one's ingenuity and flexibility in the setting up of programmes for these children, as well as the provision and development of teaching situations at all levels, for both the volunteers and qualified staff. Both situations provide a great opportunity to learn the Arabic language, but when all else fails, one's ability to improvise by using mime can lead to amusing results!

In many ways it is exciting to be so involved in the relatively early development of a country's service care for children with special needs. One's former expectations taken from western society have to be re-evaluated and more realistic applications of care can then be provided for the Omani situation. In addition, it is important to be sensitive to the strong cultural roots of these lovely people, and to work with them, rather than imposing one's own cultural beliefs in the situations faced. It is inspiring to see the major changes that have taken place in the last 23 years in the health care of the Omani people, but there is still a long way to progress, as the numerous difficulties involving lack of funding, staffing and awareness and acceptance of disability are faced.

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Brenda Hodgson,

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WORKING IN THE NORTH WEST FRONTIER PROVINCE OF PAKISTAN

From the very beginning of my career as a physiotherapist, I had had 2 aims:-

(1) to work in paediatrics.

(2) to work in developing countries.

The first ambition was relatively easy to achieve, but the second has taken me some years. Having voluntarily got onto the normal treadmill of marriage and children, the family had however always accepted that when it was felt that the children were old enough to cope without mum she'd have a go with aim number 2!

We decided that the time to start to look would be towards the end of 1993 and unbelievably a suitable job was advertised almost immediately.

The job advertisement, which was to work for the Sandy Gall's Afghanistan Appeal, (S.G.A.A.), emphasised the requirement for an experienced paediatric physiotherapist, with additional working knowledge in orthotics and prosthetics. Apart from limited experience in the prosthetic field, (how many physios, these days in the U.K. have this experience?) I felt it was worth a try. Having attended for interview, in late November, to my delight and trepidation I got the post.

My family threatened never to speak to me again if I didn't take up the opportunity. The Health Board to my amazement granted leave of absence and, by the end of January '94 I was on my way to the North West Frontier Province of Pakistan.

S.G.A.A. was founded in 1983 by the television journalist Sandy Gall after his documentary about the Soviet occupation of Afghanistan and the Afghan Resistance fighters. The fund originally was set up to help the Afghan war wounded, particularly with regard to the provision of prostheses. Since those early days there has been a considerable broadening of its remit as it continues to strive to give rehabilitation assistance to the Afghan people, both in the refugee camps in N.W.F.P. and also to those people inside Afghanistan who are suffering from the effects of the past Soviet Occupation and the current Civil War. There are currently about 3 million refugees in camps in N.W.F.P. and over the border in Jelalabad. By the end of December '94 half a million displaced people are living in temporary camps of plastic or canvas having fled this year's massacre in Kabul.

S.G.A.A. is the only aid agency in the area attempting to provide some sort of Physiotherapy service to these people, and it has been my job over the last year to attempt to supervise this service and develop it.

S.G.A.A. is based in Hyatabad in Peshawar, the last outpost before the tribal, lawless areas of the Khyber Pass.

There are 5 expatriates employed by S.G.A.A. - a Field Director, who is in administrative charge, a Senior Orthotist, a Prosthetist and 2 Physiotherapists, myself, acting as Consultant/Supervisor, and an Australian Physiotherapist, who has been running a training program to train 20 male Afghans in basic physio skills, so they can return to their country to become middle level Community Based Rehabilitation (C.B.R.) workers. This course commenced in March '94 and will last a year. It is part of the commitment to provide training to the Afghan people. Previous students now provide the work force within the camps and the S.G.A.A. organisation.

It has been my responsbility to supervise and to give on going support and training to the physiotherapy assistants working in 15 of the Refugee camps in N.W.F.P. The population in these camps vary between 9,000 - 25,000, the one exception being Nasir Bagh in Peshawar, which is the only camp that has been officially allowed to take in the new refugees. The population here stands at around 70,000 and is rising as people illegally cross the border. We do not cover all the camps as we do not have the staff nor the resources to do so. There is however a center in Peshawar, run by the Pakistan Red Crescent (P.R.C.), which acts as both a Physiotherapy Center with 3 assistants working under S.G.A.A. supervision and a hostel/referral agency for all refugees.

Our H.Q. is in Hyatabad. It is in a complex shared with other E.E.C. funded agencies, called I.T.C. (Integrated Training Center). Within this complex we have a Physiotherapy department, a gait rehabilitation area, an orthotic and prosthetic workshop. Within I.T.C. we have a staff of 7 Physiotherapy Assistants.

Also situated within I.T.C., is a hospital offering medical refresher courses for Afghans, run by a French organisation M.R.C.A., with whom we have close working links, as we provide the rehabilitation/therapy cover.

As an outreach service from I.T.C., S.G.A.A. covers the physiotherapy input to the Afghan Trauma Hospital, a 60 bed hospital situated in Peshawar. Within Afghanistan there are 3 centers each with an orthopaedic workshop manufacturing orthoses and prostheses and having small physiotherapy departments. Jelalabad has a staff of 3 and in Charicar, which lies to the north of Kabul, there are 2 physio assistants.

As S.G.A.A. evolved it became evident that the provision of artificial limbs and the rehabilitation of the war wounded was only the tip of the iceberg. With the mushrooming of the refugee camps came the diseases and conditions associated with poverty, malnourishment, overcrowding and intermarriage.

The bulk of the current caseloads, in all but the Trauma Hospital, is

Children. Previous expatriate Physiotherapists have tended to be orthopaedically trained with perhaps limited neurodevelopmental and paediatric knowledge and my appointment was an attempt to try and redress the balance.

To work with the Afghans is a very humbling, although sometimes exasperating experience. Carrying their disabled they will walk for miles over inhospitable and dangerous terrain, travelling and waiting patiently for hours to receive treatment. The men in particular are caring towards the children, although they frequently do not know the age of the child nor sometimes their name!

With many of the children I felt competent to assess, diagnose and give the correct treatment, but there were also cases that fundamentally were not physiotherapy problems, or there were those who I felt required an accurate diagnosis, before proceeding with treatment.

One of the first problems I encountered was that there was no opportunity to refer these children to a Paediatric team for treatment or consultation, as no such facility existed for the Afghans within N.W.F.P.

During a chance conversation with another member of the team at I.T.C. I discovered that M.R.C.A. were considering moving their emphasis over from trauma and adult (male) orientated surgery into that of women and children. I put forward the argument that you were unable to treat children surgically without also having a paediatric medical input running in conjunction. People listened, it was like a snowflake falling which rapidly developed into an avalanche! Within 6 weeks I'd co-written a project proposal that was presented and accepted by Help the Afghan Foundation, which is funded by the Dutch government, to set up both an out patient and inpatient facility in I.T.C. I'm still astounded by how easy it was to achieve and how rapidly it came into fruition - just like the N.H.S.!

Now within the complex we have a Paediatric O.P.D. that sees between 80 - 140 children each day, and a medical I.P.D. for 15 and day beds for 4. The bulk of those admitted have problems related to poor living conditions, typhoid, dysentery, meningitis, malnutrition, pneumonia and asthma. The 4 day beds are used for rehydration problems.

In addition in S.G.A.A. we now are able to hold a weekly joint Orthopaedic/Orthotic/Physio. Clinic.

From the physiotherapy aspect, polio is the most prevalent condition seen throughout S.G.A.A.'s caseload. This sadly is the vaccine induced type, and with better education could be to some extent eliminated. It is very rare, unfortunately, to find an acute case, those who seek treatment tend to be of longstanding duration and therefore present with deformities, contractures and weak or flaccid muscles. We work to reduce contractures and where possible strengthen muscles. Assessments for me meant delving back into memory for Oxford scales and muscle strengthening exercises.

Once the therapists are happy that they have gained as much as possible, the children are then referred onto the orthotic clinic for assessment and if necessary to orthopaedic surgery for either contracture release or tendon/muscle transplant. Hopefully then they can be fitted with orthoses and trained to become mobile.

The mud hutted refugee camps that we visit are sited throughout N.W.F.P., the more distant ones being up to 5 hours drive from Peshawar, which means some very early starts to enable me to spend a useful camp visit. Every camp visit is an unknown adventure, as I rarely know what is awaiting me, each physiotherapist being encouraged to use me according to his requirements. Often the time is taken up seeing new and often interesting cases, doing assessments with the therapist, working out treatment programs and showing and teaching them new techniques.

Afghans in general have forgotten how to play, as for over the last 15 years their prime aim in life has been survival. The physio staff themselves have needed to be taught about play, and how to encourage and to stimulate active work with the children, - much of the past work done has been passive treatment, mainly of the heat, massage and passive exercise variety.

The treatment methods are part of the Soviet and Cultural legacy the people expect to receive, a nice warm red light, even in temperatures of 50 degrees, and the pattern is difficult to break.

In 2 of the distant areas I have established 6 weekly orthotic/physio clinics, thus enabling those who would find it either difficult or impossible to get to Peshawar to have the opportunity to get an assessment. The record number attending one day was 54, of which 19 needed casting for orthoses, a tiring 14 hour day.

Apart from the high numbers of polio patients the case load can vary according to region. In the Hangau area, for example, I have seen a significant number of Downs Syndrome and gross spinal deformities. (What has happened to those cases I used to see in the U.K. in the early 70's, do they still exist?).

Other conditions frequently seen are Talipes, orthopaedic conditions caused by trauma, falling from trees or traffic accident, (the way they drive it's surprising that there are not more accidents). More heart rending are the children who lost limbs, through either mines, while out collecting kindling or looking after live stock, or through rocket bombardment in Kabul. Burns and chest conditions, caused by the life style are seen. Neuro muscular conditions of various types, also figure significantly, the most frequent being Muscular Dystrophies, Post meningitis cases and of course the Cerebral Palsies.

There are also many peculiar conditions, with unspecified diagnosis and of genetic or metabolic origins.

The Cerebral Palsy work is fascinating and extremely rewarding. They tend to fall more into traditional classifications and not the mixed bag we now tend to see in the U.K. Many of the children have never had previous therapy intervention, so much can be achieved and even the odd miracle performed.

There is no such thing as privacy when working. A westerner's visit, particularly to a Basic Health Unit in a camp is a great curiosity so the odd success is of great comfort and usually results in more patients being brought to be seen.

As in any part of the world the procurement of appropriate equipment is difficult. We have our own workshop that can produce goods, but production is limited by financial and material resources, as well as man power limitations. There is however the scope to experiment and make one off pieces.

One of my successes was the making of a prone trolley for a severely affected polio boy. When his younger sister saw him in it, having spent her life carrying him around, both of them were delighted, "now he is a proper man" she said. It made the effort worth while.

Only 6 wheelchairs can be produced in a month, occasionally funds are obtained to buy one or two more in the bazaar, but the demand for them is a bottomless pit.

Culturally the Afghans live and work on the floor so when considering appropriate positional equipment for the children this must be born in mind. Everyone wants the child to develop, but when there is perhaps only a charpoi, if you're lucky, to pull to stand at and cruise around, and plenty of willing relatives to fetch and carry it is much easier to give in and not progress. Disability is accepted more readily in this part of the world, this has both its advantages and draw backs, so much of my time has had to be spent with staff and patient, motivation of all being the prime aim, and then the odd success story does happen.

So what have I learnt? I have learnt to appreciate other peoples' problems and difficulties and I greatly admire how they can survive in the terrible conditions that they are forced to exist in. I doubt whether many of us could do the same. I also admire the way in which they look after their disabled relatives, without expecting any thing in return, a salutary lesson for this country!

I have thoroughly enjoyed my time working for the Afghans; there have been periods of both delight and extreme frustration. I have had periods of exhaustion, self questioning and fear, and I'd recommend anyone who is thinking about it to take the plunge, you'll never be the same again, I know I certainly won't!

THE OLDER CHILD - INTO ADULTHOOD

Linda Whitaker,

MCSP, Supt. Physiotherapist, Tameside and Glossop and Secretary of NW Committee.

A REPORT OF A STUDY DAY HELD AT PARK DEAN SCHOOL, OLDHAM. OCTOBER 1994

This Workshop/Study Day was held with a view to looking at the appropriate provision of physiotherapy and management of physical disability to secondary school students and school leavers in the light of the current legislation and changes in structure within Education, Health and Social Services.

Dr. Krystyna Walton, Consultant in Rehabilitation Medicine, set the scene describing the paucity of co-ordinated medical and other services for school leavers with physical disabilities and the consequent effects on their health and quality of life.

Mrs. Sue Pawson, Supt. Physiotherapist, Park Dean School, highlighted the difficulties faced by teenagers in both special and mainstream schools and the difficulties in providing adequate physical management in view of the constraints of the school timetable and the national curriculum.

Mrs. Pauline Pope, Consultant Physiotherapist, gave a very positive account of the effectiveness of good and consistent physical management of severe physical disability. She showed how it could reduce the deforming effects of gravity in the young child and control it in the teenager and young adult thus improving ability and enhancing quality of life.

Mrs. Margaret Richardson, Social Worker, wound up the morning by describing the transition process to adult services as set up in the Borough of Tameside. She outlined the choices, changes and uncertainties faced by students and their parents and the various pieces of legislation which apply at different ages.

The Afternoon Workshops

Five specialist speakers introduced the topics for the workshop discussions:-

1. Special Schooling - Mr. D. Hollinson, parent and Deputy Head Teacher, Park Dean School.
2. Integration - Mr. T. Brady, Head of Learning Support Faculty, Kaskenmoor School.
3. Transition to Adult Services - Mrs. M. Richardson, Social Worker, Tameside.
4. Physiotherapy in Mainstream - Mrs. L. Whitaker, Supt. Physiotherapist, Tameside and Glossop.
5. A Young Adult's View - Mr. S. Woodgate, Youth Worker, Disabled Young Peoples Centre, Tameside, and former student in both special and mainstream schools.

APCP NW STUDY DAY

The following are the results from the workshop discussions. There were three discussion groups.Each group was asked to compare what was happening in their services, look at the advantages and disadvantages of the various systems and to come up with ideas for solutions to problems or improvements. They were also asked to bear in mind the effects of the recent changes in legislation.

SPECIAL AND MAINSTREAM EDUCATION IN RELATION TO SCHOOL LEAVERS

Advantages

Special	Mainstream
1) More support for education and emotional needs	1) Peer group support
2) More resources available	2) If resources available works well
3) Easier communication between staff	3) Access to wider curriculum
4) Team of staff with great expertise and knowledge	4) Child and parents take more responsibility
5) Parents have greater support	
6) Parents have greater access to therapists	

Disadvantages

Special	Mainstream
1) Lack of communication	1) Lack of communication with Ed/Health
2) Socially immature	2) Equipment too large (fire risk) or lacking
3) Isolation	3) Teachers lack of knowledge
4) Less responsibility for self	4) Teachers feel intimidated by Therapists and vice versa!
5) Limited socially	5) Geography of building
6) Parents 'disabled'/spoonfed	6) Toilet facilities
	7) Availability of orthotic clinics

Solutions

1) Money - extra funding
   - integrated funding
2) Better communication - Health/Education/Social Services
3) Be more realistic - have a holistic approach
4) Encourage more parental/adolescent responsibility
5) ? Specialised HV to co-ordinate
6) Use Inset days to exchange training - Health <—> Education
7) Regular inter-agency meetings at each school

Transition to adult services

Special	Mainstream
1) Better access to career services and	1) Easier socially
2) Leavers conference well established	
3) Link system post 16	

GROUP B TRANSITION TO ADULT SERVICE

A lively discussion in this group about the difficulties experienced by young people, lack of understanding of their needs, the gaps in services and poor communications between services resulted in the following ideas for improving the system:-

Transition Services

1) Someone with 'clout', a facilitator/co-ordinator
2) Social Services named person to have responsibility (Community Care Act) Social Services best to link all groups and services together
3) Self Help Groups from young adults themselves
4) Raising the profile of disability, there is still a lot of discrimination
5) Specialist or team for 14 - 25 years
6) Co-ordinated information giving
7) Within the team appropriate person should take on specific role eg. physio counselling - knows person best but impinges on clinical time? therefore not appropriate
8) More outreach to mainstream

GROUP C PHYSIOTHERAPY IN MAINSTREAM SCHOOLS

Group members (all physiotherapists) compared notes:- all were providing an input to children in mainstream schools; some during school times, some only before school, some after school, some in clinics and some had "resourced" mainstream schools.

Advantages	Disadvantages
1) Local area	1) Equipment
2) Peer group friends	2) Funding
3) Child in context eg joining out of school activities	3) Isolated in wheelchair (at first)
(4) Know problems with eg small equipment (can see) teachers ask for help	4) "Smothering" by peer group 5) Place to treat and time 6) Storage of equipment
5) Teachers more open to advice	7) Lack of recognition of perceptual/global problems
6) Easier in primary schools	8) Special needs co-ordinators Varied abilities/money/time
	9) Communication - timetables
	10) Due to NC children have to give up lunch or social time for therapy
	11) Staff may be unrealistic

EFFECT OF NATIONAL CURRICULUM AND SEN CODE OF PRACTISE

1) Teachers targets not met if withdrawn for therapy
2) Standing frames etc. "get in the way" of the lesson
3) More onus on the family to do "physio"
4) Meeting statement wording difficult - Less time for pupil "needs" more "education"
5) Difficult to do therapy after school due to tiredness and homework
6) Lack of help if not statemented - now less children having statements
7) Pot of money varies

Solutions

1) Ex-physios as head teachers!
2) PTs with teaching experience
3) In Service Training
4) Influence on budgets
5) Use "options" for access in secondary schools
6) Raise profile of value of physiotherapy input in enabling access to curriculum
7) More ancillary support from education/health/Physiotherapy helpers
9) Joint funding schemes

SUMMARY OF THE DAY

All Participants and speakers participated to the full and Steven Woodgate kept us on track with his keynote contribution and timely reminders during the day to consider the feelings and point of view of the young people being "put through" these systems.
Several themes and suggestions recurred throughout the day which are worth recording and promoting in our own areas.

1) A co-ordinated approach from all the services with:-
   a) A named co-ordinator
   b) Joint funded schemes for support in mainstream schools
   c) Joint funding to provide transitional support
   d) Better communication between services in spite of restrictions on time and resources.

2) More links between mainstream schools and Health and Social Services especially as there is a gap between students leaving school at 16 and the Community Care Act provisions which start at 19 years.
3) Exchange of education and training between all three services.
4) Raising the profile of disability to reduce discrimination and isolation.
5) Raising the profile of therapy - it is essential for fully accessing educational and social life.

In spite of the changes and restrictions which all services are facing due to new structures, legislation and resources this was, I think, a very valuable and positive study day. My thanks to all those who came and took part so actively on the day.

Carole Hurran,

Superintendent Physiotherapist
for Community Paediatrics,
Southmead Health Services
NHS Trust, Bristol.

Also: Spokesman for the Post
Registration Education
Committee

THE CODE OF PRACTICE - 1993 EDUCATION ACT

The 1993 Education Act Part III builds upon the principles and practices first set out in the 1981 Act and places specific duties and responsibilities on LEAs and schools, the health services and social services towards all children with special educational needs. It is up to these agencies to decide how to fulfil their statutory duties in the light of the guidance of the Code of Practice, which came into operation on 1st September 1994. Schools have a year in which to get their act together and publish information on their SEN policies and report to parents on how these are being implemented.

Health and social services must also have regard to the Code and observe the new Regulations, including statutory time limits whenever, after 1st September 1994, they begin to make an assessment. Unless there are exceptional circumstances there is now a time limit of 6 weeks for a health authority to comply with a request for assessment and written advice, and if the LEA decides to go ahead with a Statutory Assessment the issuing of the Statement should be completed in 26 weeks.

The fundamental principles of the Code are that wherever possible children with special educational needs should be educated in mainstream schools, and that it is essential for schools, LEAs, health and social services to work very closely with each other, and that all work closely with parents. The Code's guidance is designed to promote partnership, but where agreement cannot be reached parents will have a quick and independent system of appeal by a new SEN Tribunal.

The LEA should seek parent's consent to any medical examination and disclosure of medical information. All therapy assessments are included in full in Apendix E and a designated medical officer is responsible for co-ordinating the contributions of all health care professionals in each health service area.

The effects of the new legislation should be to deter LEAs from delaying the statement process, once initiated, and to raise awareness of the correct procedures, particularly for annual reviews. This should enable much more effective assessment and appropriate provision for SEN with a system in place to check and review each child's progress, set aims and adjust provisions in the future. The implications for physiotherapists are the extra time needed to provide advice in more detail, and for involvement in a much more rigorous system of annual reviews. This will also include an increased need for secretarial support.

PHYSIOTHERAPY ADVICE:

The advice should give a jargon free, non clinical description of the child's difficulties, strengths and needs and their implications for the classroom. Parents should be involved with the assessment, and understand the necessity to define problems and needs to justify the provisions recommended. Details of the advice should be discussed with parents, and the child's views taken into account whenever possible. The advice should clearly state the physiotherapy needs and recommended provision with flexibility to meet future changing needs. The actual commitment of therapist time must be agreed with the health authority or other provider.

Formats for the Physiotherapy Advice for the Statutory Assessment and for an Annual Review Report have been developed in collaboration with Southmead, United Bristol and Frenchay paediatric physiotherapists and shared with the APCP National Committee for comment. (to be included in May Journal).

THE ANNUAL REVIEW:

The LEA must initiate the review by writing to the headteacher with a copy to parents, giving two months notice of the date. In practice schools could arrange their own review dates and inform the LEA. The Head requests written advice from all appropriate professionals, to be circulated at least two weeks before the meeting, inviting additional comments including from those unable to attend.

CONDUCT OF THE REVIEW MEETING:

The annual review should focus on what the child has achieved as well as any difficulties which need to be resolved. The following structure should be used for the meeting which the Head will normally chair.

1. What are the child's and parents' views of the past year's progress and their aspirations for the future?
2. What is the school's view of the child's progress over the past year? What has been the child's progress towards meeting overall objectives in the statement? What success has the child achieved in meeting the targets set?
3. Have there been any significant changes in the child's circumstances which affect development and progress?
4. Has the National Curriculum or arrangements substituted, been effective?
5. If the child is being integrated into mainstream school, are the current arrangements still satisfactory, or should the meeting recommend any adjustments to the LEA?
6. What educational targets should be adopted against which the child's educational progress can be assessed during the coming year and at annual review?

7. Does the Statement still remain appropriate?
8. Are there any amendments to the Statement the meeting would recommend to the LEA?

ACTION FOLLOWING ANNUAL REVIEW:

The headteacher must prepare a report summarising the outcomes of the meeting and setting out educational targets for the year and circulate this to all concerned including the LEA. Amendments to the Statement may be made if significant new needs have emerged which are not recorded on the Statement, or there are needs which are no longer present, or the child has to change schools.

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Due to a compositing error in the November 1994 Journal Judith Ackers' summaries of sessions 3 & 4 and the concluding remarks from the chair were mixed up. To rectify this the summaries have been re-printed in the correct order. I apologise to Mrs Ackers for any distress this mistake may have caused her. - Editor.

Judith Ackers,

Community Paediatric
Physiotherapist
Premier Health Trust,
Tamworth,
Staffordshire.

Judith won the ballot, organised by National Committee, for a place to attend the Paediatric session at Congress on September 22nd 1994.

SUMMARY OF PAEDIATRIC SESSION AT CSP ANNUAL CONGRESS HELD AT THE ICC, BIRMINGHAM IN SEPTEMBER 1994

The Paediatric session entitled "MOVEMENT DEVELOPMENT" was chaired by Mrs. Mary Clegg and consisted of the presentation of four very interesting papers. As a large proportion of clinical caseload involves cerebral palsied children it comes as no surprise that each area of research presented pertained to such children. They are therefore of valuable interest to us.

EARLY INTERVENTION BY PHYSIOTHERAPY FOR INFANTS AT HIGH RISK OF DEVELOPING CEREBRAL PALSY.

The first paper was presented by Mrs. Philippa Hallam MSc., MCSP who is a research assistant in the Dept. of Child Health, Liverpool Maternity Hospital:-

This is a longitudinal study which has been running over 8 years and requires a minimum of 6 years to continue. The study, awaiting publication, aimed to test the "hypothesis that physiotherapy started around term for infants at high risk of cerebral palsy (CP) will result in a better motor outcome than delaying its introduction until motor abnormalities appear." Randomised controlled trial was used involving 105 infants. Randomisation was made by telephone in blocks of ten.

Entry Criteria: Considered at high risk of developing CP though clinical examination was normal, but significant abnormalities were shown on cranial ultrasound as a neonate.

Treatment groups: By 13 months 13 infants had been lost to follow-up and 7 had died.

a) Around term - Early Intervention Group (EI) in the form of general positioning and care. (42 infants)
b) When CP clinically indicated - Late Intervention Group (LI). (43 infants)

Main Assessments: Carried out at

(i) 12 months of age (corrected age)
(ii) 30 months of age (corrected age)

Neurological examination was carried out in child's home using 3 tests of motor function:-

a) Griffiths

b) Limb x Limb
c) Movement Assessment of Infants (MAI)

Age at Intervention: EI - 39 weeks (36 - 41 Post conceptual age or PCA)
LI - 76 weeks (50 -128 PCA)

No significant difference was found between EI and LI groups in Griffiths motor or overall development quotient (DQ) at 12 or 30 months, even when only the 56% of children who developed CP were considered.

An imbalance in birthweight and gestation was found between the groups. 18 infants were paired according to pattern of CP and gestation. The mean motor DQ at 12 months and mean overall DQ at 30 months were found to be better in the EI group.

The detailed results will be worth studying when published, but Philippa stated that they need to be viewed with caution. "The study indicates that physiotherapy started early for infants who subsequently develop CP may improve their outcome.

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The second paper was presented by:-
J. Would, Senior Paediatric Physiotherapist, Lincoln District Health Care Trust.
F. Hainsworth, Senior Paediatric Physiotherapist, St. James University Hospital, Leeds.
E. Beckerlegge, MCSP, Hippotherapist. (Private Practice).
This was a fascinating presentation.

A STUDY OF WEIGHT SHIFT AND BALANCE IN CEREBRAL PALSY CHILDREN.

The study looks at some CP children using hippotherapy to improve balance and weight shift. Hippotherapy treatment using the movements of the horse, is widely used abroad in Germany, Austria and Switzerland. There has been an increasing interest in Britain over the past 10 years with 1994 seeing a register of hippotherapists.

The historical background goes back many years when in 400 BC it was stated "The outside of the horse is the best thing for the inside of man." Electric goniometry and videography clearly showed beneficial effects to the inside of CP children especially with pelvic mobility and balance reactions. The individual treatment uses the walking horse to elicit reactions in the rider, these reactions then being applied to a wide range of functional activities.

Functional balance is dependent upon vertical balance and lateral weight shift. The repetitive, flowing, on-going movement of the horse challenges the balance of the rider to be maintained and improved. The angle of the pelvis is important to be in balance with the horse. The forward and backward movement of the pelvis was clearly seen on videography with each step of the hind legs of the horse.
Computer analysis of results from the study show an improvement in pelvic mobility and a reduction in the inequality of weight bearing through the hips when the child was in straddle sitting on the horse.

Changes in the pattern of postural adaptation, in the CP child trying to balance and accommodate the rhythmic movements of the horse were seen to move towards that of normal riders. An interesting fact was stated in conclusion, which may well reflect on our conventional physiotherapy sessions. 110 three-dimensional movements are produced by the horse each minute, requiring responses from the rider in the order of 2,200 responses in a twenty minute session. Beat that!

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In the absence of Penelope Butler her paper was presented by Richard Major, BSc. Cert. Ed., C. Eng. who is a senior bio-engineer at the Orthotic research and Locomotor Assessment Unit, Oswestry.

THE POTENTIAL OF TARGETED TRAINING IN THE MANAGEMENT OF MOTOR IMPAIRMENT : A PRELIMINARY STUDY.

The early requirement for a child to sit without support is of paramount importance for the hands to be used in functional exploration. Accurate movement requires full dynamic control of the entire vertical weight bearing column of spine and lower limbs.

The learning of balance control is dependent on correct total feedback. Where there is involvement of many uncontrolled joints as in the CP child correct total feedback is unrealistic.

With single case study research targeted training has been shown to have considerable potential as an effective strategy in the management of motor impairment. Targeted training reduces the number of joints at which learning must simultaneously occur.

Seven children with spastic CP were included in this preliminary study. Their ages ranged between 2yrs 5mths to 7yrs 5mths. They had head control but were unable to sit independently without hand support. Their schedules were individualised using specially designed equipment to stabilise distal joints beneath the targeted joint. Treatment progressed by releasing adjacent joints. Assessment was carried out to define the joint at which targeting commenced.

Independent assessment showed an increase in control clearly associated with the commencement of targeted training. Sitting balance was gained in 12 to 25 weeks and maintained for a maximum follow up of 71 weeks. In contrast, with the use of conventional therapy, the child receiving no targeted training only gained sitting balance after 59 weeks. The analysis has shown that targeting segmental control sequentially from above downwards is likely to be the most successful strategy.

This interesting research can be viewed as a positive step in contributing to the complex and labour intensive physiotherapy management of motor impairment.

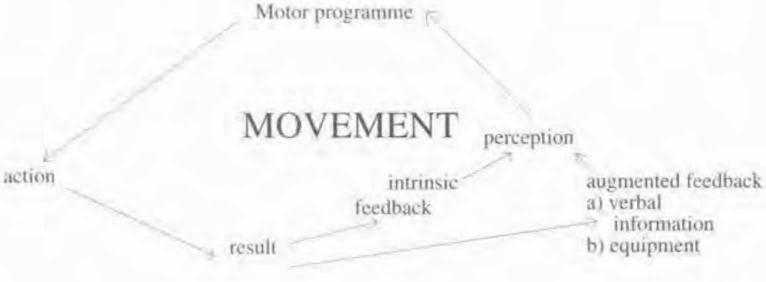
Butler, P B and Major, R E (1992) "The learning of motor control. Biomechanical considerations" Physiotherapy 78 (1) p 1-6.

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

The final presentation came from Mr. Adri Hartveld MCSP, Senior Physiotherapist, Combined Health Care, Stoke-on-Trent.

AUGMENTED FEEDBACK TO INCREASE MOTOR PERFORMANCE AND MOTOR LEARNING.

He stated that "movement is a dynamic interaction between action and perception"



→ PRACTICE - improves skill
conditioning
→FEEDBACK from movement is crucial for: - performance
- learning

Augmented feedback from a person or an object enhances performance. Whether this produces a long term improvement of motor skills depends on the motor programme chosen and the strength, frequency and timing of the reinforcement.

Artificial feedback with the use of electronic aids has been reviewed by the author from recent trials. From these considerations he concluded that computers could be used as feedback aids to bring about improvements in motor function.

The author conducted his own study on the effects of augmented feedback from commercially available computers and computer games.

Using replicated AB - single-case experiments he tested the hypothesis "that frequent weight shift practice improves standing balance in CP children" EMGs, joint angles and position in space were used as biofeedback.

Graphic analysis of the data showed that there was an improving trend in the treatment period in comparison to the mainly static trend of the baseline period. The long term use and effectiveness of computers is not known but in conclusion from the review of biofeedback literature and single case studies the author stated "balance exercises on a balance board done frequently with computer feedback produce an improvement".

The concluding remarks from the chair highlighted 3 words:-

TARGETING

FEEDBACK

PLACEBO

There was a close link with PLACEBO from the founder's lecture earlier in the day.

In the light of these papers and ongoing research it is important as therapists to question what we are doing and why.

BOOK REVIEW

Elements of Paediatric Physiotherapy
Edited by Pamela M Ekersley.
Churchill Livingstone
ISBN 0 443 03 894 5

This volume was published in 1993 and is aimed at students of physiotherapy and their teachers and physiotherapists new to the paediatric field. The level of knowledge presented throughout this volume is appropriate to this group but would also provide useful reference in some areas for experienced physiotherapists. Most sections are well referenced and provide further reading suggestions.

Throughout the book the position of the child within the family and the importance of seeing the child in this perspective is emphasised. A partnership with the parents is encouraged and the physiotherapists responsibilities in advising and counselling alongside clinical input are highlighted.

A vast area of knowledge is covered in the book, ranging from neonatal and respiratory problems through neurological and neuromuscular conditions, orthopaedic aspects of disorders and learning and behaviour difficulties. Disorders are described from the medical, orthopaedic and physiotherapy viewpoints. Most chapters provide clear explanations of each disorder and any associated problems. The sections on treatment systems and methods provides a good unbiased introduction to various treatment approaches. The technology section introduced a range of communication and computer hardware but failed to consider powered mobility for children.

Two sections that I think required more current knowledge were the treatment of children with specific motor learning difficulties coined in the book as "Clumsy Children". No mention was made of the role of the sensory systems and the use of sensori-integration therapy. The section of seating was particularly disappointing as it isolated sitting from the total postural management of children and did not stress the impact of postural control on motor and cognitive function and its role in the control of deformity. Principles of postural control were sacrificed to the descriptions of a variety of seats.

Despite these few criticisms, which are easily outweighed by its informed content, this volume provides a good basic text for paediatric physiotherapy and is a must for every paediatric department and student library.

Terry Pountney
MCSP

THE WOOSH CHAIR

James Lecky design has recently launched their new WOOSH chair which comes in four sizes.

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- * Adjustable trunk supports
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- * Pushbar handle
- * Side pads
- * Sacral pad

Gill Brownson

Chairman

REPORT OF NATIONAL COMMITTEE WORKSHOP

A National Committee Workshop was held in October at the James Gracie Centre in Birmingham. In order to make full use of the time and to make best use of the travel costs involved, we arranged to hold as many sub-committee meetings as possible, throughout the 2 days, which resulted in a very productive time.

At lunchtime on the Thursday, the Regional Treasurers met with the National Treasurer and a representative from the Auditors, for an afternoon meeting on procedures for account-keeping. At the same time the Editorial Board held a meeting, and during the afternoon, the National Committee members arrived for a National Committee Meeting which commenced at 5.00 p.m. This meeting broke for supper but reconvened for a long evening session. Unfortunately we did not reach the end of the agenda and we had to reconvene again at a convenient point during the next day and a half.

Friday was an extremely long day. It began with a summary of the Outcome Measures, which are being formulated by a group of London-based Superintendent Paediatric Physiotherapists, and was led by Michele Lee. Viv Williams then gave a resume of the Outcome Measures used by a working party from the South Glamorgan ACPM.

Our aim for the main part of the workshop was to formulate proposals and methods for the production of a document to calculate Paediatric

Thursday afternoon editorial board meeting

Physiotherapy Caseloads. It was a response to a large number of requests from members for recommendations on appropriate staffing levels and acceptable caseloads in Paediatric Physiotherapy.

The day was led by Joyce Wise, Rehabilitation Services Manager for North Tees General Hospital. Joyce has a very thorough knowledge of Paediatrics, Physiotherapy Management and Professional Practice - she is a dynamic, entertaining and forceful workshop leader. Being divided into groups we worked hard throughout the day. It is at these times that it is noticeably so important to have a good mix in the National Committee of wide-ranging clinical and managerial experience and not just a managerial bias.

After a break for tea the Regional Representatives on the National Committee met with the P.R.O. to formulate 'job descriptions', the Post-Registration Education Committee held a meeting, the Editor worked on putting the November Journal together and the remaining people formed a working party to pull together the day's work. With the help of Fiona's word-processor we were able, by the end of the evening, the produce a draft document that could be presented to the others on the Saturday morning.

During the rest of Saturday morning Carole Hurran, as Post-Reg Education Spokesman, presented the Code of Practice for the 1993 Education Act unravelling for us the statutory procedures. This is reproduced for members elsewhere in this journal. She also presented

The remaining people formed a working party to pull together the days work the Avon Special Provision Matrix project and a draft proposal for a suggested new format for Statement Advice.

By the time we left at Lunchtime we all felt exhausted but had a great sense of achievement. The working party met again during November and the final document was distributed to National Committee Members for their consideration. It will have been discussed at the January National Committee Meeting, and if approved, will be printed and made available to members in March.

My thanks go to all the National Committee who so readily travel huge distances, give up time and energy during busy working lives and leave their families to fend for themselves while they work on behalf of Paediatric Physiotherapy and the Membership of APCP.

NOTICE

Iam sure that many members will be sorry to hear of the recent death of Denise Woods who was a founder member and the first secretary of the Association. On behalf of APCP I wish to offer condolences to her family and friends - Editor.

The 22nd Annual General Meeting
of the
Association of Paediatric Chartered Physiotherapists
will be held on

SATURDAY 1st APRIL, 1995

at

Herriot Watt University, Edinburgh

commencing at 9 a.m.

All paid up members of the Association are entitled to attend.
Voting will be restricted to full members of the Association and a
current membership card will be required.

Minutes of the last AGM are available from the Secretary on receipt of a SAE.

Nominations are invited for 4 committee vacancies.

Nominations should be sent to the Secretary by the end of February together with a proposer and seconder who should be fully paid up members of the Association.

The following committee members are due to retire :
Jill Brownson - Chairman (co-opted), Viv Williams - Vice Chairman,
Jenny McKinlay - Membership Secretary and Michele Lee PRO (co-opted).

The following committee members are due for re-election :
Fiona Corkhill - Secretary, Ann Shanks - National Committee

Nomination Form on Back Page.

Association of Paediatric Chartered Physiotherapists

LIST OF PUBLICATIONS

BOOK/TITLE	**QUANTITY PRICE LIST**
SERIAL SPLINTING IN HEMIPLEGIC CEREBRAL PALSY *by Margaret Jones (2nd Edition)*	£3.50
THE CHILDREN ACT 1989 *'A Synopsis for Paediatric Physiotherapists'*	£2.50
PAEDIATRIC PHYSIOTHERAPY *Guidelines for Good Practice*	£2.50
DYSPRAXIA - A HANDBOOK FOR THERAPISTS *by Michele Lee and Jenny French*	£5.50

Post & Packing	Single copies	£0.50
	2 -5 copies	£1.00
	6-10 copies	£2.50
	Over 10 copies	Charged according to weight.

Terms: Strictly cash with order

Cheques and postal orders should be made out to "A.P.C.P. Publications" and included with order. International Money orders accepted.

SEND ORDERS WITH PAYMENT TO:

Carol F. Foster
A.P.C.P. Publications
Birmingham Childrens Hospital
Physiotherapy Department, Ladywood Middleway, Ladywood, Birmingham, B16 8ET

Please supply Name & Address for delivery

PROFILE OF THE EDITOR

Lin Wakley

BA MCSP

Lin qualified in 1969 from the Oswestry School of Physiotherapy and has spent her professional life in paediatrics. She became a member of APCP in 1976 after returning from 4½ years in Norway where she had worked in several special schools.

She was elected to the Northwest Committee in 1986 and during her 7 year term held office as regional representative and chairman and in 1992 she was elected to the National Committee. Lin was chairman of the organising committee of the APCP National Conference held in Chester last year.

Her current post is Superintendent physiotherapist of the paediatric service of the Countess of Chester NHS Trust.

Lin's other interests include a wide variety of handicrafts, swimming, reading and she enjoys unusual adventure holidays in out of the way places. She has just completed an honours degree with the Open University.

Lin with Christopher during a treatment session at home.

REMINDER

NOW IS THE TIME TO RENEW YOUR MEMBERSHIP

The convenience and advantages of paying your annual subscription by DIRECT DEBIT are now available to members.

The Direct Debit Instructions to your Bank/Building Society are obtainable from your regional representative.

Forms are also available for members who prefer to pay by cheque.

* * *

ARE YOU WILLING TO TREAT PRIVATE PATIENTS?

The National Committee regularly receives letters from parents requesting private physiotherapy treatment. The National Committee of APCP wish to compile a register of physiotherapists, specialising in paediatrics, who are prepared to treat private patients. If you wish to be included in the register contact the Membership Secretary. Please state name, address, telephone number and speciality, if appropriate.

REGIONAL REPORTS

EAST ANGLIA

Sue Whitby
3 Manor Way
Hail Weston
St. Neots
Huntingdon
Cambridgeshire
PE19 4LG

LONDON

Dianne Coggins
7 Union Street
High Barnet
Herts
EN5 4HY

N. IRELAND

Finola Beattie
Physiotherapy Department
The Royal Belfast Hospital
for Sick Children
Falls Road
Belfast BT12 6BE
Tel. 0232) 240503 x2049

The evening meeting on 7th November on the "Muscle Clinic" by Tish Dunn Physiotherapist, was well attended. It provoked a lively discussion on the management of the child with DMD at mainstream school. Views differed!

The Committee at present are in the process of organising a Study Day on "Hydrotherapy in Paediatrics" for February/March and a 2 day workshop on "The Pre-term Infant" for May. Details to follow later. Our AGM will be held on Monday 6th March 1995 in Physiotherapy Department RBHSC at 7.30 p.m. This will be followed by an "Update on Asthma" by Dr. Mike Shields. Please make a special effort to attend!

NORTH WEST

Alex Winney
14 Langley Road
Spital
Bebington
Wirral
Merseyside
L63 9HW

Hopefully you will have received some literature in a separate mailing, namely an application form for the AGM on March 11th 1995, which again follows the same format as other AGMs. Also included was a nomination form for membership of the North West Committee, as two of the committee are due to retire. Please fill them in and return them to us as soon as possible, if you have not already done so. I am due to retire at the end of March from the North West Committee and also hand on the regional representatives job to someone else. We will let you know who the next representative will be, probably at the AGM or in the May Journal.

The summer study day is to be held on Friday July 14th 1995 at the Post-Graduate Centre, Alder Hey Children's Hospital, Liverpool. Dr. Iris Musa is going to lecture on the Neurophysiology of Spasticity and there are sessions and open discussion on the treatment of spasticity. There probably will be video presentation on the treatment of it. Application forms and further details will be sent out with the May Journal or under a separate mailing.

Plans for an Autumn study day on Seating and Orthotics are also on the way. Possible dates for that are October 7th or 14th 1995.

Again any fresh ideas for courses would be welcomed by the committee. I hope to see many of you in March. Best wishes - Alex.

NORTH EAST

Liz Hardy
45 Kestrel Close
Norton
Stockton on Tees
Cleveland
TS20 1SF

Happy 1995 to you all!

As you known our first ½ day course for many years was held in York in November. It seemed to be a great success, and I'm sure the Christmas shopping went well afterwards. Do you want to do this again next autumn? Thanks are due to Winslow Press for putting on an exhibition of paediatric books.

Now, looking forwards, the next study day will be held on Saturday 4th March, at Leeds and is to be a Really Special Event - and not just because it's the AGM. Colin Stevens will be enthralling us with his superb handling skills as he demonstrates the treatment of several children with CP. Places are limited, and will be very sought after, so book your place early. Can you afford to miss it???

Many thanks to those people who have bravely volunteered their services for the Regional Committee. There is still time for YOU to get involved - give me a ring if you want to know more.

SOUTH EAST

Sheila Minet
Old Knowle
Frant
East Sussex
TN3 9EJ

SOUTH WEST

Gill Smith
23 Gunville Crescent
Castle Mead
Bournemouth
Dorset
BH9 3PZ

Happy New Year to you all. **Please note** our Study Day - Evaluating Physiotherapy in Cerebral Palsy, Four Completed Studies, and AGM is now on Saturday 25th February 1995. For further details please contact: Tess James, Superintendent Paediatric Physiotherapist, Children's Centre, Damers Road, Dorchesher, Dorset. Tel: 0305 251150 ext. 4747

Our next regional committee meeting will be held on Friday 3rd February at 2 pm in Salisbury. We would be pleased to hear your local news and we hope to be planning further study days for the coming year.

REGIONAL REPORTS

TRENT

Margaret Cameron
Flat 6
19 Newcastle Drive
The Park
Nottingham
NG7 1AA

The proposed 'Sharing Afternoon' on Syndromes planned for February has been postponed to later in the spring. The next event will be the AGM on 8th March at 5 pm at the Children's Centre, City Hospital, Nottingham. We hope to have a talk on Botulinum Toxin and it's use in the child with cerebral palsy. Refreshments will be provided and all are welcome to attend.

SCOTLAND

Lyn Campbell
19 Craigmount Avenue North
Edinburgh EH12 8DH
Tel: 031 539 0619
Work Tel: 0236 456100

Our AGM will be held on Saturday 6 May 1995 in conjunction with a talk by Susan Horsburgh, the Superintendent Physiotherapist of the Scottish Bobath Centre but further details will be sent to you nearer the time.

We look forward to seeing as many of you as possible at the Conference in Edinburgh.

WEST MIDLANDS

Carol Foster
Physiotherapy Department
The Childrens Hospital
Ladywood
Middle Way
Birmingham
B16 8ET

WALES

Barbara Bowen
Childrens Assessment
East Glamorgan Hospital
Church Village, Nr. Pontypridd
Mid Glamorgan
CF38 1AB

Our Medieval Banquet at Cardiff Castle was enjoyed by all. Our thanks to Penny.

On 10 February 1995 we have a Study Day on Cystic Fibrosis at UHW. The programme has been circulated.

Our AGM and Symposium on muscular conditions will be held at Hensol Castle on 25 February 1995

A 'Sharing Day' is planned for April in Neville Hall Childrens' Centre.

Please make every effort to attend the AGM to plan for 1995.

Blwyddyn Newydd Dda

A.P.C.P.
ANNUAL CONFERENCE
1995

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EDINBURGH
SCOTLAND

31st March - 2nd April 1995

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For further information please contact :
Lyn Campbell, 19 Craigmount Avenue North, Edinburgh EH12 8DH
Home Tel. 031 539 0619. Work Tel. 0236 456100

COURSES

PRACTICAL STUDY DAY ON DYSPRAXIA

Venue: Vallance School, Westerham, Kent on March 4th 1995. Organised by S.E. Region APCP. Tutors: Jane O'Halleron, Occupational Therapist and Peter Cartlidge, Teacher.

The course aims to provide practical ideas for therapists and teachers involved in the management of children with dyspraxia.

Applications to : Mrs J Watson, 19 Priory Drive, Reigate, Surrey, RH2 8AF. Fee: £18 members, £20 non-members.

PRACTICAL SKILLS IN CLINICAL AUDIT

Tuesday, April 18, 1995

Clinical audit is here to stay in today's health service. This course is designed to be a fresh approach to clinical audit and to equip you with the necessary skills to be able to understand how clinical audit has evolved, identify good audit topics, distinguish audit from research, write a measurable standard, know how to collect audit data, examine an audit project critically, plan a progamme successfully, how to get help, how to present an audit project and much more!

This practical course is specifically designed for physiotherapists who are interested and/or involved in clinical audit. It will be invaluable to physiotherapists who manage services and who may be required to develop a clinical audit programme.

Each session is designed to present information clearly and give you a chance to apply it before going back to the workpace.

Fee: £50, to include lunch and refreshments, to be sent with application, payable to the 'Physiotherapy Fund'. Please send an A5 SAE. Places limited to 30.

Applications to Mrs D Swan, MCSP, Acute Therapy Services Manager, Department of Rehabilitation, North Tees General Hospital, Hardwick, Stockton on Tees, Cleveland TS19 8PE.

Accommodation list available if required.

MSc IN HEALTH SCIENCES

School of Occupational Therapy and Physiotherapy
Health Policy and Practice

A new Modular MSc designed to meet the needs of health professionals will start in April 1995. The programme provides both profession specific units for occupational therapists and physiotherapists and also opportunities for interdisciplinary learning.

For further information and details of application contact : Tracey Hourd - Postgraduate Admissions, School of Occupational Therapy and Physiotherapy, University of East Anglia, Norwich, NR4 7TJ. Tel: 0603 593083.

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COURSES

AUDIOLOGY AND COMMUNICATION DISORDERS IN CHILDREN

A DEVELOPMENTAL APPROACH

Venue : Newcomen Centre, Guy's Hospital
Date: 15 -1 9 May 1995

This advanced course is designed for educationalists and senior paediatric specialists in medicine, psychology, audiology and communication. It aims to present from a developmental perspective some of the more recent work in this field with an emphasis on multidisciplinary working.

Fees for one week	:	£310 (non-residential)
Daily rate	:	£80
Monday only	:	£90*

(* to include lunch)

Application forms and further information from :
Ann Darrington, Newcomen Centre, Guy's Hospital, St. Thomas Street, London SE1 9RT. Tel: 071 955 2610 or Fax: 071 955 4950

BOBATH INTRODUCTORY PAEDIATRIC COURSE

2 DAY COURSE ON THE BOBATH APPROACH TO THE TREATMENT OF CEREBRAL PALSY

To be held at Southmead Hospital, Bristol on Friday 21st and Saturday 22nd April 1995.

Fee £80 - places limited. closing date March 21st

Application forms from Rachel Woolfson, Course Organiser, The Bobath Centre, 250 East End Road, London N2 8AU Tel. 081-444 3355, Fax 081-444 3399

or contact Carole Hurran, Claremont School, Tel. 0117-942 5689 for further details.

NORTH WEST REGION AGM AND STUDY DAY LEGAL ASPECTS

Venue : Post Graduate Medical Centre
Warrington District General Hospital
Date : Saturday 11th March 1995
Speakers : Jane Wright - Solicitor
Legal issues affecting paediatric physiotherapists
John Davies - Solicitor
Moving and Handling Law. The new E.E.C. Directives
Cost : APCP members £12.50 Non-members £15.00
Students £8.00

For further information contact :-
Sue Leech, Community Physiotherapist, Eccles Health Centre, Corporation Road, Eccles, Manchester M30 0EQ. Tel: 061 789 5135.

COURSES

SYMPOSIUM ON NEUROMUSCULAR DISORDERS AND WELSH BRANCH APCP AGM.

Date : 11th March 1995
Lecturer : Nicky Thompson MCSP
Superintendent Physiotherapist,
Marjorie Crow Neuromuscular Centre,
Guy's Hospital, London.
Venue : Hensol Castle Conference Centre
Cost : £20 APCP members £25 non members (lunch included)

Application to : Donna Morris, Senior Paediatric Physiotherapist, Physiotherapy Dept., Prince Charles Hospital, Merthyr Tydfil, Mid-Glamorgan, CF47 9DT. Tel. 0685 721721 ext. 8109

Closing date : 3rd March 1995.

JOB VACANCY

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Countess Wear - Exeter - Devon EX2 6HA

Roll - 180

HEAD OF THERAPY DEPARTMENT

Due to the pending retirement of the present post holder after 14 years, applications are invited from suitably qualified and experienced physiotherapists for the post of Head of the Therapy Department - physiotherapists (3), occupational therapist (1), speech and language (2), music (2) - at this day/boarding school/college for visually impaired children and young people.

The successful applicant will be expected to undertake a 70% case load and a range of Departmental management tasks, no residential requirements but some evening work with FE College students in term time.

Excellent specialist facilities within an attractive location on the edge of the City.

Salary : £18,251 - £2,704 (NHS Scale Related) 41 hours for 42 weeks per year.

For further details write to the Headmaster's Secretary.

Association of Paediatric Chartered Physiotherapists

Nomination Form for Election to National Committee

NAME ....

ADDRESS ....

....

TEL. NO. ....

C.S.P. NO. ....

A.P.C.P. NO. ....

PLACE OF WORK ....

POSITION ....

PROPOSER ....

ADDRESS ....

....

TEL. NO. ....

A.P.C.P. NO. ....

SECONDER ....

ADDRESS ....

....

TEL. NO. ....

A.P.C.P. NO. ....

BRIEF PERSONAL PROFILE IN SUPPORT OF YOUR NOMINATION

....

....

....

....

Please return completed form to : APCP Secretary, Mrs. F. Corkhill, 3 Severn Gardens, Oakley, Basingstoke, Hampshire, RG23 7AT, to arrive no later than 4 weeks prior to the AGM.

Notes for Contributors

The Editorial Board welcomes research material; referenced articles and evaluations of physiotherapy practice; informal articles.

Manuscripts should be sent to Lin Wakely, 2 Ash Bank, Pipers Ash, Chester, Cheshire, CH4 7EH, U.K.

Copy to be submitted should be typed on one side of the paper, double spaced and with ample margins. All pages should be numbered consecutively.

Manuscripts should provide the title of the article and the author(s) name(s) and full postal address for correspondence.

References should be given in the Harvard System.

In text	Author(s) name and initials followed by the date of publication. Use a,b, to indicate more than one publication in the same year. Where there are 3 or more authors use first name followed by et al.
For books	Laszlo, J. & Bairstow, P. (1985) *Perpetual Motor Behaviour* (Rinehart and Winston)
For chapters within books	Morley, T.R. (1992) Spinal deformity in the physically handicapped child, in : G.T. McCarthy (Ed). *Physical Disability in Childhood* (Churchill Livingstone)
For articles	Scott O.M., Hyde S.A., Goddard C.M., Dubowitz V., (1981a) Prevention of deformity in Duchenne muscular dystrophy. *Physiotherapy* 67(6), 177-80.

Tables and Figures

The approximate position of the tables and figures should be indicated in the manuscript.

Keys to symbols should be included.

Tables should be numbered by Roman numerals and figures by Arabic numerals.

Figures should be supplied in a finished form, suitable for reproduction. Figures will not normally be redrawn.

Proofs will be sent to authors if major alterations have been made to the text.

The Editorial Board reserves the right to edit material submitted for publication.

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CHARTERED SOCIETY OF PHYSIOTHERAPY
DIGNA SEQUI

In this issue

Travels to Siberia with
Steeper Orthopaedic Ltd.

A Short Stay in the Black Forest.

An Indian Experience.

Paediatric Physiotherapy in Oman.

Working in the North West Frontier Province
of Pakistan.