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<i>Contents</i>	<i>Page</i>
Editorial	3
Letters to the Editor	4

ARTICLES

Measuring Motor Goals in Children with Cerebral Palsy	6
Eva Bower and D L McLellan	
Assessing Motor-skill Acquisition in Four Centres for the Treatment of Children with Cerebral Palsy	15
Eva Bower and D L McLellan	
Disclosure of Developmental Disorders	23
Dr Ian McKinlay	
Bobath Baby Course	28
Joyce Roberts	
Paediatric Physiotherapy in Cape Town	29
Adele van der Westuizen	
Group Therapy for Children with Co-ordination Problems	32
June Norton & Helen Twentyman	
Standards of Service for Children with Disability	36
Jill Brownson	
Statements and Annual Reviews	39
Carole Hurran	
National Conference - Edinburgh 1995	43
Reports from AGM 1995	48

REGULAR FEATURES

Here and There	63
APCP Matters	66
Membership Matters	71
Regional Reps. Reports	75
Courses	79
Job Vacancies	85

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EDITORIAL



LIN WAKLEY

Editor

Having already edited one Journal and now being in the final stages of my second, I decided, it was time, to find out what I was supposed to be producing. To do this I consulted the dictionary.

The dictionary (Collin's Concise) definition is: **JOURNAL**, noun 1. a newspaper or periodical, 2. a book in which a daily record of happenings etc. is kept, 3. an official record of the proceeding of a legislative body, and two other definitions relating to book-keeping and engineering. Looking at the first three definitions I felt that the APCP Journal fits them reasonably well.

No one can dispute that it is a periodical (definition: a publication issued at regular intervals) and in the loosest context it does contain some news items so could be classed as a newspaper. It's not so long ago we changed it's title from Newsletter.

The Journal is a record of happenings, albeit, not on a daily basis. It contains articles reporting happenings around the regions and overseas.

It isn't the official record of proceedings of the legislative body as that is in the minute book held by the secretary but it does, however, report the proceedings of National committee meetings which are relevant to members.

This edition of the Journal appears to fit these definitions fairly well. Although it has no common theme running throughout but is a mixed bag of subjects it does contain the required elements of a journal. The articles range from research papers to reports of general interest including the Annual Conference and the AGM and the second part includes the regular features, APCP and membership matters, regional representative reports, courses and job vacancies. I therefore sincerely hope that you will all find it as interesting and stimulating to read as I have found it to edit.

This year we have changed the order for reporting the proceedings at the Annual Conference. In order that the Organising Committee have more time to collate the lecture notes they will not be published until November. It is however important that the members unable to attend Conference should have reports from the AGM as soon as possible so they have been included in this edition.

The August edition has the title **SPORT AND RECREATION**. If any one has anything of interest that would come under this title I would be very pleased to hear from you. It could be an account of your involvement as a paediatric physiotherapist in any sport or activity with disabled or able-bodied children during work or in your free time.

LETTERS TO THE EDITOR

From: Lindsay Wrightson
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Dear Madam

I am reading for a degree in Health Studies and want to look at two topics which I am finding difficulty in getting literature on:-

- a) are other physio's being asked by Health Visitors or G.P.s to double check at eight months (or so) for possible CDH? Especially on the strength of an asymmetrical buttock crease?
- b) are other physios being asked to treat talipes calcaneo-valgus in the neonate? If so are all or some being referred? Is there a criterion for referral?

Thank you
Lindsay Wrightson

P.S. Well done on the new look and better quality Journal



sektionen för habilitering

Anna Kågeson
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Sweden

Dear Representative for Physiotherapists for children,

I am writing to You as the director of board of the Section of Habilitation - Physiotherapists (rehabilitation of children with congenital diseases) part of the Swedish Physiotherapist Union.

The section has 450 members, spread all over Sweden. We work in hospitals, out-patient clinics and habilitation centres.

The objective of the work of the section is to:

- support unity between physiotherapists working with children nationally and internationally.
- spread information about actual research.
- initiate mutual efforts in quality assurance of the PT methods being used.
- work for qualified training of PT:s in the children's field.
- be a body of remittance for the authorities.
- spread information to people about children with handicaps.

The work is carried out by:

- General Annual meeting in March every year.
- written information to the members 3 - 4 times/year.
- seminars.
- workshops.
- meetings and discussions.
- participation in various arrangements concerning children with handicaps.

LETTERS TO THE EDITOR

The board of the Section meets about 7 times a year. To it's help the Board has 38 contact persons around Sweden.

Our members are very active and interested in their field of work. Many travel abroad and work abroad. A lot would like to visit colleges and places in other countries.

With this letter we want to get in contact with colleagues abroad. It would be very worthy to exchange experience with each other and perhaps have the possibility to visit each other. Perhaps we can make a list of addresses to other physiotherapist-organisations/sections around the world working in this special field.

We would also be ever so happy to welcome You to Sweden.

Yours Sincerely
Anna Kågeson

**COPY FOR THE AUGUST 1995 JOURNAL
MUST BE WITH THE EDITOR BY
JULY 1st 1995**

The Editorial Board reserves the right to edit
material submitted

PLEASE NOTE

At present there is **NO CHARGE** for course or job vacancy advertisements included in the Journal. I must however point out that, as it is only published quarterly and the copy date is one month before publication, contributors must be careful to send any material in good time, or they may miss their application closing dates.

MEASURING MOTOR GOALS IN CHILDREN WITH CP

Authors **E Bower** and **D L McLellan** Rehabilitation Research Unit, University of Southampton, Southampton

This paper has been re-printed from **Clinical Rehabilitation 1994; 8:198-206**, with kind permission from the publishers **Edward Arnold** and the authors **Mr Eva Bowers & Dr D L McLellan**

Four children aged two to three years with four limb cerebral palsy and apparently 'normal' intellect received randomized periods of conventional amounts of physiotherapy and a period of intensive physiotherapy directed at goals with both functional and pattern motor skill objectives. Using a single case experimental design, functional motor change was found to be continuous throughout the study period in all four children. Changes in the pattern of movement were difficult to detect or grade objectively and none of these goals was achieved, in contrast to the functional goals of which 58% were achieved. Intensive physiotherapy directed at goals that could not be achieved was associated with an increase in unco-operative behaviour in some children.

Introduction

We have suggested that the prospective identification of specific individual and measurable goals may be a feasible means of establishing the effectiveness of different intensities of physiotherapy in relatively small groups of children in the clinical situation.¹ Individual goals were set for each child and were measured regularly over a period of time during which different intensities of physiotherapy treatment were given. The goals were formulated so that it could be clearly established whether they had been reached or by how far the child had fallen short or exceeded them.

That study involved children ranging from two to 11 years with four limb cerebral palsy and severe learning difficulties attending a day school for children with multiple handicaps. The intensive period of therapy and the assessments were both undertaken by the researcher (EB). We suggested that increasing the intensity of physiotherapy in children with severe learning difficulties and cerebral palsy could accelerate the acquisition of motor skills.¹ The effect of intellect upon motor skill acquisition is unclear.²⁻⁴ Impaired intellectual function might reduce the range of skills that could be acquired and the capacity to maintain concentration over a prolonged period of intensive therapy.

Some approaches to the management of children with

cerebral palsy are concerned primarily with motor function and we have measured progression over time both by the goal method,¹ and by the Gross Motor Function Measure.⁵ Other approaches are concerned with the quality of movement, which has problems with objective assessment in the clinical situation. If postural deformity or contractures can be caused by a child using repeated abnormal patterns of movement,⁶⁻⁷ and if these deformities can cause the child to become increasingly restricted in movement, then it may be important to guide the child repeatedly to move as normally as possible.^{6,8} The treating physiotherapists in the present study were concerned with the manner in which the motor skill goals were achieved so that there was an 'acceptable pattern of movement' objective as well as a functional objective of movement for some of the goals.

The purpose of this study was to evaluate the effect of routine and intensive periods of physiotherapy with both functional and pattern objectives on motor skill acquisition in children with four limb cerebral palsy and an apparently normal intellect in the clinical situation.

The problem of establishing a stable baseline and controlling for natural maturation is particularly relevant in young children with cerebral palsy who may well change as a result of increasing age and maturation. In this study we have adopted a single-case experimental design⁹ replicated over four

MEASURING MOTOR GOALS IN CHILDREN WITH CP

children to observe the effectiveness of different intensities of physiotherapy treatment being given to a broadly similar group of children in whom a number of parallel outcomes can be measured, only some of which are targeted by the intervention. If an improvement is found only in those outcomes when the treatment is introduced then the improvement is likely to be the result of the treatment and not as a result of natural maturation. By introducing the intensive treatment at different times for different children, enhanced effects would be seen only during the intensive treatment and, in addition, a single blind design could be incorporated with the assessor masked from the intensity of therapy. Each subject was used as its own control while intensive physiotherapy was introduced and then withdrawn.

Method

Physiotherapists

Two full-time physiotherapists agreed to participate. The physiotherapists had been qualified for 18 and nine years with 16 and seven years experience of working with children respectively.

Subjects

The physiotherapists were asked to identify children under five years of age with an established diagnosis of four limb cerebral palsy.

Four children coded 1, 2, 3 and 4, aged two to three years, of apparently 'normal' intellect and all boys were identified by the physiotherapists.

The children were classified on the Standard Recording of Central Motor Deficit,¹⁰ by the research physiotherapist with the treating physiotherapist and a parent. The results are shown in Table 1.

Location

Three of the boys (1, 2 and 3) from one playgroup were treated by one physiotherapist and the fourth boy (4), was treated by the other physiotherapist attending a different playgroup.

Identification and formulation of goals

The treating physiotherapists assessed each of their children and set the number of goals per child that they considered could realistically be achieved during the study period. A total of 26 goals were set for the four children of which 24 were in the category we have previously designated 'achieve a motor skill'.¹ Only the results relating to these 24 goals will be presented here. Eighteen goals were set before the first five-week control phase and five additional goals were set at the end of this phase. Three of these additional goals belonged to child 3 and two of them belonged to child 4.

The goals were negotiated with parents and playgroup staff. Programmes relevant to the goals were suggested throughout the entire study period as was customary by the therapist.

Categorization of goals

Eleven of the 24 goals had acceptable pattern of movement objectives (pattern objectives) plus functional movement objectives (functional objectives) and 13 had functional objectives only.

An example of a goal with a functional objective was:

Child 1, Goal 1:

Baseline: when placed in forearm support prone lying by physiotherapist did not maintain position independently.

Gal: Maintain position for 30 seconds independently.

An example of a goal with a functional and pattern objective was:

Child 2, Goal 5:

Baseline: in high kneeling position (*with legs abducted*) at a table could support himself independently with his right arm and hand and play with a toy with his left hand *whilst maintaining a level pelvis for 5 seconds*.

Goal: maintain position for 30 seconds independently.

The three children (2, 3 and 4) who were set both types of goal showed a discrepancy between their achievement of functional objectives (F) and their achievement of pattern objectives (P).

MEASURING MOTOR GOALS IN CHILDREN WITH CP

Table 1 Classification of all the children ($n=4$) on the Standard Recording of Central Motor Deficit

Child age	1 2 years, 1 month	2 3 years	3 2 years, 9 months	4 2 years
Observed abnormal unwanted movements				
a) at rest	No	No	No	No
b) with movement	Yes	No	No	Yes
Felt abnormal tone	Yes all limbs increased	Yes all limbs increased except L upper arm	Yes all limbs increased	Yes all limbs increased
Distribution of problems	U>L	Rt > Lt	L>U	U>L
Oral problems				
1) dysarthria	Yes	Yes	Yes	Uncertain
2) dysphagia	Uncertain	None	None	None
3) dribbling	None	Yes	None	None
Functional motor skills				
1 = least severe				
4 = most severe				
Head and neck	2	1	1	2
Trunk	3	3	2(W sit) 3 (legs in front)	3
Lower limb	4	4	4	4
Upper limb	4	3	3	3
Diagnosis	Spastic quadriplegia	Spastic quadriplegia	Spastic quadriplegia	Spastic quadriplegia
Medication	200mg eplim daily	None	None	None
Intellectual impairment	None	None	None	None
Visual defect	None	None	Yes, squint	None
Hearing defect	None	None	None	None
Communication difficulty	Yes	None	Yes	None
Seizures	Yes	None	None	None

U = upper limb
L = lower limb
Rt = right side
Lt = left side

Source: Evans et al.¹⁰

MEASURING MOTOR GOALS IN CHILDREN WITH CP

The goals have been divided retrospectively into two groups, one in which pattern and functional elements were identified (P + F) and one in which only functional elements were identified (F).

Provision of therapy

The children were assigned by the treating physiotherapist masked from the researcher, to an ABAA or AABA trial design. Child 1 was on ABAA design and children 2, 3 and 4 were on an AABA design.

The study lasted 20 weeks, comprising four treatment phases of five weeks. During 'A' phases the children received their usual amount of physiotherapy, approximately one hour per week, during 'B' phases they received one hour each weekday.

Assessment

Measurements of the activity in which goals had been set were taken by the research physiotherapist before the study began and at five-weekly intervals throughout the study period. These were agreed by a joint decision between the treating physiotherapist and a parent. By specifying a time or distance to be achieved it was possible to express progress towards the functional objectives in percentages. Where a time or distance was not specified, the research physiotherapist assessed the progress towards the functional objective as a percentage and this was agreed with the treating physiotherapist. There was very little, if any, divergence of opinion. Pattern movement objectives could not reliably be graduated by this method. These were recorded by agreement as above, as either achieved or not achieved.

Measures

- 1) Performance of the specific measurable goals set individually for each child as outlined above.
- 2) Gross Motor Function Measure.⁵ This measure has a selection of 88 items arranged in five groups (1) lie and roll; (2) sit; (3) crawl and kneel; (4) stand; (5) walk, run and jump. The starting position is described for each item and the progression from it scored through four stages. The score is only counted if performed without any hands-on help.

Results

Status of the children prior to treatment

The functional motor skill abilities of each child prior to the study are shown in Table 1. Children 2, 3 and 4 were mobile on the floor, i.e. child 2 and child 4 commando-crawled and child 3 bunny hopped. No child reciprocally crawled.

Additional therapy given

The mean amount of treatment given to each child during an 'A' (control) phase of five weeks amounted to four hours 48 minutes and the mean number of sessions per child amounted to eight. In 'B' (intensive) phases of five weeks it amounted to 23 hours 58 minutes and the mean number of sessions amounted to 24.

Type of therapy given

The therapy given in this study was largely of the 'neurodevelopmental school',⁶ including periods of inhibition to abnormal postures by corrective positioning and handling and facilitation of more normal methods of movement along developmental and functional lines, the physiotherapists using key points of control at the proximal joints of the children usually administered by their hands.

Goals

P + F goals

By the end of the study period, 10 of the 11 goals with both pattern and functional objectives had achieved their functional objectives but not their pattern objectives. One goal had been 'partly achieved', that is the child could maintain the correct position independently but not for the length of time required to attain the goal.

F goals

By the end of the study period, three of the 13 goals with functional objectives only had been achieved, two goals were 'partly achieved' (as described above), five goals required hands-on facilitation and three goals had been abandoned.

Relationship between intensities of therapy and rates of progress towards the goals

P + F goals

For seven of the 11 goals with both pattern and functional objectives, the fastest rate of functional progress was achieved during the phase directly before the intensive phase of therapy. In three, functional progress was fastest during the intensive phase of therapy. In three, functional progress was fastest during the intensive phase and in one, functional progress was fastest in the final phase.

Rates of progress towards motor skill goals are tabulated in Table 2.

F goals

Of the 13 goals with functional objectives only one showed fastest progress in the first phase. One in the second phase prior to the intensive phase, seven showed fastest progress during the intensive therapy phase, one in the post intensive phase and three showed no progress at all.

Rates of progress towards motor skill goals are tabulated in Table 3.

Figure 1 illustrates that the rate of progress towards the functional objectives of all the 24 motor skill goals changes significantly ($p < 0.01$) in all phases except in the final phase.

Changes in the Gross Motor Function Measure⁵

After the Gross Motor Function Measure was administered at each of the five assessments we divided the dimensions on the inventory of the Gross Motor Function Measure (e.g. lie and roll, sit, etc.) into those in which goals had been set and those in which goals had not been set. Consequently, at the end of the study period we were able to compare changes in overall function in goal and nongoal dimensions for each treatment period.

Goal areas of the Gross Motor Function Measure

Three out of four children improved in the first phase and one child remained static. All children improved in the phase immediately before the intensive phase. All children improved in the intensive phase and all children regressed in the final phase (figure 2).

Nongoal areas of the Gross Motor Function Measure

Three out of four children improved in the first phase and one child regressed. All children improved in the phase immediately before the intensive phase. All children improved in the intensive phase and all children regressed in the final phase (Figure 3).

Table 2 Changes in the percentage rate of *functional* progress of each goal ($n=11$) with both pattern and functional objectives during the different intensities of physiotherapy treatment (P + F goals)

Discussion

The Standard Recording of Central Motor Deficit¹⁰ used in this pilot study to classify the four children may be a useful tool to identify broad similarities and differences in children with a central motor deficit. It would be helpful to adopt this system in future studies so that results can more easily be compared.

These study results raise the possibility that intellect may influence outcome. Children included were considered to have normal intellect by the treating physiotherapist and nursery staff. It was difficult to find measurements of intellectual capacity in the children's hospital or nursery notes. We suspected that child 1 did have a mild learning disability.

The intensive treatment period in this study was longer than in our first study. The children with least evidence of learning disability had most difficulty in tolerating it.

The full complement of therapy during the intensive treatment periods of 25 hours given over 25 sessions could not be achieved in every case because of tantrums displayed by child 3, the least disabled child and 4, the youngest child. Therapy of this intensity could lead to boredom, frustration and behavioural problems in certain children, especially if they have an active mind and like to set their own objectives in day-to-day activities or if they find the goals too difficult or incomprehensible. This seemed to us the most likely explanation for the tantrums that occurred.

MEASURING MOTOR GOALS IN CHILDREN WITH CP

Table 2 Changes in the percentage rate of *functional* progress of each goal ($n = 11$) with both pattern and functional objectives during the different intensities of physiotherapy treatment (P + F goals)

Goal no.	Routine treatment			Intensive treatment	Routine treatment	
	First assessment	Second assessment	Third assessment		Fourth assessment	Fifth assessment
5	16.66	20	25		66.66	50
7	15	50	100		100	100
9	16.66	26.66	400		800	800
10	0	0	100		100	100
11	25	25	100		100	100
12	*	0	36.66		66.66	100
15	10	50	100		100	50
16	0	50	100		100	50
17	0	0	100		140	300
18	0	50	120		600	600
19	0	50	100		100	100

*Goal 12 set after first routine treatment period

Table 3 Changes in the percentage rate of progress of each goal ($n = 13$) with functional objectives only during the different intensities of physiotherapy treatment (F goals)

Goal no.	Routine treatment		Intensive treatment	Routine treatment	
	First assessment	Second assessment		Third assessment	Fourth assessment
1	0	6.66		26.66	3.33
2	25	25		30	30
3	0	16.66		26.66	6.66
4	20	20		100	100
Goal no.	Routine treatment		Intensive treatment	Routine treatment	
	Third assessment	Fourth assessment		Fifth assessment	
6	0	30	100	100	100
8	0	20	20	60	50
13	*	0	25	100	100
14	*	0	0	0	0
20	0	20	30	50	50
21	0	0	0	0	0
22	16.6	40	0	0	0
23	*	16.6	22.5	50	45.8
24	*	0	0	0	0

*Goals 13, 14, 23 and 24 set after first baseline period

MEASURING MOTOR GOALS IN CHILDREN WITH CP

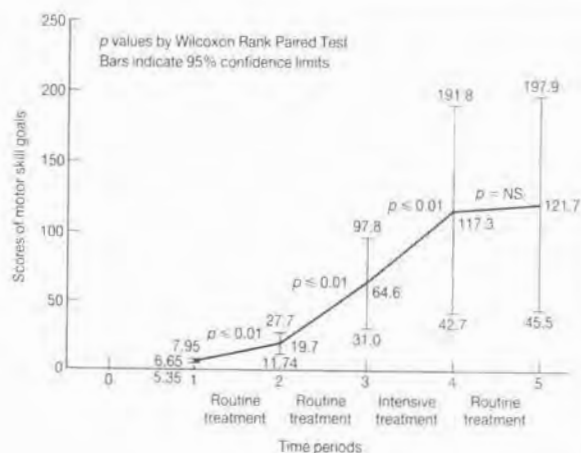


Figure 1 Change in the rate of motor skill progress (function only) in all 24 motor skill goals; p values by Wilcoxon rank paired test; bars indicate 95% confidence limits.

Two goals plateaued during the intensive phase and regressed during the final phase. This might be explained by the fact that this child was mobile on the floor using commando-crawling and he may have been frustrated by his attempts at holding a position with an imposed pattern objective. He was one of the children who displayed tantrums during the intensive phase of therapy. In other children, however, increased intensity may provide encouragement, for example child 1, the most severely disabled child, became much more tolerant towards physiotherapy and the mother of child 2, developed a much better relationship with the physiotherapist during the intensive phase.

There was no evidence to suggest that parents gave differing amounts of input to the children during different treatment periods. Three of the children had younger siblings and the mother of the fourth had a job.

Single-case research is based upon gaining steady-state conditions before intervention and then comparing intervention to this baseline. A steady-state baseline of improvement was on the whole obtained. By measuring motor change before and after successive periods of routine and intensive therapy the study has illustrated that functional improvement was continuous and could not be attributed to change in intensity of therapy. Figure 1 illustrates this point.

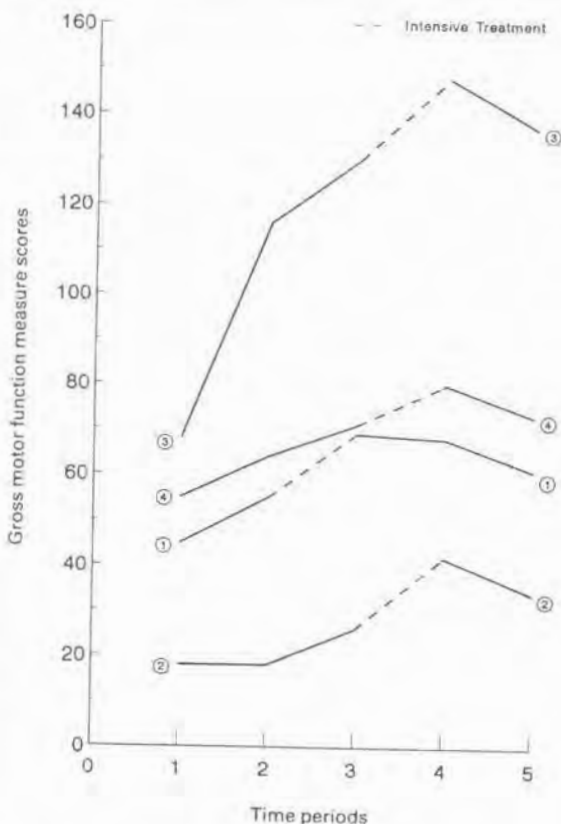


Figure 2 Individual children's Gross Motor Function Measure⁵ scores in the dimension into which goals were set during the study period

As progress was made in both goal and nongoal areas of the Gross Motor Function Measure⁵ as illustrated in Figures 2 and 3 it is probable that these children were improving by natural maturation.

A no-treatment period was not included in this study to control for motivational effect. Although this is to be regretted it was felt that control for the washout effect and the problems to be encountered with parents, therapists and ethical committees would have been insuperable.

As the therapists in this study were concerned not only with quantity (whether motor objectives were achieved) but also with quality (the manner in which the movement was carried out) they may have restrained functional change to encourage the development of a more normal pattern of movement.

MEASURING MOTOR GOALS IN CHILDREN WITH CP

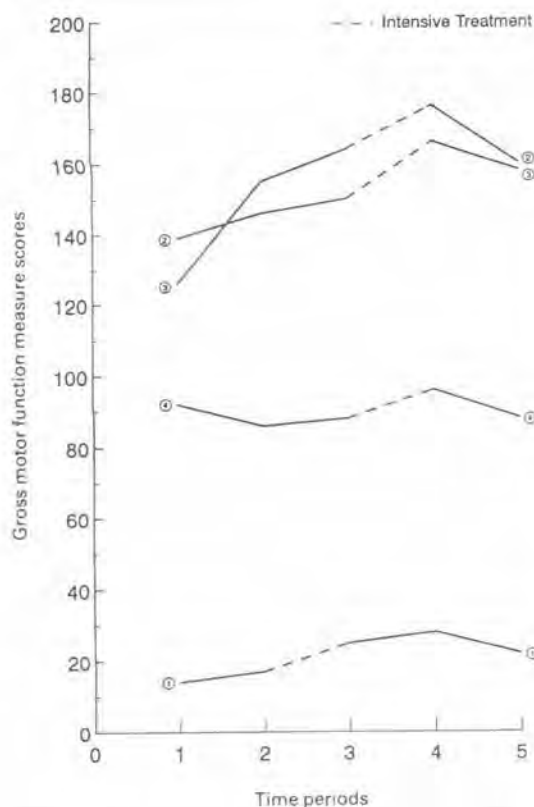


Figure 3 Individual children's Gross Motor Function Measure⁹ scores in the dimensions into which goals were not set during the study period

This may have influenced the large number of motor function objectives, nine out of 11, achieved by unacceptable patterns of movement before the intensive phase of therapy. It is possible that the children were more interested in whether a functional objective was achieved than in how it was achieved, and that their parents were better able to assess progress towards functional than towards pattern objectives.

Some disabled children, like nondisabled children, may acquire a motor function first and perfect it later, for example the early valgus broad-based gait often seen in otherwise normal children when they first walk. It is also possible that the children would never have been able to perform the movement in an acceptable pattern because of the type or extent of their deficit, in other words unrealistic pattern

objectives had been set. A sense of failure and disappointment may not be the only unwanted effect of setting unrealistic pattern goals. As the Bobaths¹¹ pointed out delayed weight bearing may cause a lack of 'modelling' of the hip joint leading to subluxation and dislocation. If there is a genetically programmed time for children to acquire a motor function it may be incorrect to try to override this by holding a child back in the hope of obtaining a more normal pattern of movement or in trying to advance it by practise. The two goals with both pattern and functional objectives, which exceeded their functional objectives by 700% and 500%, were both concerned with sitting. Children with moderately severe quadriplegia, controllable tonic neck reflex activity and intact parachute reactions should achieve independent sitting before six years of age.¹²

Only three goals with functional objectives only were achieved. Two were dependent upon getting both hands forwards to grasp a bar, a visual and manual task, and the other goal required verbal prompting throughout to remind the child.

The three goals 'partly achieved' were all static goals in which the child was placed in, and could hold, a position as required by the physiotherapist even if not for the length of time specified. Children may find it easier to be placed in a static position and hold it as required than to perform a dynamic movement as required.

The results indicate that the therapists' expectation for function were more often met than their expectations for improvement in the pattern of movement. It was difficult to detect or measure objectively the rate of progress of the pattern objectives throughout the study period despite the use of videotape. In any future study a rigorously controlled standardized protocol both for filming and interpreting the videotape would need to be developed.

Both the treating physiotherapists found the precise definition of the treatment goals, as opposed to the formulation of generalized treatment aims, to be a new and difficult task. It is clear from the results that goal setting can be a difficult exercise. Ten goals were achieved earlier than expected and 12 goals were never achieved. Twenty weeks may have been too

MEASURING MOTOR GOALS IN CHILDREN WITH CP

long a period over which to set goals especially if the usual goal setting period was much shorter and this may have led to some distortion in the goal setting process. Further studies of the goal setting techniques in current use would help to improve the design of trials of treatment.

Acknowledgements

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ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

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Despite claims that certain regimens of training motor skills are more effective than others (Cottam and Sutton 1986), there is no good evidence or understanding of the effect of any one centre's approach to the acquisition of motor skills in children with cerebral palsy (Bower 1993).

It is difficult to test scientifically whether one centre of treatment is more effective than another. The individual attributes, expectation and experiences of the children being treated, and those of their families and the staff treating them, are likely to vary. A prerequisite for such a study is a systematically collected body of information about the centres.

We have suggested that goal-setting in physiotherapy involves identifying and formulating standards of motor activity which are in advance of the child's current capacity or which retard deterioration. The process consists of assessing the child, setting the goals, undertaking the intervention and, after a set time-period, evaluating the goals to ascertain to what extent they have been achieved (Bower and McLellan 1994).

The initial aim of this study was to evaluate the goal-setting procedures of four different centres for treatment of children with cerebral palsy and to test them against gains in skill subsequently achieved by children treated there. Parental satisfaction with the treatment at each centre over the time in which change was expected was also evaluated. During this process, we collected further information which provided a basis for systematic comparisons to be made between centres.

To include all the important factors across the range of available schools of treatment, we selected four centres espousing different approaches to cerebral palsy. Centre 1 defined their approach as aim-oriented management (Scrutton 1984); centre 2 used the Bobath approach (Mayston 1992); centre 3 used conductive education (Cotton, personal communication); and centre 4 defined their approach as eclectic (Levitt 1982).

Method

The head of each centre was approached, and the purpose of the study was explained. It was emphasised that we were seeking a method of describing the salient features of such centres and that at this stage we were not attempting to establish whether one centre was more effective than another. The heads of the first four centres approached readily agreed to participate. The features of the centre and of its treatment considered by the head to be of particular significance were noted, and these were collated into a single inventory which we subsequently employed. It was agreed that we would carry out assessments on a relevant subpopulation of the children at each centre at different stages during their treatment and discuss the objectives set with the staff and parents concerned.

Since the children were being selected by the centres and no randomisation procedures were being employed, we advised the centres that we would not be in a position to evaluate the effectiveness of the treatments, but would simply relate the approach used to the severity of the children's motor impairment, and record the extent to which changes in the motor abilities of the children reflected the objectives set for them by the staff.

Phase 1 of the study included these initial approaches, the collection of relevant data and the identification by staff at each centre of all children with an established diagnosis of quadriplegic cerebral palsy (previously confirmed by a consultant paediatrician) under the age of eight years and currently receiving treatment from the centre.

Phase 2 involved a series of assessments of nine of these children (or as many as possible if fewer than nine were available at any centre) by E.B., in conjunction with their usual therapist and parent in the location in which treatment usually took place. Each child was seen on three occasions, the intervals between being governed by the customary frequency with which objectives were reviewed - varying

ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

between two weeks at centre 3, five weeks at centre 4, and three months at centres 1 and 2. On the first occasion, the initial objectives were set and the functional status of each child was classified on the Standard Recording of Central Motor Deficit (Evans *et al.* 1981). On the second occasion, the initial objectives were reviewed and adjusted; and on the last, the objectives were expected to have been reached.

At each assessment, the child's parent and therapist completed separate written questionnaires in the presence of the observer and without reference to each other. The questionnaires included visual analogue scales to measure parents' expressed satisfaction with the treatment. The therapists were asked to document their goals for the defined time-period (as summarised in Appendix A). On each occasion the child was assessed by the researcher using the Gross Motor Function Measure (GMFM) (Russell *et al.* 1989). In all centres except centre 3 referral had been in conjunction with a paediatrician; a questionnaire was sent to each referring paediatrician, seeking the information summarised in Appendix B (all questionnaires are available from the authors on request).

Results

PHASE 1

Selection of children

Centre 3 selected specific children aged between 18 months and seven years for their intervention. The other three centres accepted any children for treatment, although all children at centre 4 were aged over three years since it was a school.

Treatment

Children attending centre 1 received the least amount of treatment: it varied from once-weekly to once every six weeks, according to perceived needs. At centres 2 and 4, children usually received between 30 and 60 minutes once- or twice-weekly. Those attending centre 3½ received two to three hours twice-weekly if aged under 3½ years, and seven hours daily if older.

Therapists from centre 1 treated children in their own environment; centres 2, 3 and 4 expected children to

attend the centre.

Centre 2 expected a parent to be present throughout treatment. At centre 3, children aged under 3½ years worked with a parent; older children did not have their parents present.

Children attending centre 3 aged over 18 months were seen in groups led by nursery nurses or teachers. At the other three centres children were seen individually by physiotherapists.

Assessment and goal-setting

None of the interventionists at any of the centres routinely used established assessment scales. Range of joint movement and muscle strength were often measured before orthopaedic appointments at centre 1. Intellectual assessment featured prominently only at centre 3.

All centres set aims or goals. Centre 3 set goals which were always documented, measurable and were expected to be achieved within a two-week period. The other three centres were less systematic, and their aims or goals often did not lend themselves to precise measurement.

Centres 1 and 2 reviewed their children three- and, more formally, six-monthly. Centre 3 reviewed children fortnightly. Centre 4 reviewed children half-terminally (1 ¼ months) and, more formally, terminally (2 ½ months).

PHASE 2

Nine of a total of 55 potentially eligible children were selected by centre 1, nine out of 38 by centre 2, nine out of 10 by centre 3, and six of an unknown total of potentially eligible children by centre 4.

The mean number of years for which the children had been attending each centre was as follows: centre 1, 2.3 years; centre 2, 1.6 years; centre 3, 1.6 years; and centre 4, 1.5 years.

The mean ages of the four groups of children were: centre 1, 3.1 years; centre 2, 3.3 years; centre 3, 3.9 years; and centre 4, 5.5 years. Table 1 gives a breakdown of the motor skill in different parts of the body. The children of centre 1 appear similar to those of centre 4, but they are on average 2.4 years younger. The levels of function apparent at the age of three would be expected to have improved by the age of

ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

TABLE I

Mean scores of children on the Standard Recording of Central Motor Deficit (sections 5 to 7)

Functional motor skills*	Centre 1	Centre 2	Centre 3	Centre 4
Head and neck	1.6	2.5	2.0	1.8
Trunk	2.4	3.0	2.8	2.5
Lower limb	3.5	3.8	3.4	3.1
Upper limb	3.1	3.6	3.2	3.1

*1 = least severe; 4 = most severe.

TABLE II

Goals set for each child on each occasion in each centre

	Centre 1	Centre 2	Centre 3	Centre 4
N goals set				
Median	4	3	4	5
Mean	4.1	3.2	4.5	4.5
Range	2-6	2-6	2-6	3-7
N of above goals which could be allocated to dimensions of GMFM				
Median	2	2	3	2
Mean	2.2	1.8	2.6	2.2
Range	1-3	1-3	1-4	1-3
Mean N of set goals allocated to following dimensions of GMFM:				
Lie and roll	0.2	0.2	0.4	0.2
Sit	0.6	0.9	0.8	0.6
Crawl and kneel	0.3	0.1	0.0	0.2
Stand	0.3	0.6	0.9	0.6
Walk, run and jump	0.7	0.1	0.5	0.5

5½ years, therefore it is probable that the children attending centre 1 had a somewhat less severe disability than those attending centre 4. Centre 2's children were the most severely impaired and centre 4's children were the most ambulant, but they were also the oldest.

Two children from centre 3 withdrew after the first assessment session. One child withdrew from centre 2 after the second assessment session.

Although it was intended that each child would be assessed at the beginning of the study, at the midpoint and at the end of the study, in practice the midpoint assessment time varied in all the centres due to changes of appointment both by the interventionists and the parents.

Aims or goals

By asking interventionists to document their aims or goals for each child, we were able retrospectively to select those expected to change a gross motor skill. We then divided the dimensions of the inventory of the GMFM for each child in each centre into those for which motor-skill aims or goals had been set and those for which motor-skill goals had not been set. This enabled changes in the children's overall function or goal and non-goal dimensions to be analysed.

Examples of aims or goals which could be allocated to the inventory of the GMFM were: improve rolling to gain independent floor mobility; increase length of hamstring muscles to improve long

ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

sitting position; facilitate reciprocal movements in upper and lower limbs to improve creeping; maintain standing, holding with one hand only; and transfer and bear weight on right leg, enabling stepping with left leg.

Examples of aims or goals which could not be allocated to the inventory of the GMFM were: improve relationship between child and therapist; obtain an electric wheelchair; and improve sleeping habits.

The number of aims or goals set per occasion per child and the number that could be allocated to the GMFM in each centre are shown in Table II.

Changes in motor function

During the period of observation no one category of change in function predominated, but improvement did occur in all the children. A few functions deteriorated in some children at each centre, but in every case such deterioration was offset by gains in other areas.

There were nine children at centre 1, and combined review periods totalled six months; there were eight children at centre 2, and the combined review periods also totalled six months; in centre 3 there were seven children, whose combined review periods totalled one month; and centre 4 had six children, whose combined review periods totalled 2½ months.

Figure 1 illustrates the change in dimensions of the GMFM in which aims or goals were and were not set. The only statistically significant difference was found at centre 1 during the first study period, in improvement between aim and non-aim dimensions ($p < 0.05$, Wilcoxon signed rank test); however, this result was not sustained in the second study period, nor did it persist when both periods were combined. No other significant differences were found between the aim/goal and non-aim/goal dimensions at any of the other centres in either improvement or deterioration, for the first, second or combined study periods.

Parental satisfaction

During the period of observation, parents of the children attending centre 2 were the most satisfied and parents of children at centre 4 were the least

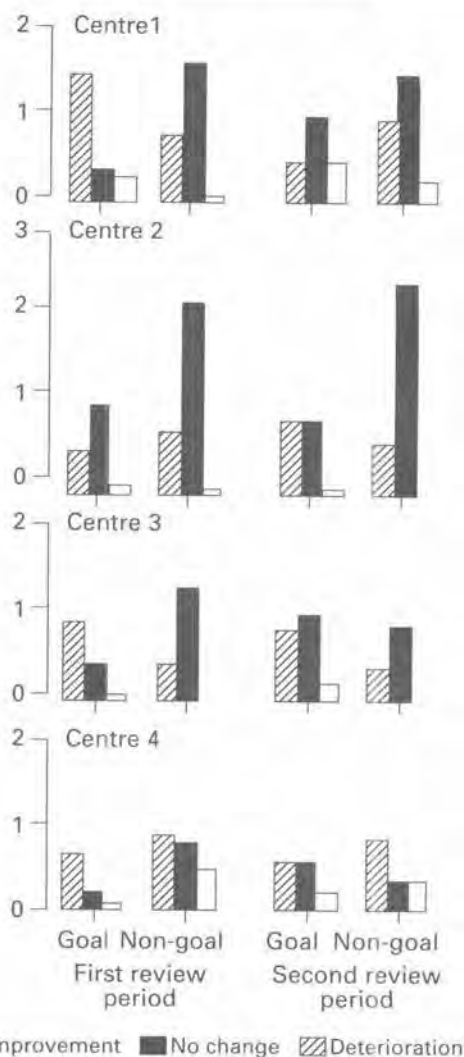


Fig. 1. Mean scores of children who shows improvement, no change and deterioration in dimensions of the Gross Motor Function Measure, in which therapy aims or goals were set or not set in each of two review periods at each centre.

satisfied with the treatment. Figure 2 illustrates the change in parental satisfaction over the study period. No significant differences were found between the assessments in any of the centres. The greatest improvement occurred during the first period at centre 1 and the greatest deterioration during the second period at centre 4.

ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

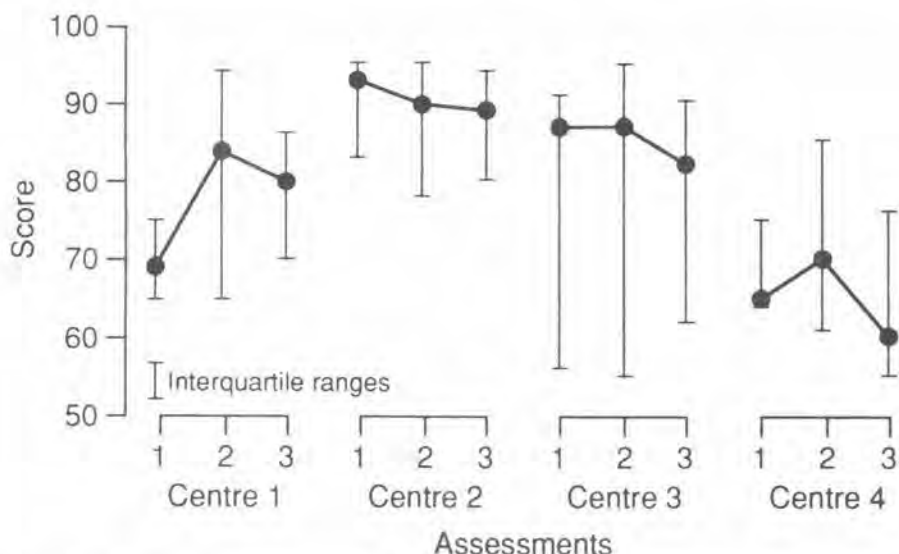


Fig. 2. Median raw scores (and interquartile ranges) of parental satisfaction with treatment at each centre at each aim- or goal-review session.

Discussion

In evaluating the relative effectiveness of different methods of treatment, appropriate approaches may be a series of single-case studies employing randomisation and control of biasing factors (Gianutsos and Gianutsos 1988), or group trial designs. The latter method is more difficult and costly to mount, and may not be the most efficient way of settling the issue, given the wide range of factors likely to determine effectiveness in an individual case. At present there is little to guide the clinician who is asked to advise a child and parents on the approach most likely to help. We suggest that the range of information reported in this study is potentially valuable both for planning future systematic trials of treatment and for enabling parents and clinicians to make an informed choice as to which centre to approach.

The data demonstrates systematic differences between the centres in most of the areas in which information was sought. Geography, transport and finance were all significant factors. For example in centre 1 therapists travelled to see the child, but in centre 4 children were brought in by bus from a wide area. Thus the therapist working in centre 1 had much more contact with parents, and although the therapists

themselves spent fewer hours in carrying out the treatment, the programme incorporated periods during which parents would practise helping their child to achieve the set objectives.

One weakness of this study is that children were selected by staff from all those with quadriplegic cerebral palsy attending the centre. This was a practical necessity in enlisting co-operation and allaying fears that we might make inappropriate claims for or against the effectiveness of their treatment. Nevertheless, it is self-evident that children with severe impairment would more readily be included by centre 2 than centre 3, where treatment methods depend on the child's ability to communicate effectively.

One of our original aims in mounting this study was to relate the goals of intervention to subsequent changes in function or motor skill. The accuracy with which future change is predicted depends to a large extent on the experience and skill of the therapist making the prediction. Skill in prediction is not necessarily the same as effectiveness in bringing about change in function, but it is hard to see how any therapist can refine his or her treatment method without auditing the achievement or non-achievement of objectives. There is good evidence that skills tend

ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

to generalise poorly. Therefore an indirect indicator of the precision - to put it no stronger - of a treatment is the differences between changes in functions incorporated within the objection and changes in functions that lie outside it. We have adopted this approach elsewhere, in a series of single-case experiments using the GMFM (Bower and McLellan 1994).

In the present study, all four centres included other categories of aims or goals in addition to skill acquisition, and these aims or goals were all perceived as equally important by the staff. The goals set at centre 3 related mainly to manual dexterity and cognition. The other three centres included a wider variety of aims or goals, many of which could be classed in our categories 'achieve a state' and 'establish a daily programme' (Bower and McLellan 1992).

Improvements in motor skills could be observed in both aim/goal and non-aim/goal dimensions of the GMFM at all centres. Over the combined two study periods there was a slightly higher improvement in the goal dimensions of the children attending centre 3. However, centre 3 selected its children, had a well-defined goal-setting procedure over a short period of time and had more goals in the lie and roll dimension of the GMFM than did the other three centres.

The children we studied at centre 2 (who tended to be more severely impaired than the other children, and whose treatment focused on quality of movement) showed less evidence of deterioration over the study period. This may reflect a lower tendency for day-to-day variability among more severely impaired children. The children attending centre 1 were the most able, and routinely received the least treatment. This was the only group that showed statistically significant improvement in targeted areas of motor function compared with non-targeted areas, and even this result was not sustained during the second period. Such a discrepancy could reflect the re-acquisition of previously achieved function during the first phase.

Children attending centre 4 were the oldest and most ambulant in this study. Both their improvement and deterioration were the most labile, and they demonstrated fewer instances of failure to change

during the study period.

The most satisfied parents were those who had requested treatment and were attending the centre at which they were expected to be present during treatment. During the study the greatest increase in satisfaction occurred in the group of parents whose children achieved significant improvement in targeted, as opposed to non-targeted, areas. These parents were encouraged to practise the skills at home. The greatest decline in satisfaction was displayed by parents who routinely had least contact with the therapist. This could reflect an initial burst of increased morale brought about by the increased contact involved in initial assessments.

Given that there is still no convincing evidence to support a general preference for one treatment method over another on the grounds of effectiveness, the subjective opinions of referring paediatricians and staff of the centres and parents are of direct clinical relevance in making comparisons and choices between centres for individual children and their families. These opinions have to be linked to relevant characteristics of the staff and parents themselves in order to establish effective guidelines to help parents choose the centre most likely to satisfy their, and their child's needs.

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ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

Appendix A

Documentation of aims or goals at each of the three assessment sessions.

The interventionists were asked to document their aims or goals for each child by replying to the following questions:

- (1) Are the goals divided into different categories? if so, please state categories:
 - 1.
 - 2.
 - etc.*

- (2) Are the goals set expected to help an underlying daily living function to improve? If so, please state:

Goal	Function
1.	1.
2.	2.
<i>etc.</i>	

- (3) Are the goals measurable? If so, how are they measured?
 - 1.
 - 2.
 - etc.*

Appendix B

Summary of information collected from referring paediatricians' questionnaire*

	Centre 1 (N=9)	Centre 2 (N=8)	Centre 4 (N=6)
Who first suggested that the child be referred for physiotherapy?	Doctor (N=6) Not known (N=3)	Parent in all cases	Doctor in all cases
What is the most valuable benefit of physiotherapy likely to be to this child?	Better movement pattern (N=2) Child feels more confident (N=2) Prevention of deformity (N=1) Increased independence in later life (N=1) Parents feel more supported (N=1) Don't know (N=2)	Parents better able to handle child (N=5) Better movement pattern (N=2) Increased confidence in later life (N=1)	Prevention of deformity (N=4) Better movement pattern (N=1) Increased independence in later life (N=1)

*Medical referral was not required at centre 3.

ASSESSING MOTOR-SKILL ACQUISITION IN FOUR CENTRES FOR THE TREATMENT OF CHILDREN WITH CEREBRAL PALSY.

SUMMARY

An inventory of factors has been established that are important in defining the nature and circumstances of centres providing treatment for children with cerebral palsy. A method was developed for assessing the precision of the effects of aim- or goal-setting procedures, which were found to differ widely between centres. A knowledge of these factors and an understanding of the needs of individual parents and children is of potential value in the design of future trials employing randomisation and control of biasing factors, and in helping parents choose the centre most likely to meet their needs.

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DISCLOSURE OF DEVELOPMENTAL DISORDERS

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It is now 10 years since Cunningham, Morgan and McGucken (1984) demonstrated unsatisfactory progress in early disclosure of Down's Syndrome. They re-iterated sound recommendations that such information should be given by an experienced, sympathetic doctor to both partners together with the baby present in a quiet room. The possibility of a friend or professional sitting in and following up the discussion by a home visit, the need to offer early support and the value of a second meeting to discuss questions were encouraged. Some departments have written policies for disclosure and teach good practice to medical students as well as doctors in training.

Yet parents continue to complain about early counselling. The parents of children with cerebral palsy (Scope 1994) report that disclosure was handled poorly with longstanding consequences. There are grounds for concern and a need for a positive response. Yet there are reservations about "Right from the Start". The section on "why the delays?" is not as helpful as it might be, and will alienate doctors, even those who are sympathetic, especially the accusations of deliberate concealment for medico-legal reasons. Down's Syndrome is diagnosable at birth, though a chromosome test may be needed to be certain, whereas cerebral palsy is not and has no validating test. It is confusing to discuss both together though the principles of good practice apply to all disabilities.

Each general practitioner has one new child patient with Down's Syndrome in a career of over 30 years, including about 200,000 consultations. Only one general practitioner in two has a child patient with Down's Syndrome. Many doctors do not meet one during training. Down's Syndrome affects a third of children with learning disability and is, by far, the commonest cause. There is a wide range of expression of the disorder from those who are capable of school leaving certificate exams and independent employment and are in good health to those who never walk or talk and those who have major associated congenital malformations of the heart or bowel.

Likewise each general practitioner has a single child with cerebral palsy on his/her list. Given the diverse types of cerebral palsy he/she will only see one child (i.e. new baby) with a particular type of cerebral palsy in a professional lifetime. A general practitioner will see an athetoid child patient once in 250 years i.e. only one in six will ever have such a patient. The frequency is intermediate between cystic fibrosis and muscular dystrophy. To expert doctors in primary care to handle diagnosis and disclosure without expert support is not realistic.

There are many ways in which child health surveillance in general practice has proved beneficial. But the doctors concerned were required to attend 4-6 half days of theoretical teaching and 4-6 practical training sessions before being accredited in all aspects of surveillance. This training includes growth, nutrition, immunisation, vision and hearing, hip

DISCLOSURE OF DEVELOPMENTAL DISORDERS

examination for dislocation, detection of heart lesions, examination for undescended testes, the range of normal motor and language development, child protection and other matters. Each general practitioner sees 25 new babies per year, so the emphasis in training is to deal with common problems and to detect treatable disorders. Many paediatricians thought that this training period was far too short and are unclear about the way surveillance will be audited. But the training period will not be extended.

Only every second health visitor has a child with cerebral palsy on her "list". A new baby with cerebral palsy will come a health visitor's way every 5-10 years. A newborn athetoid child will be seen once in 100 years i.e. most will never see one. Most babies who have problems with feeding, crying, not sleeping or being sick settle down with general advice and time. It is not surprising that a health visitor may take some time to suspect cerebral palsy.

Of babies who have suffered symptomatic asphyxia (i.e. as well as having objective evidence of asphyxia they have neurological symptoms such as seizures, inability of swallow leading to tube feeding, irritability, unexplained vomiting, excessive stiffness or floppiness) only between a quarter and a sixth turn out to have cerebral palsy (Brown 1976). Symptomatic asphyxia affects 6 babies per thousand. All the parents of those children will be desperately anxious about the outcome. Yet, for most, the outcome is not that they have a child with cerebral palsy.

Many babies under 1000 grams at birth have brain abnormalities on ultrasound (Paneth et al 1994). Some degree of intraventricular haemorrhage or intercerebral haemorrhage or cystic change is commonplace. Few turn out to have cerebral palsy and prediction is difficult. Some have extensive pathology (periventricular leucomalacia) which makes it probable that the child will have cerebral palsy. Conversely a number of children with later diagnosed cerebral palsy have normal brain scans. All parents of low birthweight babies are anxious about the outcome.

Premature babies who have not been ill often feel stiff instead of semi-flexed 40 weeks after conception. This is described as dystonia of prematurity. More than ninety percent of them turn out to be normal but all of their parents will have been concerned.

There is a wide range of normal motor development. In the National Child Development Study of over 15,000 children born in a week in April in 1958 and followed up, it was found that 42 children per thousand were not walking at 18 months (Davie et al 1972). Of these about 2 per thousand turned out to have cerebral palsy.

There is a normal variant of motor development associated with low muscle tone in 5-10 per cent of the population (Robson 1970). Such children do not crawl - they roll, creep, bottom shuffle or just stand and

DISCLOSURE OF DEVELOPMENTAL DISORDERS

walk. Some of these children are not walking at 2 years 3 months old, yet turn out to be normal. One whom I saw years ago who did not walk till 2 years 6 months has become a professional footballer. Many parents of such children are worried about there being "something wrong" but there is a good outcome. Indeed there are some advantages in later life in having lax tone e.g. for high jumping or playing snooker or gymnastics and some such children excel. Paediatricians have been trained to be aware of this, and to be wary of describing children as abnormal when they are not.

It is common for children to go through a phase when they show unusual motor signs which are temporary. These range from excessive stiffness from overstimulation (e.g. by excessive use of baby walkers or supported walking) or floppiness and lack of balance from understimulation (e.g. from excessive time spent in a pushchair). Their physical signs will raise concern about cerebral palsy but children outgrow them.

Nelson and Ellenberg study (1982) described children who outgrew cerebral palsy. A large cohort of children born in one week was followed up. They were all examined at the age of 1 year by doctors with paediatric training. The doctors were asked to say whether the children had "definite" or "suspect" cerebral palsy at this examination. Of those described as "definite" (229) followed up till 7 years, 32 had severe cerebral palsy, 40 moderate cerebral palsy, 32 mild cerebral palsy, 7 possible cerebral palsy and 118 no cerebral palsy. Of those described as "suspect" (425) only 7 were "definite" at age 7, 7 were "suspect" and 411 had no motor disability at this age.

Those children who do turn out to have cerebral palsy go through phases of unusual posture, movement or tone which are temporary and could have other outcomes and explanations. Many are floppy (low tone) for weeks or months. Then those who are going to show signs of spastic cerebral palsy begin to develop increased tone at the ankle or hand and this spreads proximally with time. They are diagnosed between 6 and 9 months after birth unless very severely affected. Those who are going to become athetoid or ataxic may not show specific signs of these disorders till their second year. Indeed the full effects of the brain disorder may not be clear until adolescence as I found examining 20 students with "hemiplegia" at Beaumont College some years ago. Many had developed involuntary movements as well as their longstanding spasticity.

To suggest that doctors conceal information because they don't know how parents will take it or because of fears of litigation are misrepresentations. Doctors would like to satisfy their patients' parents. There is concern about how parents receive the information, and the processes of denial, anger, depression and acceptance take time with repeated counselling of both parents together, ideally backed up by home visits by an informed colleague who has sat in on interviews with parents'

DISCLOSURE OF DEVELOPMENTAL DISORDERS

permission, by written information, by contacts with other parents and with appropriate help (therapy, social work, developmental psychology, education).

Recently I saw the mother of a child with abnormal eye movements and a big head. Tests showed agenesis of the corpus callosum and mild hydrocephalus. The consultation lasted an hour and a half to explain everything and show her the scans. She could not bring her partner but brought a friend and a professional colleague sat in with me. It was followed by a written report to the parents, GP, health visitor, social worker and physiotherapist. Three days later there was a call from the health visitor who had made a home visit. The mother told her that as soon as I said there was something abnormal about her baby's brain she went blank and could not remember another word. At the time she had asked questions, examined the scan and appeared to understand what was said. To spend long sessions in quiet, sympathetic counselling only to get feedback later that "he never told me anything" or worse may seem frustrating. But follow up is necessary and part of the process.

In the last 2 years I have seen 8 children in Salford who were diagnosed by consultants as having cerebral palsy in the past but who do not have it now. In that cerebral palsies are disorders of posture, movement and tone, as opposed to diseases, the original descriptions were understandable. But some parents are angry about going through the process of trying to come to terms with their child's cerebral palsy (in one child this included 2 operations) only to have to unlearn this later.

It would be wrong to make the doctor the centre of the discussion. That is for the child and the parents. But understanding the doctor's dilemma as the diagnosis evolves by increasing suspicion through a phase of doubtful development is part of the process of improving practice. Berating doctors has not worked. The recommendations in "Right from the Start" are sensible but achieving such practice requires informed discussion.

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7.12.94

BOBATH BABY COURSE

Joyce Robertson

Senior Physio, BCH NHS Trust.

The first Bobath Baby Course for Therapists was held at the end of last year at Birmingham Children's Hospital. It was led by Dr. Elizabeth Kong and Mary Quinton MCSP. These 2 ladies, now in their 70's and 80's have been teaching together for the last 40 years on the continent, in the USA and other parts of the world.

Dr. Kong, until her retirement, was medical director of the Cerebral Palsy Centre in Bern. In 1955 she began pioneering work in early detection and treatment of Cerebral Palsy. At this stage she met Mary Quinton on a Bobath Course in London and asked her to come and work in Switzerland.

The theory behind their work is that intervention is most effective before 6 months of age. At this stage there is a competition of patterns, of movement (Milani). Whilst there is still a variety of patterns abnormal postures can be changed more easily and normal patterns are more easily facilitated. Touwen described detection "as a concept of increasing suspicion." When suspicion is confirmed, patterns have become more established and treatment is less easy.



Dr. Kong with Lauren and her mother, Birmingham, November 1994

On the course we were given a deeper understanding of normal development and its great variability and also the process of abnormal patterns becoming dominant. We practised handling techniques developed by Mary specifically for use with young babies.

As always in this field, scientific proof and research is harder to come by and opponents have argued that we may be treating a percentage of normal children. One of the most encouraging papers we looked at was a control study by Margit Hoch Leitner from Innsbruck in which she showed that treatment

resulted in greatly reduced percentage of patients with severe pathological symptoms and a higher per-centage with minimal symptoms.

Certainly those who attended the course found the techniques they learnt most useful and effective. They felt as if they were just glimpsing the great depth of knowledge to be explored in this area.

Adèle van der Westhuizen

Senior Paediatric Physiotherapist
Tygerberg Hospital
Cape Town
South Africa.

From June 1991 to February 1993 I had the opportunity to work as a Community Paediatric Physiotherapist in East Anglia. During this time I experienced being part of a caring, well organised paediatric team who worked together to give every child, with special needs, the opportunity to develop all their potential and skills, to the best of their ability. I acquired a lot of new ideas to bring back home to South Africa, but unfortunately circumstances differ so much here. Due to social, economical and cultural aspects, the majority of the ideas are very hard, or even impossible, to implement.

Trying to compare paediatric physiotherapy services in South Africa with those offered in the U.K. is a difficult task. Services vary from expensive private treatment at private clinics or hospitals to absolutely no services at all in remote rural areas. I have therefore decided to highlight the services offered by the general teaching hospital in Cape Town, where I am currently employed as Senior Paediatric Physiotherapist.

The paediatric physiotherapy caseload is covered by 3½ physiotherapists. This includes both in- and outpatients, community clinics and specialist group therapy. Students from the University of Stellenbosch receive clinical instruction during the mornings throughout the year. Their caseload include patients with respiratory, orthopaedic and neurological problems in both in and outpatient departments.

The 8 bed paediatric ICU sees all patients up to the age of 12 who need high or intensive care. Diagnoses vary from pneumonia, TB, septicaemia, shock, meningitis due to various organisms (including TB), croup and paralysed patients due to Guillain Barré Syndrome, sepsis to the spinal cord or traumatic spinal injuries. Post surgical cases are nursed in the ICU after cardiac surgery, neurosurgery, cranio-facial surgery and general surgery (elective or post-traumatic). All children are fully assessed by the physiotherapist and receive therapy as needed. After discharge from the ICU, patients are followed up in the ward, as outpatients or referred to physiotherapists in other hospitals for final rehabilitation.

In the 16-bed neonatal ICU, physiotherapy is offered to babies, both premature and full term, mostly to those with lung complications due to infection or ventilation and intubation. Babies are mobilised if necessary and positioning is supervised to ensure optimum lung and motor function. Physiotherapists also play an integral role in the assessment and treatment of high risk babies, both as in and outpatients.

9 paediatric wards with approximately 200 beds include respiratory, internal medicine, neurology, long term tracheostomy, neurosurgical, orthopaedic, oncology, neonatal and cranio-facial patients. Patients receive appropriate therapy during their stay in hospital. During this time they also receive Occupational and Speech therapy, and are followed up

PAEDIATRIC PHYSIOTHERAPY IN CAPE TOWN

as outpatients or in the community, if necessary, by all disciplines. If no services are offered in their communities or areas, parents receive instruction to continue therapy as required.

In the outpatient department, it is mainly children with neuromotor developmental problems, due to meningitis (viral, bacterial or TBM), cerebral palsy (especially due to neonatal problems), or head injuries who are treated. Referrals are received from the high risk infant clinic, paediatricians, neurologists and orthopaedic surgeons, or from other institutions. Children with motor problems, attending the pre-school for children with hearing impairment, receive individual or group therapy, as indicated. All cranio-facial patients are assessed fully before corrective surgery.

Outpatients are seen up to twice a week, but in many cases this is not possible due to lack of funds or transport, as most of the patients seen at provincial hospitals are unemployed and have serious financial problems. Children from rural areas are often only assessed and treated when seeing consultants at clinics. This may only be at 2-3 monthly intervals and time is mainly spent on updating the home programme. Many rural areas have no therapists. This causes a lot of frustration when children are in dire need of regular therapy. Many children return with severe deformities or abnormal movement patterns which could easily have been prevented with regular therapy. Equipment is scarce and many a child's only form of supportive seating is a cardboard box. Recently, a few therapeutic devices and chairs have been marketed, but are still well out of reach of the average patient. Medical Aid would cover the cost of some appliances, but only a small percentage of the patients seen at our institution belong to a Medical Aid.

Recently therapists have started an outreach into the community. Physiotherapists and Occupational Therapists visit community clinics, offering 3-5 hours a week to 5 clinics in the area. This way many more patients are able to attend, who have been unable to visit the hospital as regularly. Unfortunately venues are small and due to lack of storage space and poor security, equipment must be taken from the hospital every time. During one session up to 15 patients are consulted or treated. This makes in-depth sessions virtually impossible. The current trend is to decentralize services to the community but at present the current manpower finds it hard to cope. Talks of cutting the numbers of healthworkers might make circumstances even more difficult.

Due to the shortage of staff, training programmes have been started to educate healthworkers or community workers. These workers come out of the community and deliver an invaluable service. They identify problems in their specific community and, in liaison with health professionals, are able to address the different needs of individuals. In

this way more children with special needs are identified and can be seen at clinics, whereas, in the past, they would have been hidden away from society. The risk of therapists entering townships, with poor security, has also diminished. Healthworkers are accepted and trusted much more by the community and can build bridges between cultural groups previously divided by misunderstandings.

A playgroup for children with Down's Syndrome has been started recently for children in the area close to the hospital. The Down's Syndrome Association organize meetings and Physiotherapists offer help with movement problems during these sessions. Parents are finding the support and interaction with other parents very fulfilling. These meetings have been so successful that they may be extended to other groups i.e. preschool children with learning disabilities and children with other special needs.

As the health policy in South Africa changes, Physiotherapy services will need to adapt accordingly. This is a very unsure but otherwise exciting time for all health professionals. Hopefully an improvement in economical and social circumstances will enable us to reach each and every child with special needs and offer each one the opportunity to develop to their full potential in a secure environment.

GROUP THERAPY FOR CHILDREN WITH CO-ORDINATION PROBLEMS

This article has been adapted from a talk given to G.P.s and Health Visitors in Salisbury in order to raise their awareness of the problems encountered by children with co-ordination problems and to encourage early detection and referral to the therapy services.

JUNE NORTON

Senior I
Paediatric Physiotherapist

Firstly let us identify the sort of children we are concerned with. They are not a medical emergency. Their problems may be mentioned in the G.P.s surgery when parents come about some other problem or mentioned "by the way" when another child in the family is ill.

Many different descriptions may be given of the child and definitions have changed and evolved over the years. They may be thought of as:

1. Clumsy
2. Minimal brain deficiency
3. Inco-ordinate
4. Dyspraxic
5. Motor-learning difficulty
6. Visio-spatial or perceptual difficulty
7. Hyperactive
8. Slow
9. Lazy
10. Stupid
11. Just plain odd!

HELEN TWENTYMAN

Senior I Paediatric
Occupational Therapist

Department of
Child Health,
Salisbury District Hospital

A good description of these children was given by Arnheim and Sinclair (1979).

"Clumsy children are usually subjectively identified as those who fall a lot, are continually knocking into things and have bruises to show for it, drop things, and cannot keep up with other children in physically active games. They are also described as individuals with whom other children will not play because they are "no fun", who have difficulty climbing, throwing and jumping, who play with children younger than themselves or who prefer to play less strenuous activities than their more active peers."

To understand something of how this must feel remember when you were learning to drive; the conscious thought that is required to keep control of the car, to organise the pedals without looking at your feet and to be aware of the busy traffic all around. This confusion and panic is how these children feel most of the time.

Dyspraxia

"Dyspraxia is a disorder of sensory integration interfering with the ability to plan and execute skilled or non-habitual tasks. Usually there is some inability to relate the sequence of motions to each other."

Ayres 1972

DEFINITIONS

GROUP THERAPY FOR CHILDREN WITH CO-ORDINATION PROBLEMS

Praxia

Having talked about clumsiness and dyspraxia, perhaps we should define "praxis".

"Praxis is an uniquely human skill requiring conscious thought and enabling the brain to conceptualise, organise and direct purposeful interaction with the physical world."

Ayres, Mailloux and Wendler 1987

Praxis involves all that comes before movement and culminates in the execution of a smooth skilled task. Dyspraxia is an impairment in the organisation of movement i.e. ideation, motor planning and execution. A dyspraxic child has difficulties using his body. These difficulties are identified in a number of areas:

1. Low muscle tone
2. Poor shoulder stability - so important in writing skills and hand function.
3. Poor hip stability - necessary for hopping and kicking a ball.
4. Poor extension - these children often move in patterns predominantly of flexion.
5. Poor eye-hand and eye-foot co-ordination - required in ball skills and writing.
6. Inability to cross the midline.
7. Poor directional awareness.
8. Poor body awareness - necessary to walk through a door without bumping into it.
9. Poor body organisation - essential for self-care skills.
10. Poor motor planning.

They may also show disturbances in their emotions:

1. Being either overactive and restless, or hypoactive and slow at finishing tasks.
2. With low self esteem and not being accepted as playmates by other children.
3. Being irritated by things which do not bother other people e.g. being touched (especially light touch), bumped into, held by the hand, or having their hair cut or teeth brushed, or the feeling of tight clothing.
4. Being impulsive. Doing whatever comes into their mind without thinking.

A video highlighting the children's problems in various areas was shown at this point.

GROUP THERAPY FOR CHILDREN WITH CO-ORDINATION PROBLEMS

HOW GROUP THERAPY BEGAN....

Approximately two years ago we spent time discussing several patients we had in common. We were each seeing children individually for Physiotherapy and Occupational Therapy who would no doubt benefit from a joint approach to their therapy, with expertise from each discipline combining to give a more holistic and rounded approach to their treatment.

Due to the low self esteem of the children and their difficulty in making new friends, we decided it would be more appropriate for the children and a more efficient use of our resources, to see the children in a group.

The groups began in February 1993. They were held in the Physiotherapy gym in the new Salisbury District Hospital. The groups were held after school for one hour between 4-5 pm for a six week period. Initially there were two groups; one for children between 5-8 years and the other catering for the 9-12 year age group. Each group was subdivided into four basic areas covering gross motor skills, perception, ball skills and fine motor ability. This pattern of subdividing the groups proved to be effective from a treatment perspective and from the child's point of view regularly changing activities and with variety, helping to cope with their distractibility and poor attention span.

CURRENT SITUATION

Since the establishment of the groups, they have grown and evolved for various reasons:

1. There is more awareness of the need of referrals by schools, doctors and parents etc. and because treatment can be offered for this group of children.
2. It is more efficient and effective to treat children in groups rather than individually or simply provide a programme of therapy.
3. Parents report the value of the groups.
4. Children see the groups as their "club", they enjoy attending and succeed in physical activities; sometimes for the first time.

Currently five groups are held. Two cater for the pre-school age group, a further two groups have children from 5-9 years and the final group is for those who are 10 and over.

THE WAY AHEAD

The groups were initially run almost as a pilot study and have blossomed from there. Due to the integral development of the groups we feel we need to:

1. Formulate more specific aims, objectives and criteria for the groups.
2. Improve standards and objectivity by utilising standardised tests and questionnaires.
3. Develop our treatment to incorporate Sensory Integration.

GROUP THERAPY FOR CHILDREN WITH CO-ORDINATION PROBLEMS

CONCLUSION

We have painted a picture of the child we are concerned about, identifying their areas of difficulty. We have shown you how we are endeavouring to help these children in Salisbury and what our plans are for the future. What we asked of the G.P.s and Health Visitors was to try and identify these children early and to consider the following points when carrying out a developmental assessment.

1. **Quality** of movement and not the success of a task.
2. **How** the child approaches the task.
3. **Frustration** level of the child for the task.
4. **Distractibility** of the child in various situations.
5. **Associated movements** a child "subconsciously" performs.
6. The child's **general appearance**.
7. **Parental concern**, because they may just be right!

The talk provoked many questions and much interest from the audience, however whether this will result in earlier and more appropriate referrals has yet to be seen.

REFERENCES

- Dyspraxia - A Handbook for Therapists, Michele Lee and Jenny French
Praxis Makes Perfect, Dyspraxia Trust
Sensory Integration and the Child, J. Ayres
The Clumsy Child, Ann M.D. Grimley and Ian A. McKinlay

STANDARDS OF SERVICE FOR CHILDREN WITH A DISABILITY

An abstract of the presentation given by Jill Brownson, A.P.C.P. Chairman to the British Paediatric Association meeting held at Nottingham on March 3rd 1995.

INTRODUCTION

I am delighted to be here today representing the Association of Paediatric Chartered Physiotherapists, the largest of the Clinical Interest Groups attached to the Chartered Society of Physiotherapy, with a membership of approximately 1200. We aim to represent all physiotherapists working with children, whether or not they are members of our association.

I plan to present to you where we, as an association, stand in the production of:

- Standards of Clinical Practice
- Outcome Measures
- Advice concerning Caseloads.

STANDARDS OF CLINICAL PRACTICE

Clinical Interest Groups have been encouraged by the Chartered Society of Physiotherapy to produce their own specific standards of Clinical Practice, based on their own Standards for Physiotherapy Practice. This provides a framework for the setting of appropriate standards and the use of suitable mechanism for the measurement of outcomes and the monitoring of such standards.

A 'Guidelines for Good Practice' publication produced by APCP several years ago has now been upgraded and is in the final stages of production. This concentrates specifically on standards relating to:

- The Child and Family
- Teamwork
- Assessment
- Treatment/Management
- Environment and Equipment
- Professional Development

This leads naturally to the development of Outcome Measures i.e. the monitoring and measurement of the effectiveness of our intervention.

OUTCOME MEASURES

Outcome Measures should evaluate within our practice:

- Improvement
- The prevention of deformity
- The ability to maintain status quo
- The ability to minimize the effects of a progressive disorder

A working party within APCP evaluated and produced standardized outcome measures initially in relation to the treatment of:

- Dyspraxia
- Neurologically based Gross Motor Dysfunction
- Orthopaedic conditions

In the case of Dyspraxia, the definition used by Gubbay was accepted and used.

The recommended measure having been developed, evaluated and modified will look at:

- Eye/foot co-ordination
- Spatial awareness
- Sequencing of verbal instructions
- Eye/hand co-ordination
- Sequencing of visual instructions
- Bilateral integration
- Symmetrical integration
- Reciprocal integration
- Motor planning

Each item is scored initially and re-measured after a course of treatment.

With regard to Gross Motor Dysfunction, existing assessment forms were evaluated. Finally the Canadian 'Gross Motor Function Measure' was recommended for adoption as an Outcome Measure by APCP.

This divides into 5 main sub-headings looking at the ability to perform a movement rather than defining the quality of the movement. When used, it produces "clusters of impaired function" and makes goal setting more logical.

It does not however provide a suitable outcome measure for the treatment of profound disability; this subject is to be addressed separately in the future.

As physiotherapists, we are the 'hands on' profession, our method of working being closely associated with the nurturing of support and care of the families with whom we are involved. This area is poorly defined and difficult to measure. How do we create outcome measures for the support we give to families when a changing pattern of care is needed with a progressive disorder? It is impossible to separate our various roles; but as providers of a service we are being pressurized into issues of skill-mix that could be interpreted as "erosion of a service".

CASELOADS

Physiotherapy originally developed using the medical model. We now provide our own ideas and opinions, expecting to have a free hand with regard to our methods and levels of intervention. However we wish to work closely with our medical colleagues, especially when dealing with family issues. We recognise our need of their strong voice in the acknowledgement of our contribution in its measurable and un-measurable state to the purchasers of our service and those making decisions about levels of service provision.

STANDARDS OF SERVICE FOR CHILDREN WITH A DISABILITY

Considerable time has been spent establishing a consensus of opinion with regard to the levels of physiotherapy intervention, recognising the need to standardize terms that can be understood by both Health personnel and those in Education. Definition of terms in relation to Disability in Childhood are well covered in the document convened by the British Association for Community Child Health. Procedures for coding disability in eleven categories are comprehensive and will be invaluable in describing levels of disability.

In order to consider the calculation of a workable caseload, 3 levels of input were identified.

Review an occasional overview in varying environments to ascertain possible change of need. Advice can be given or management plans adapted.

Maintenance regular input once or twice a month in the form of 'hands on' treatment or review of advice to carers.

Intervention can range from once a week to daily intervention, using well defined goal setting to include monitoring the ability of the family to manage change in circumstances.

The use of these terms, together with agreed formulae for the calculation of available direct patient contact time results in a statement that: "A mixed non-acute caseload for 1 wte paediatric physiotherapist should be 30 children." This concurs with the statement in the BACCH draft Standards of Service for Children with Disability.

Currently a random survey across the country gave caseloads varying between 44 and 70 and very occasionally in excess of 100.

Paediatric physiotherapists have had a tendency not to say "goodbye" to patients, but we cannot deliver a quality service if we are attempting a caseload of 60+ children.

Finally I would like to raise the question of the suitability of always treating children within their homes. Is it appropriate for the vast number of Team members within a Community Service to be queuing at the door, invading people's privacy and perhaps creating a situation where they feel unable to say no to the proposed visit of a 'professional'. Could it be that the effort needed to attend for treatment is a measure of the level of acceptance and responsibility being taken?

STATEMENTS AND ANNUAL REVIEWS

INTRODUCTION

In the February 1995 issue of the APCP Journal Carole Hurran's article 'The Code of Practice - 1993 Education Act' (page 29) explained the changes in the statementing process as a result of the new Code of Practice.

The following pages describe suggested formats for both the Statement and the Annual Reviews, with guidelines to what information may be included under each heading.

These formats have been agreed and adopted by Southmead United Bristol and Frenchay paediatric physiotherapists.

The Post-Registration Education Board wish to produce an APCP Factsheet on Guidelines to Statementing, using these formats as a basis, so they would appreciate some feedback from members, including any proforma you may be using in your district. Any comments etc. should be sent to:

Carole Hurran, APCP Post-Reg Ed Spokesman
23 Bayswater Avenue, Westbury Park, Bristol BS6 7NV

Suggested details to be included under format headings:

GENERAL

'User friendly' paragraph about the child; include diagnosis, explain main physical problems in non-medical terms, behaviour, co-operation, prognosis i.e. deteriorating, improving, static.

FUNCTIONAL ABILITY

Ability in lying, sitting, standing, changing position.

Mobility - rolling, crawling, walking.

Aids used, distance covered, stairs, slopes, rough ground, safety in playground.

P.E. - balance, co-ordination.

Use of wheelchair, trike.

Motor Planning - organization, body and spatial awareness.

Hand Function - dominance, grasp.

Special seating or aids.

Self-help - dressing, eating, toileting.

Social Skills - concentration, behaviour, understanding.

Aids and Appliances, Orthotics.

SUMMARY OF CHILD'S NEEDS

Main problems and needs including dependency.

Medical, physical, manual handling and access needs.

AIMS OF PHYSIOTHERAPY PROVISION

Prevent contractures maintain/develop motor skills and functional ability.

Enable access to educational curriculum with suitable positioning, seating and other equipment.

STATEMENTS AND ANNUAL REVIEWS

SUGGESTED FORMAT:
(Health Service headed paper)

PHYSIOTHERAPY ADVICE FOR STATUTORY ASSESSMENT OF SPECIAL EDUCATIONAL NEEDS

Name..... dob

Address

School/Centre date request received

General

Physiotherapy input to date

Functional Ability

Summary of Child's Needs

Aims of Physiotherapy Provision

PROVISIONS RECOMMENDED

1. Non-Educational Provision - Physiotherapy

2. Educational Provision

- i) Physical Requirements
- ii) Situation and Transport
- iii) Specialist Resources

THIS IS A STATEMENT OF RECOMMENDED PROVISION FOR THE CHILD'S NEEDS AND NOT OF AVAILABLE HEALTH SERVICE RESOURCES.

Details of this advice have been discussed with the parents.

Physiotherapist:

Signed **date**

Superintendent Physiotherapist:

Signed **date**

STATEMENTS AND ANNUAL REVIEWS

SUGGESTED FORMAT :

(Health Service headed paper)

PHYSIOTHERAPY ADVICE FOR ANNUAL REVIEW

Name dob

Address

.....

School review date

FUNCTIONAL ABILITIES

(describe changes, progress and whether previous goals were met, current problems and needs)

AIMS OF PHYSIOTHERAPY

Long Term Aims (ie over next year or more)

Short Term Goals (over next 3-6 months as appropriate)

RECOMMENDED PROVISIONS

(include any changes necessary)

1. Non-Educational - Physiotherapy

2. Educational

- i) Physical Requirements (adult help, how much, when and what for)
- ii) Situation and Transport (if moving school or needs are changing e.g. needs to travel in wheelchair)
- iii) Specialist Resources (additional equipment to be provided by LEA - special furniture recommended - give approx. cost and supplier - adaptations to toilet, improvements to access etc.)

Physiotherapist:

Signed date

Base

STATEMENTS AND ANNUAL REVIEWS

PROVISIONS RECOMMENDED

1. Non Educational Provision - Physiotherapy

Face to face treatment, monitoring and review by the physiotherapist at appropriate intervals.
Advice and teaching to education staff with joint planning of an in-school programme.
Provide or advise on mobility aids, special footwear, splints and braces supplied by Health Authority.
Time out for home or hospital visits.
Access to hydrotherapy.

2. Educational Provision

The advice must contain evidence of the child's needs in order to justify the provisions recommended.

i) Physical Requirements

Regular individual work on a programme of motor or mobility skills recommended by a physiotherapist.
If General Assistant support is needed to carry out physiotherapy programme specify time e.g. 15 minutes per day on individual motor skills programme, supervision for P.E. - 2 hrs. per week, help with toileting, transfers, walking, manipulation of tools and equipment, placing in postural equipment, putting on splints.

ii) Situation and Transport

Access to adapted school buildings - ramps, lifts etc.
Therapy room or suitable quiet, comfortable area.
Specialist transport for powered wheelchair.

iii) Specialist Resources

Include furniture, aids and equipment **not** provided by the Health Service or Privately with cost and suppliers.

NATIONAL CONFERENCE - EDINBURGH 1995

The 1995 National Conference was held at Heriot Watt University, Edinburgh on Friday 31st March - 2nd April. The lecture notes will be printed in the November Journal but here is a pictorial record of some of the lighter side of the proceedings.

THURSDAY EVENING

It is customary for the local Organising Committee to entertain the National committee on the evening before conference. This year we visited the City Chambers in Edinburgh. The evening included a conducted tour of Mary King Close, which has remained in-tact underneath the City Chambers and is reputed to be haunted, and finished with supper in one of the many fine rooms of the building.



*Mr. Wilson The Deputy Lord Provost of Edinburgh
Our Guide For The Evening*



Members of the Local Organising Committee



Members of National Committee with The Deputy Lord Provost

NATIONAL CONFERENCE - EDINBURGH 1995

FRIDAY AFTERNOON - OPENING OF CONFERENCE



Lyn Campbell (standing) Chairman of the Organising Committee with Miss Maureen Grant MCSP Chairman of the First Session and Prof. Colwyn Trevarthen, the first speaker.



Conference Delegates waiting for the conference to begin

NATIONAL CONFERENCE - EDINBURGH 1995

SATURDAY EVENING - SHERRY RECEPTION



*Two of our honoured guests Penny Robinson (left)
Director of Professional Affairs
Penny Roberts, Vice Chairman of Council*



Some of National Committee Relax with a glass of sherry



Ann Grimley & Jenny McKinlay, dweep in conversation



*Penny Roberts chats to Dr. Ian McKinlay with
Jenny McKinlay in the background*



Members from the North West



We are Piped Into Dinner

NATIONAL CONFERENCE - EDINBURGH 1995

CONFERENCE DINNER



The Guest Speaker Euan Kennedy, Scottish International Rugby Player



*The Top Table
Jill Brownson, Penny Roberts & Christine Shaw,
our Master of Ceremonies for the evening*



Linda Cunningham cuts her surprise 40th Birthday cake

NATIONAL CONFERENCE - EDINBURGH 1995



**FRIENDS &
ACQUAINTANCES
OLD & NEW
CHAT OVER
A GLASS OF WINE
AFTER A SUPERB
DINNER.**



ANNUAL GENERAL MEETING 1995

The 22nd Annual General Meeting of the Association of Paediatric Chartered Physiotherapists was held on Saturday 1st April 1995 at Heriot-Watt University, Edinburgh.



The Executive Committee

*Left to right - Carole Hurren - Post Reg. Ed. Spokesman. Michele Lee - Retiring PRO
Viv Williams - Retiring Vice Chairman. Fiona Corkhill - Retiring Secretary
Jill Brownson - Chairman. Angela Gwyn-Davies - Treasurer*

CHAIRMAN'S REPORT

Jill Brownson

I would like to welcome you to the 22nd Annual General Meeting of the Association.

I hope to review for you the work of the Association, especially the National Committee over the past year.

As usual we have held 4 National Committee meetings and a number of sub-committee meetings for specific purposes. The meetings were held at the CSP in London, at G.O.S. Hospital, and in Birmingham during the workshop weekend, and here on Friday morning.

Angela Gwyn-Davies became Treasurer and Carole Hurren became Post Registration Education Officer but otherwise the Officers of the Association remained the same.

ANNUAL GENERAL MEETING 1995

After this AGM however we will have a number of changes.

I reported on the National Committee's workshop weekend in the February issue of our Journal and am delighted to be able to follow that with the announcement that the Fact-sheet on Guidelines for Calculating Physiotherapy Caseloads is now available. I had anticipated that it would be here at Conference but the copies have not arrived. It will be available from the Publications Officer at a cost of £2 per copy. I recommend it to you for each department, and particularly for those services not managed by a Physiotherapist.

I also have very great delight in telling you that the Standards of Physiotherapy Practice document has been approved by the CSP's Quality Assurance Working Party and Professional Practice Committee. It is now with the Printers and will be eligible for inclusion in the CSP Standards pack.

Copies will be available to Members within the next few weeks. All current members will receive a free copy and it will be included in the New Members Pack. Copies will also be available from the CSP and from our Publications Officer who will be pleased to take orders for them.

We are very grateful for the hard work and expertise of Sandra Holt and Mary Clegg who jointly produced the document.

During the past year committee members have represented the association in various ways.

Carol Foster as a member of the Clinical Interest Groups Liaison Committee and a Professional Practice Committee continues to disseminate information to us and we have had requests to look at papers such as The Review of Clinical Interest Groups and Occupational Groups, and Contract Minimum Data Set (these being Care Objectives and Care Programmes).

Carol Foster and Rowenna Hughes attended the CIG conference in May. The topic was Pathways of Care and Patient Focused Care.

This year the Clinical Interest Groups conference is to be held in Harrogate and the topic is Research and Technology. We are able to send 3 representatives.

Rowenna attended a Professional Practice Committee 'Protocols Working Group' which looked at Guidelines for producing a protocol and formulated a briefing paper. This has now been consolidated into a draft

ANNUAL GENERAL MEETING 1995

Protocol Paper which looks at all the aspects of developing protocols and includes the multi-disciplinary team.

At the Annual Representatives' conference in Birmingham in September we were represented by Carole Hurran and Margaret Cameron - both undertook to present difficult motions to the conference and represented our Association well.

Our continued liaison with the Advisory Assessment Service of SCOPE is proving valuable.

Viv Williams, Fiona Corkhill and I attended one of the receptions to launch SCOPE and the relationship that we have developed with SCOPE was commented on by their Chief Executive.

At a recent meeting we decided to plan a jointly produced leaflet for parents of children with Cerebral Palsy which will guide them with what to expect from a physiotherapy service and will encompass the standards that parents can expect paediatric physiotherapists to work to and statementing advice. It will aim to 'fill the gap' and cement working relationships between the Advisory Assessment Service of SCOPE and Paediatric Physiotherapists.

SCOPE themselves liaise with other Voluntary Agencies and Interest Groups to provide information leaflets so we foresee a stronger bond in the future for the provision of information to families.

The result of the Working Party who looked at Outcome Measures is that this Association will adopt the Gross Motor Function Measure as the recommended Outcome Measure for CP. Carole will enlarge on this in her report.

The Dyspraxia Outcome Measure developed by Michele Lee will also be adopted as our recommended Outcome Measure.

The GMFM is not deemed appropriate for the Profoundly Disabled Child and the Working Party will continue to consider other measures for that and other conditions.

The PRO and Post-Registration Education reports will inform you of other specific functions and activities of the committee.

At the beginning of last month, I represented the Association at a British Paediatric Association Conference in Nottingham. This meeting looked at Standards of Service for Children with a Disability. I joined other representatives from the professions allied to medicine to report on and discuss Standards and Service Provision; as a result of this we are invited

ANNUAL GENERAL MEETING 1995

to join a working party of the BPA to produce a definitive document.

At this AGM we are losing several long-standing members from the National Committee.

During the year Jeanne Lacey relinquished her job as editor to Lin Wakley.

Last year I told you about the changes to the Editorial board for a new style publication - this was launched for the August edition - a new size, a new layout and a new colour. I want to thank Jeanne for her leadership on the Editorial board throughout this significant time and for her vision for the future of our journal. She will say that she continued in the way led by past editors and of course each editor has hall-marked their time in office in an individual way, but each with the purpose in mind of producing a high quality informative publication. Jeanne was co-opted on to the committee for her term of office, having previously been a very active member of the S.E. Region. She will be missed.

Viv Williams retires from the committee having been an elected member for 8 years and the Regional Rep for Wales prior to that. Members will know that she was co-writer of the Guidelines for Good Practice, she was one of the Working Party who produced our publication on the Children Act, she has been Chairman of the Post-Registration Education Committee and Vice-Chairman of the Association, and of course has been actively involved in many other issues.

The National Committee has valued her loyalty and dedication and will miss her enthusiasm and humour.

Jenny McKinlay also retires from the National Committee. As Editor she made her mark, not least by being the editor who organised the date of the journal to be put on the cover, not inside. Jenny then took on the role of Membership Secretary - including the minefield of Information Technology, and she and Angela have battled through the teething troubles of the Direct Debit system.

Michele Lee also retires from the committee; she has been Publications Officer, Secretary and most recently PRO - all these offices have demanded high organizational skills - a fact not un-related to her joint-authorship of the publication 'Dyspraxia - a Handbook for Physiotherapists'.

Michele has been a member of the Working Party who looked at Outcome Measures, and jointly with Lin Wakley and Rowenna Hughes organized the very successful Introduction to Paediatrics Course.

National Committee Members who hold Executive Office give

ANNUAL GENERAL MEETING 1995

enormously of their time and reflect true dedication to our profession and the Association.

Fiona Corkhill has completed 4 years as a nationally elected member. She is eligible for re-election and has been nominated to stand again. She will however, stand down as Secretary - an office she has held for 3 years.

I have said before that the office of Secretary is quite exacting - I am extremely grateful for Fiona's efficiency, patience and tolerance. She is the first port of call for most enquiries to the Association and has to have a reliable memory and accurate knowledge.

Ann Shanks too has completed a 4 year term as a nationally elected member. She has decided not to stand for re-election. During her time as a committee member she has assisted when our response to documents was needed and has liaised with BABTT and has been actively involved with the Working Party for Outcome Measures.

Finally my sincere thanks go to all the committee who work so hard on behalf of the members to maintain the standards of an Association we can all be proud of.

TREASURER'S REPORT

Angela Glyn-Davies
Hon. Treasurer.

The Accounts are presented in a different way than they have been previously, following a successful meeting with the Accountants who inspect our accounts.

We decided that when they were presented as Amalgamated Accounts which included each Region's monies as well as National's it was impossible to see how APCP obtained its income and how that money was spent to run the Association.

You only have before you the details of the National Accounts - each Region's accounts being detailed separately and bound copies incorporating all the accounts are available for inspection.

Before I go through the National Accounts, I must congratulate the Regional Treasurers on their successful presentation of their individual accounts. I must explain that we held a Regional Treasurers Workshop with the Accountant, and he produced a standard format for accounting and presentation and also a request to send them to be inspected in January. He reported to me that all this happened and that it made their work quicker and easier and this will be reflected in their charges, saving the Association money.

ANNUAL GENERAL MEETING 1995

The first sheet is fairly straight-forward, although I would like you to note the £8,000 Grants to Regions and the total at the bottom of the page, both of which I will come back to later.

On the next page you will notice we have not yet received our Capitation fee from CSP. This is because they have changed their system of paying it and they have assured me that it will be paid shortly.

You will also note that our biggest income is from subscriptions and of course this is how we are able to run our Association. We currently have over 900 members but the more we have the wider the costs are spread which enables us to keep the subscription to a reasonable amount - so please encourage any colleagues who are not members to join the Association.

Under 'Expenditure' the only notable increases from the previous year are firstly, the catering and accommodation which is accounted for by the working weekend for National Committee that occurs every other year, and this year produced the Guidelines for Calculating Caseloads booklet. Secondly, the increase in the section under postage is due mostly to the substantial rise in the price of stamps.

The next page is the Account for the Introduction to Paediatrics Course run by APCP and is self explanatory. This Account is going to remain separate from the National Account at present and will be used for the next course.

The last page is the Conference Account and again is fairly straight-forward and the profit of £7,576 is recorded in the Income section of the National Account.

As announced by last year's Treasurer at the AGM, each region who organised Conference were to be awarded a sum of money to compensate for all their hard work and the fact that they were unable to run fund raising courses during that time. It was decided that £1,000 was a suitable amount so this accounts for the £8,000 I mentioned earlier. There are actually 10 regions, but Northern Ireland do not organise a Conference and Scotland will have their £1,000 from this year's Conference.

The other innovation this year was the invitation to all members to pay their subscription by Direct Debit. This was a result of a unanimous vote at the last AGM. Despite this however, a disappointing 170 members only took this up by the 1st January although another 150 have done so since. There has been an initial cost for setting up the system, but it will save the Association money in the long run as long as the scheme is supported by the majority of members. I do urge you to take up the offer

ANNUAL GENERAL MEETING 1995

when you receive your form with the November Journal.

It has taken a lot of extra work to get the Direct Debit scheme up and running and I must say a special thank you to Jenny McKinlay, the Membership Secretary who has done a large bulk of the work and who has helped and supported me through all the difficulties.

Lastly, but probably most significantly, I must come back to the figure at the bottom of the first page in conjunction with the figure at the bottom of the second. As you will see from the first figure, our capital assets dropped by £7,384 which is due to the rise in the running costs of the Association (the second figure). If we take this figure £26,983 and assume that we will get 1100 members this year, the cost per member, based on this sum for last year will be £24.53 per member. Now the subscriptions at the moment are only £16.00 but because we still have plenty of capital at the moment, we clearly do not want to put the subs up to this amount. However, by increasing them by £2.00 to £18.00 this would bring the income up from £17,571 to £19,800 which would be a shortfall of £7,183 based on this year's expenditure and this should be covered adequately by the capital assets. Please also bear in mind that all present members and all new member swill receive a free copy of the Paediatric Standards. Before I make this proposal formally, I should like to say my thanks to the rest of the National Committee who have been very understanding and helpful during my first year as Treasurer. I have very much enjoyed serving on the Committee.

* * * * *

The proposal to raise the subscription to £18 was carried by a majority vote.

* * * * *

Adoption of Accountants

The present accountants Neill Hill were re-adopted.

ANNUAL GENERAL MEETING 1995

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

NATIONAL ACCOUNT

BALANCE SHEET

31ST DECEMBER 1994

	1994		1993	
	£	£	£	£
FIXED ASSETS - Amstrad Word Processor		598		598
- Computer		1,014		1,014
		1,612		1,612
CURRENT ASSETS				
Stocks	537		537	
Cash at Bank and Building Societies	17,167		25,145	
Debtors	-		2,780	
		17,704		28,462
		19,316		30,074
CURRENT LIABILITIES				
Sundry creditors (incl Advance Subscriptions)		1,146		5,497
		18,170		24,577
		18,170		24,577
ACCUMULATED FUND				
Balance brought forward at 1.1.94		24,577		22,898
Less: Grants to region from prior years' surpluses		8,000		-
		16,577		22,898
Add: Surplus for the year		1,593		1,679
Balance carried forward at 31.12.94		18,170		24,577
		18,170		24,577

ANNUAL GENERAL MEETING 1995

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31ST DECEMBER 1994

NATIONAL ACCOUNT

	1994		1993	
	£	£	£	£
INCOME				
Capitation Fees	-		1,004	
Subscriptions	17,571		15,764	
Publications	2,611		472	
Bank & Building Society Interest & Charges	451		968	
Sundry	134		290	
		20,767		18,498
Contributions due from National Conferences				
1993	233		2,780	
1994	7,576		-	
	<hr/>		<hr/>	
		7,809		2,780
		<hr/>		<hr/>
		28,576		21,278
EXPENDITURE				
Catering and accommodation	3,615		374	
Committee travel and subsistence	6,315		5,599	
Clerical and computing services	491		316	
Honorarium	1,020		690	
Postage, stationery and telephone	10,781		6,471	
Accountancy fees	1,146		1,034	
Course fees	150		75	
Publications	2,044		3,425	
MEM fees	1,063		1,331	
Bank charges and interest	143		76	
Sundries	215		131	
Gifts and donations	-		77	
	<hr/>		<hr/>	
		26,983		19,599
SURPLUS FOR THE YEAR		<hr/>		<hr/>
		1,593		1,679
		<hr/> <hr/>		<hr/> <hr/>

ANNUAL GENERAL MEETING 1995

COURSES ACCOUNT

BALANCE SHEET

31ST DECEMBER 1994

	£	£
CURRENT ASSETS		
Lloyds - Current Account		2,325
		=====
ACCUMULATED FUND		
Surplus for year		2,325
		=====

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31ST DECEMBER 1994

	£	£
INCOME		
Courses		5,075
EXPENDITURE		
Catering & Accommodation	813	
Speakers Fees	1,290	
Post & Stationery	55	
Adverts	20	
Speakers Expenses	572	2,750
	-----	-----
SURPLUS FOR THE YEAR		2,325
		=====

ANNUAL GENERAL MEETING 1995

CONFERENCE ACCOUNT 1994

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31ST DECEMBER 1994

	£	£
INCOME		
Registrations : Members	13,158	
Non Members	1,104	
	<hr/>	14,262
Float from National Committee	500	
Sponsorship	585	
Sale of Sweatshirts and Mugs	1,672	
Bank Interest Received	71	
Benevolent Fund Raffle	265	
Trade Exhibitors Fees	6,082	
Trade Advertisement	50	
Trade Exhibitors Accommodation	510	
	<hr/>	9,735
		<hr/>
		23,997
		<hr/> <hr/>

EXPENDITURE

Catering & Accommodation Chester College	11,098	
Printing & Photocopying	599	
Entertainment	150	
Purchase of Sweatshirts	1,798	
Committee Dinners	630	
Lecturers Fees & Expenses	943	
Committee Travel Expenses	208	
Sundry Expenses	105	
Directional Signs	199	
Benevolent Fund	265	
Refund Conference Fees	236	
Photographer	120	
Postage	52	
Stationery	18	
	<hr/>	16,421

SURPLUS FOR THE YEAR

7,576

PAYMENTS TO NATIONAL ACCOUNT

6th July 1994	7,500
21st November 1994	76
	<hr/>
	7,576
	<hr/> <hr/>

ANNUAL GENERAL MEETING 1995

PRO REPORT

Michele Lee
Public Relations Officer

Last year proved to be a very busy year with the Centenary events. Many Physiotherapy departments throughout the country held open days and events all of which assisted to promote physiotherapy to the public. I was frequently asked for ideas for stands and for the APCP leaflets.

The Public Relations Department at the CSP have continued to keep us informed of their happenings and events over the last year. They have had a busy year with the events for the centenary - all of which were a great success. A new careers poster has been published together with a number of new leaflets. These included Physiotherapy and Back Pain and Look After Your Back which both coincided with National Back Pain Week in October plus the leaflet Looking After Your Back Over the Christmas Period. Physiotherapy and Occupational Health and Physiotherapy and RSI were produced to coincide with the Health and Safety at Work week. Other titles included Physiotherapy and Osteoarthritis, Physiotherapy and Hospice Care and Physiotherapy the Orthodox Alternative. The leaflet Physiotherapy and Oncology and Palliative care was produced at the beginning of this year. Copies of the leaflets may be obtained from the Public Relations Department at the CSP. I have continued to keep the regional representatives and national committee informed of the CSP happenings and published them in my PRO news report in the APCP journal.

The regional rep. meeting continues to be held in January and July each year prior to the national committee meetings. Local issues and concerns are raised and brought to the attention of the national committee. A list of forthcoming courses run by the APCP regions has now been drawn up and is reviewed at each meeting. This ensures that regions are aware of subjects at the study days so that duplication in close vicinities is avoided. I am also occasionally informed of other paediatric courses being held by other organisations and again these are always submitted to the journal for publication.

The "Introduction to Paediatric course" which was run in October last year at the CSP headquarters was very successful and oversubscribed. Very positive feedback was given to the course committee from the delegates who all found it a very worthwhile course to attend. Their comments on how the course could be improved have been taken on board by the Post Graduate Education Committee for the next course in February 1996. The results of the students MCQ papers were very high ranging from 75% - 91% and the case studies from 45 - 76%. The names of those delegates who completed the course will be published in a future APCP journal.

The book Dyspraxia - a handbook for Therapists has been very popular and is currently being re-printed. A number of new leaflets have been

ANNUAL GENERAL MEETING 1995

drawn up and I have submitted these to the Post Graduate Education Committee for their approval. The titles include Paediatrics as a Career, Dyspraxia a Fact Sheet on Physiotherapy for Parents and Carers, and Cerebral Palsy a Fact Sheet on Physiotherapy for Parents and Carers. It is hoped that these will be ready for publication mid year.

The group working on Outcome Measures has continued to meet quarterly over the last year. The outcome measures for dyspraxia and orthopaedics have been now tested and are working well and close to publication. The group looking at neurodevelopment and neuromuscular have been working hard considering a number of different measures. They have concluded that the Gross Motor Function test would most suit our needs and this has been reported on in the post registration education report. In addition they have devised measures for the severely handicapped which they feel the Gross Motor Function test does not cover. These will be published with the other Outcome Measures in the near future.

I would like to thank all the regional representatives and the other national committee members for all their help and support to me over my 9 year term of office. I have thoroughly enjoyed my time on the National Committee, made many friends and learnt a great deal. Although I shall miss everyone, I know that the friendships will continue and the experience I have learnt will be put to good use as publicity officer for the Dyspraxia Trust. I wish the new PRO well and hope she enjoys her term of office as much as I have.

POST REGISTRATION EDUCATION REPORT

Carole Hurren
Spokesman for
Post Reg Ed. Committee

The committee reformed after the last AGM and was able to meet together 3 times during the year. Viv Williams, Rowenna Hughes and Lyn Campbell formed the core group with me, and Mary Goy and Michele Lee were co-opted to give additional help in planning and running post graduate courses. We are also fortunate to have support and advice from Mary Clegg, Sandra Holt and Jenny French in a consultative capacity.

This year has been a busy and rewarding one with the successful running of the APCP Introductory Course in Paediatrics, thanks to thorough planning and organisation by the course team, Michele Lee, Lin Wakley and Rowenna Hughes. Plans are now well under way for the next 5 day course to be held at the CSP from February 26th to March 1st 1996.

During the year we continued looking at standardised tests and check lists for assessment and had several examples sent in by members. The collection has grown, with many tests from the USA in particular, but very few met the specific needs of paediatric physiotherapists. One that looked promising for children with cerebral palsy was the Gross Motor Function Measure. This has inspired some useful debate and not a little

controversy but plans are going ahead for a joint study day on the Measure with BABTT on the 23rd June with Eva Bower, Research Fellow at Southampton University, leading the way.

Another major topic for discussion this year has been the Code of Practice for the Identification and Assessment of Special Educational Needs, and how paediatric physiotherapists should use the guidance it gives on the 1993 Education Act. Many examples of the Physiotherapy Advice for Statements were looked at by the committee and a booklet of guidance and suggested proformas is planned for publication later this year.

Many letters have been received asking for advice on the Codes of Practice, the David Hart Walker and on Manual Handling in particular. A Fact sheet of guidelines on manual handling is being prepared for the future and any problems, safe practice advice and policies which members are willing to share would be very helpful in putting this together. Leaflets are also being drafted on topics of interest to parents and carers, so far on cerebral palsy and dyspraxia.

In addition to dealing with requests for information, meetings and preparation of papers I was fortunate to attend the European Academy of Childhood Disability which is becoming an important forum for presentation of research papers to a wide ranging medical audience. Research and development in paediatric physiotherapy is increasingly important if we are to remain in control of our professional work and use our skills to the best advantage for the children. The CSP continue to encourage us to come up with ideas and will offer practical help and support in writing research proposals and carrying them through.

My thanks to Viv Williams for help and guidance in my first year as Spokesman and to all the Committee for their support.

ELECTION OF COMMITTEE MEMBERS

There were 4 vacancies on the National Committee.

Viv Williams and Jenny Mckinlay had completed 8 years as national committee members.

Ann Shanks had completed 4 years but did not wish to be re-nominated.

Fiona Corkhill had completed 4 years and was prepared to be re-nominated for a further 4 years.

4 nominations were received. They were:

Fiona Corkhill, Alex Winney, Caroline (Carrie) Jackson, Lyn Campbell.

All 4 were therefore duly elected to serve for a period of 4 years.

ANNUAL GENERAL MEETING 1995

HONORARY MEMBERS

The members were informed that the National Committee had received and accepted a nomination for Ann Murdock to become an honorary member of the Association. She was nominated in honour of her involvement with the Association in the early years. She was the first scottish regional representative and a member of the national committee and held office as vice chairman.

* * * * *

CONSTITUTION

Amendments to the wording of the constitution were proposed. These amendments do not change the content of the constitution but remove some of the ambiguities of the previous wording.

Members attending the AGM had an opportunity to read the amendments prior to the AGM.

The amendments were accepted by a majority vote so the revised constitution was duly adopted.

COPIES of the Constitution are available, on request, from Regional Representatives or the Secretary of APCP.

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THE NEXT AGM WILL BE HELD ON 28th MARCH 1996 IN CANTERBURY

BOOK REVIEWS

THE HONG KONG CONDUCTIVE EDUCATION SOURCE BOOK

Theory, Method, Application, Development and Organisation

Collected articles 1986 - 1993

Edited by Anita Taplow

Published by: Working Group on Conductive Education Joint
Council for the Physically and Mentally Disabled (Rehabilitation
Division, Hong Kong Council of Social Service) Duke of Windsor
Social Service Building

15 Hennessy Road, Hong Kong

ISBN 962-7003-42-5

No. of pages: 303, soft-back A4 size. Price \$30

This large and very well presented volume is based on the collaborative effort of a large group of people and contains a series of about 60 articles written from practical experience as well as much theoretical information with its roots in the teaching and work of the Peto Institute in Budapest. The purpose of the book is to share the philosophy, theory, knowledge and experience of Conductive Education gained locally over many years with rehabilitation staff, parents, administrators and policy makers. It fills a wide gap in the literature by fully documenting Conductive Education as a combined educational-therapeutic system for people with neurological disorders including innovation and development of methods for a wide group of children and adults in Hong Kong. It is refreshingly free of the arguments of the purist approach which insists that only qualified Conductors can provide Conductive Education and demonstrates how successfully professionals can work together in harmony if the will is there.

The book is divided into 4 parts: Theory, Method, Application, and Development and Organisation. The range of authors is impressive and includes many well known to U.K. therapists such as Ester Cotton, Lillemor Jernqvist, Rowenna Kinsman and Margaret Reid Campion as well as many therapists, teachers, nurses and other workers from Hong Kong. There

are interesting descriptions and comparisons of other approaches such as Bobath and Montessori written by experts in those fields.

The Editor who is also the Hong Kong C.E. Project Co-ordinator has linked the articles together in a clear and systematic way and writes with confidence, dedication and sincerity. There are some strongly subjective views which not all will share such as 'The results in Budapest are far better than anything achieved elsewhere' though this is indicative of the faith and commitment of the C.E Project workers in developing their own comprehensive intervention programme in Hong Kong.

There is so much in this book of value and interest to anyone using a holistic approach to motor disorders and an interest in modified systems of Conductive Education: the text is well illustrated with many black and white photographs and good clear diagrams. It is the ultimate 'how to do it' book and compares very well with one other practical text recently published in Britain, 'The Peto System and its Evolution in Britain', edited by Alexander Russell and Ester Cotton.

**Carole Hurran BA Grad DP MCSP
March 1995**

RUNNING A TEAM FOR DISABLED CHILDREN AND THEIR FAMILIES

Clinics in Developmental Medicine, 130.

Martin F Robards

MacKeith Press/Cambridge University Press, London

113 pp. Price: not stated

After a tour of British child development teams and centre, the late Professor Donald Court observed that local differences were as striking as similarities and that no two services were identical. It would have been possible for the author of this book to give a detailed account of his team's work in a Kent market town in ways which bore little relevance to services in inner cities. He avoided this by wide consultation in Britain and North America during the writing and the result will be welcomed widely.

Controversial subjects are addressed and dealt with using suitable references to the literature available, rather than to fundamentalist beliefs. Though some could be expanded into books in their own right, the chapters add up to a helpful collection of contemporary ideas.

Children with complex neurodevelopmental disabilities deserve a flexible, comprehensive service with continuity of professional advice and good liaison between professionals, statutory and voluntary agencies. This is not available through general ambulatory paediatric clinics. For similar reasons specialist services have been established for children with cystic fibrosis, cancer, muscular dystrophy and, to an insufficient extent, epilepsy.

Examples are given of types of children and specific children referred to the development team. These raise issues of success and disappointment. Treatment can fail, advice may be rejected, parents may follow their own programmes and some children die. Parents grieve for their children's disabilities and this can be expressed as denial, anger or depression. Though help is possible through counselling and psychological intervention, this is less freely available than physical treatment.

Debate about terminology is reviewed with thoughtful reference to the literature and helpful definitions. A reasoned case is presented for child development centres as an identified base for teams and a place where special services can be concentrated.

Of 126 centres in England and Wales responding to a questionnaire 94 had some form of district handicap team. In sum 39 different types of professional are involved in such teams and 16 different types of professional lead them but 4 out of 5 of these are doctors. Such heterogeneity implies diverse operational policies but these make more sense in the context of other local services. There is discussion of the need to evaluate efficiency and value for money of services, including therapy, with examples.

Other themes include the need for continuity mutual education of professionals and parents, fostering liaison [currently threatened by fragmentation of public services] and use of combined medical notes [though the sheer bulk of these and the frequency of diverse appointments may make this a counsel of perfection].

Much has been learned from parents of disabled children who campaigned for such services over 40 years ago. It is gratifying to record progress so far, but there is still much to learn.

Ian McKinlay

BSc [Hons] M.B. ChB. DCH FRCP

Senior Lecturer in Community Child Health

University of Manchester 12th January 1995

PROMOTING COLLABORATIVE PRACTICE

The document 'Promoting Collaborative Practice' is a joint statement produced by the College of Speech and Language Therapists, the College of Occupational Therapy and the Chartered Society of Physiotherapy. It 'highlights the benefits of collaborative practice whilst demonstrating the specific skills that each profession contributes' and its purpose 'is to encourage a review of current practice and generate wide ranging debate among clinicians, managers and others concerned with the provision of care in health, education and social services, and the voluntary and private sectors.'

Available from: CSP Professional Affairs Dept. price £5.00

As well as the joint statement leaflets, on collaborative practice in specific clinical areas, are being produced. These 'may be used as a guide to advise purchasers/providers of the roles played by the different therapy professionals in providing a comprehensive team approach.' The first of these 'Collaborative Practice in Dysphagia' is now available. price 10p.

FOR SALE

An assortment of paediatric equipment and developmental toys, some new and some second-hand but in excellent condition, includes crutches, walkers, a roll, chairs and playthings.

Contact: Sophie Levitt

Tel: 0171 289 6038 or 01225 782267

THE NATIONAL COMMITTEE

After the AGM the National Committee met to elect the new officers of the committee.

CHAIRMAN	Jill Brownson (co-opted)
VICE-CHAIRMAN	Lyn Campbell
SECRETARY	Mary Goy
TREASURER	Angela Glyn-Davies
P.R.O.	Alex Winney
POST-REG ED SPOKESMAN	Carole Hurren
PUBLICATIONS OFFICER	Carol Foster (West Midlands Rep)
MEMBERSHIP SECRETARY	Liz Harty
EDITOR	Lin Wakley
NATIONAL COMMITTEE MEMBERS	Carrie Jackson Fiona Corkhill Rowenna Hughes (co-opted)
REGIONAL REPRESENTATIVES	are also full members of the National Committee.

PROFILE OF THE TREASURER

Angela Glyn-Davies MCSP

Angela trained at Middlesex Hospital and qualified in 1960, starting in Paediatrics when she returned to work after the last two (twins) of her four children started school. She began at a Residential School for Physically Handicapped Children then to a special unit for children with Severe Learning Difficulties, moving to her present job in Community Paediatrics in 1981 where she is now Head of Paediatric Physiotherapy.

Having joined APCP she spent many years on the Committee of East Anglia Region and was Secretary to the Conference Committee in 1992 and that year was elected on to the National Committee, taking over as Treasurer in 1994.

As well as keeping house for her large family and their friends and looking after her dogs and cat, she enjoys various sporting activities, painting, singing in a choir, reading, sewing and other handicrafts, adventure holidays and world wide travel.



INTRODUCTION TO PAEDIATRIC COURSE '94

The first Introduction to Paediatric Course was held at the Chartered Society of Physiotherapy, London in October 1994. There were 30 delegates, 21 of whom completed the course by submitting their case studies. All the delegates passed the multiple choice question examination at the end of the course.

The comments made by the participants were very favourable and positive. They all felt that the course had been very worthwhile and they had learnt a great deal. Some felt that a future course needed to have more practical sessions such as for Cerebral Palsy and longer course time for subjects such as Neurology and Muscular Dystrophy. Many felt that the overall standard of lecturing had been very high and that the Dyspraxia, legal aspects, respiratory, Orthopaedics and Neurology sections had been most helpful. Other comments included that there should be less study time and during study time specific tasks should be set. All these comments have been taken aboard and as a consequence the programme has been modified for the next course in February 1996.

The course team would like to thank all the lecturers, the delegates and all those involved in the course for making it such a successful one and look forward to running many more! Finally, we would like to send our many congratulations to those participants who completed the course all of whom gained pass marks with their case studies.

Claire Brown	Samantha Arch
Judith Whitton	Carolyn Smith
Hilary Foran	Nicola Ho
Zoe Ann Lloyd Jones	Belinda Miles
Rebecca Biggs	Laura Staines
Joanne Kendal	Susan King
Eleanor Coates	Alison Hall
Brian Houston	Jane Deavin
Karen Roach	Paula Wilson
Karen Kerr	Sarah Leer
Helen Thornton	

Michele Lee
Public Relations Officer/Course Leader

NEW PUBLICATIONS

The Association is launching two new publications this month.

GUIDELINES FOR CALCULATING PAEDIATRIC PHYSIOTHERAPY CASELOADS - FACTSHEET *price £2.00*

This document has been produced in response to the demand of members. It was compiled during the National Committee workshop weekend held in Birmingham in October 1994.

It describes a method of calculating the total caseload of a paediatric physiotherapy service and, using these figures, how to calculate the staffing level required to deliver a quality service.

NOW AT THE PRINTERS

STANDARDS OF PRACTICE-PAEDIATRIC PHYSIOTHERAPY *price to be confirmed*

This publication has evolved from the APCP Guidelines to Good Practice and should be used in conjunction with the CSP Standards of Practice. 'The booklet will help to provide a framework for the development of local standards and quality assurance'

**N.B. All current members will receive a free copy of
The Standards of Practice and a copy will be included in the
'new member' packs.**

LIST OF PUBLICATIONS

BOOK/TITLE	QUANTITY	PRICE LIST
SERIAL SPLINTING IN HEMIPLEGIC "CEREBRAL PALSY" <i>by Margaret Jones (2nd Edition)</i>		3.50
THE CHILDREN ACT 1989 <i>'A Synopsis for Paediatric Physiotherapists'</i>		£2.50
PAEDIATRIC PHYSIOTHERAPY <i>Guidelines for Good Practice</i>		£2.50 £2.50
DYSPRAXIA - A HANDBOOK FOR THERAPISTS <i>by Michael Lee and Jenny French</i>		£5.50
GUIDELINES FOR CALCULATING PAEDIATRIC PHYSIOTHERAPY CASELOADS - FACTSHEET		£2.00
STANDARDS OF PRACTICE - PAEDIATRIC PHYSIOTHERAPY		<i>price to be confirmed</i>

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 and Address for delivery

Jenny McKinlay

There have been a few teething problems this year with the initiation of the Direct Debit system, but everything will come out alright in the end.

That is, things will truly be OK if more and more members are willing to come over to use the system. Currently only some 30% of our members have been prepared to switch which means much time and effort will have to be continued in processing the complicated forms that so many of you want to continue to use.

Your continuing support of the work of the APCP is greatly appreciated. It would help your committee to devote more resources to the ever growing demands made on them and their time if you would pay by Direct Debit.

Changes have been made to the form which came out last November with your Journal, and you are urged to look out again for that form this November. There will be adequate explanations again as to how Direct Debit works, and be assured that, by getting your forms in on time, you will no longer have to worry about whether you have renewed your subscription or not - it will all be taken care of. And be assured that you will not lose any cash for Christmas presents - nothing comes out of your account until the New Year.

All depends on two things:
firstly that you receive the Direct Debit form,
secondly that you fill it in and send it in on time.

The only third point is to whom you send things - after eight years on committee I am now due to retire, but your new Membership Secretary will be waiting with baited breath to see how quickly you all respond to this new challenge. Very best wishes to you all,



**ANNUAL
SUBSCRIPTIONS
FOR 1995
£16**

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

Associate Membership is open to suitably qualified professionals working in the field of paediatrics.

New applicants require to be proposed and seconded by full members of the Association.

Retired Members are only required to pay HALF the total annual subscription.

**Membership runs from January to December
Cheques made payable to 'APCP' should be sent to:
Membership Secretary, Mrs. E. Harty MCSP
Jubilee Cottage, 20 Tullyroan Road, Dungannon, N. Ireland BT71 6NF.**

**Application form at back of Journal.
For members to use to encourage non-members to join.**

The Jenx Research Award

- *Worth £500 to spend on research*
- *Open to all Paediatric Physiotherapists who are members of the Chartered Society of Physiotherapists.*
- *Entries welcome from Individuals or Groups*
- *Sponsor looking for research ideas to improve the scope of the physiotherapy profession relevant to the treatment of children.*
- *Any enquiries should be made to Steve Clark or Jane Scott on 0113 239 35 35.*

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MEMBERSHIP MATTERS

THE JENX RESEARCH AWARD

This award, worth £500, has been established to heighten awareness of the importance of research by offering financial assistance to a worthy project.

Sponsored by Jenx Limited, one of the UK's leading manufacturers of furniture and therapy equipment for special needs children, the award is open to all paediatric physiotherapists who are members of A.P.C.P. and currently practising in the UK.

Criteria

The entrant can be an individual or group of physiotherapists.

The sponsor is looking for ideas to improve the scope of the physiotherapy profession relevant to the treatment of children.

The research should be the idea of the entrant, not copied, and should aim to improve the understanding and care of children.

The entrant should be able to demonstrate the following:

- a) an opening for their planned research
- b) a method of research appropriate to their expected funds
- c) a sound plan of how they propose to conduct the research
- d) a benefit to both the profession and children from the results.

Entry

The research project should be explained within 1500 words with support material submitted if appropriate. (All material must be clearly marked with the name of the entrant).

Closing date for entry:

(If launched at the Conference, entry forms could be issued in May/June and closing date could be November).

Judges

There will be a panel of four judges - one from the APCP Committee, one from Jenx and two independent judges who understand the requirements of special needs children.

Prize

There is one overall prize of £500 for the winner to spend on research. Half the money will be paid at the time of winning and the second half on submission of the completed research. (However, should financial hardship be experienced in completing the research, this can be reviewed).

Research should commence no later than 6 months after the date of winning.

Eligibility

The award is open to all paediatric physiotherapists who are members of A.P.C.P. and currently practising in the UK.

ENTRY FORM ENCLOSED ON A SEPARATE SHEET.

REGIONAL REPORTS

NORTHERN IRELAND

Finola Beattie
Royal Hospital for Sick Children
Falls Road
Belfast BT12 6BE

The AGM was held on Monday 6th March. The two vacancies were filled by Caroline Welsh and Judith Morrison - Welcome. Thanks to Angela Wilson, who retired from the committee, for her hard work and commitment for the past three years.

After the AGM Dr. Mike Shields gave a comprehensive and very up-to-date talk on Asthma Profiles and Drug Treatment. It made me want to go home and immediately vacuum out! - I didn't.

The 2 day Workshop on 'The Pre-term Infant' has been re-scheduled from 12th/13th May to 9th/10th June, due to the speaker's commitments. All current APCP members should have received an application form by now. Places are limited to 25, so be quick.

Unfortunately we had to cancel the planned hydrotherapy study day in February, again due to difficulties with the speaker, but we hope to run this in the autumn.

TRENT

Elaine Lloyd
18 Ballisfire Grove
Leicester LE4 0LT

The AGM held on 16th March was attended by approximately 35 members. We had interesting talks on Botulinus Toxin and the role of Gait Analysis.

Our next study day will be held on 25th May in Peterborough and the topic is 'CP Hips'. The speakers will include David Scrutton and 'Genesis Orthotics'. For further information please contact: Ruth Hilton, c/o Child Development Unit, Peterborough District Hospital, Thorpe Road, Peterborough PE3 6DA.

Finally, I would like to thank Margaret Cameron for her work as the first secretary and then Chairman and regional representative of APCP Trent. She will be missed by the members of Trent. I hope the move to London goes well.

EAST ANGLIA

Sue Whitby
3 Manor Way
Hail Weston
Huntingdon
Cambs PE19 4LG

We held a very successful Study Day on 'Syndromes' together with the AGM at Cambridge on 4th March. Thanks to the organisers.

The committee has changed again. Our thanks go to Linda Fisher, our retiring Chairman, and to our Ex-Treasurer Duo, Jean Offord and Elva Mason, who have both retired from work and the committee. We welcome Karen Roach, from Stevenage, and Gillian Spokes from Cambridge.

Our next Study day is on 21st June at Colchester when we shall be trying to unravel the mysteries of M.E. in Children (see course advert).

At the AGM we decided to produce a list of Paediatric Physiotherapists and their work place contact numbers. Please let me have details of paediatric physiotherapists in your own or other local organisations, including any 'internal post' systems which could be used for the cascade information.

REGIONAL REPORTS

NORTH WEST

Sue Leech
4 Hartland Avenue
Urmston
Manchester M41 9QG

Alex Winney has now finished her 8 year term of office with the North West Committee, the past four as regional rep. Our thanks go to her for all the hard work. We wish her 'Good luck' in her new role as PRO to the National Committee.

Legal Issues was the topic for our study morning and AGM held on 11th March in Warrington. 70 members attended to hear Jane Wright and John Davies, solicitors from Sheffield give us a very informative tour through the judiciary system with special reference to the EEC Manual Handling Law and the legal aspects of working with children, in relation to being an expert witness or a witness of fact.

Our next study day will be 'An up-date on Neuroplasticity' with Iris Musa as course tutor. It will be held on 14th June at Alder Hey Hospital. The committee are planning a day on 'seating' in October (the venue to be decided) and we are already looking at next years programme. Please let us know if there are any particular topics you would like us to consider. We are still able to consider requests for £50 bursaries towards courses or conferences. For an application form send a S.A.E. to: Eileen Walters, Community Paediatric Physiotherapy, Community Health Clinic, Blachall Road, Kendal, Cumbria.

SOUTH EAST

Sheila Minet
Old Knowle
Frant
East Sussex. TN3 9EJ

Our AGM held on 4th March was poorly attended, though the dyspraxia study day attracted many non-members, physiotherapists (who were encouraged to join APCP) and local teachers. All officers were re-elected en bloc. The plans for 'Conference 1996' are now advancing well. It will be held at Canterbury on 29th - 30th March 1996 and is entitled 'Heads, Shoulders, Knees and Toes'. The University accommodation has been improved since the last conference was held there so we hope many of you will attend.

Our only study day planned for 1995 is at the Kent and Sussex Hospital Post Graduate Centre on 23rd June. The title is 'Working with Families' and the speaker is Enrique Valles, Clinical Psychologist. (see course adverts)

WALES

Donna Morris
25 Willow Close
Willowtown
Ebbw Vale
Gwent NP3 6WN

Our Study Day on neuro-muscular disorders was very well subscribed and proved an excellent course appreciated by all.

The AGM was during the lunch break and we welcomed many new members. A new committee was elected and we are very pleased to have such widespread representation throughout Wales. The committee is meeting on 4 April to plan events for this coming year.

FORTHCOMING EVENTS

Care of the Dying Child - 3 May 1995

County Hall, Atlantic Wharf, Cardiff

REGIONAL REPORTS

A 'Sharing' Day - 9 June 1995

Neville Hall Childrens Centre, Abergafenny

Many thanks for all your support and good luck to our new Rep Donna 'McMorris'!

NORTH EAST

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

Sorry to all those of you who were unable to get a place on the last study day in March. Due to the extremely high level of interest, we hope to persuade Colin to come again very soon. Those applicants who were unsuccessful last time will get first chance of a place.

The next study day will be on Neonatal Care. Such a lot of babies referred for treatment have been premature, and spent their early days on NNU/SCBU, so there should be some interest for everyone. Details are on the insert enclosed with this Journal.

There have been several changes to the Regional Committee. We must say 'Goodbye' to Fiona Hainsworth, and thank her for all her hard work over the last 7 years, especially as Branch Secretary. She has been elected to the Executive Committee of ACPRD and we wish her well.

We are delighted to welcome Jane Howland from Driffield and Georgina Thornton-Keighley from Huddersfield. They are already proving to be valuable assets!

SOUTH WEST

Gill Smith
Children's Unit
Salisbury District Hospital
Salisbury.
SP2 8BJ
Tel: 01722 336262
Extension 2280

We had a very interesting and informative Annual General Meeting and Study Day on February 25th. Eva Bower presented 4 completed studies on Evaluating Physiotherapy in Cerebral Palsy.

26 members attended this day at the Children's Centre, in Dorchester. We are hoping to organise two further study days later in the year on Dyspraxia and Neonatal care.

Please send all your news to me well in advance so it can be included in our Regional Newsletter.

LONDON

Di Coggings
7 Union Street
High Barnet
Hertfordshire EN5 4HY

Our AGM was incorporated in a Study Morning on Saturday, 4th March at The Royal London Hospital. The topic was 'Rett Syndrome' and 30 people attended. The speakers, Lynn Weekes, Physiotherapist for the Rett Society and Paul Davies, Orthopaedic Surgeon, gave very good talks and highlighted all the problems associated with the Syndrome and current treatments.

A questionnaire was sent to all London Region Members with their February Journal, asking members to try and give us some ideas of the Study Days/Evenings they would like us to provide. We have so far had 20 replies, but ask that more members put pen to paper.

REGIONAL REPORTS

Although we have recruited some new members, there are old members who have not renewed this years membership, and we encourage anyone who knows who they are to "give them a nudge."

Future study days/evenings shall be arranged at our next Committee Meeting in May and advertised in "Frontline".

SCOTLAND

Lyn Campbell
19 Craigmount Avenue North
Edinburgh EH12 8DH
Tel: 0131 539 0169

The annual APCP conference has just been held in Edinburgh and the committee are now recovering! We hope it was enjoyed by all those who managed to attend and we will now turn our thoughts to the running of courses etc. for all the Scottish members.

Our AGM is to be held in Glasgow on the 6th May and at that time we will be looking for new committee members as some of us will be retiring, so do give it some thought.

I would like to take this opportunity to thank all the organising committee of the Conference for all their support and hard work.

WEST MIDLANDS

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

The AGM was held on March 22nd at Good Hope Hospital, between 25-30 members attended and an interesting talk was given by Caroline Dunn entitled "The Children Act 1989 - Where are we now".

Your committee for 1995 will be meeting in May to arrange a programme of events for the forthcoming year. We have been joined by a new committee member Heather Iszatt from the Stourbridge area. The membership for the West Midlands stands at 96 and includes 15 new members.

Please let me know of events in and around the West Midlands.

COURSES

APCP REGIONAL STUDY DAYS

NE REGION

PREMS AND PROBLEMS

Venue: Postgraduate Centre
Barnsley District General Hospital
DATE: SATURDAY, 24th JUNE 1995
Speakers: Dr. Alan Gibson, Cons. Neonatologist
Jennifer Schooling, Sen. Physiotherapist
Anna Simpson, Sen. Physiotherapist
For further information contact:
Georgina Thornton-Keighley, Supt. Physiotherapist
Barnsley District General Hospital
Tel: 01226 730000 ext. 2375

SW REGION

WORKING WITH FAMILIES

Venue: Postgraduate Centre
Kent and Sussex Hospital, Tunbridge Wells
DATE: FRIDAY 23rd JUNE 1995
Tutor: Enrique Valles, Clinical Psychologist
Application forms from:
Joy Watson, 19 Priory Drive
Reigate, Surrey RH2 8AF

TRENT REGION

MANAGEMENT OF HIPS IN CP CHILDREN

Venue: Peterborough District Hospital
DATE: FRIDAY 26th MAY 1995
Main Speaker: David Scrutton
Cost: Members £20 Non-Members £25 - (includes tea and coffee)
Application forms from:
Ruth Hilton, Child Developmental Unit
Peterborough District Hospital, Thorpe Road
Peterborough PE3 6DA

EAST ANGLIA

M.E. IN CHILDREN

Venue: Essex County Hospital, Colchester
DATE: WEDNESDAY 21st JUNE 1995
Speakers: Diane Cox OT
Dr. Franklin
ME Society
Cost to be finalised-budget priced!
Details from:
Jean Ritson, 23 King Cole Road, Lexden
Colchester, Essex CO3 5AQ

COURSES

OTHER COURSES

CARING FOR CHILDREN WITH COMPLEX NEEDS. THE RIGHTS OF CHILDREN WITH DISABILITY

Venue: Cowdray Hall, RCN, London

DATE: 10th JUNE 1995

This conference will address aspects of caring for children with complex needs, which contribute to improving their quality of life.

Emphasis will be on their rights to be recognised first; to be accorded dignity, to be safe and to be accepted as individuals in their own right within their families, within communities, and within society as a whole.

Organised by the Children's Trust, Tadworth. £152.72

Apply with payment to Nicola Fulton

Course and Exhibition Unit, Nursing Standard, Viking House

17-19 Peterborough Road, Harrow, Middlesex HA1 2AX

PARTNERS IN PRACTICE - the way to better services

A major conference for
therapists and people with
disabilities

Organised by Therapy Weekly

15th JUNE, 1995

Kensington Town Hall, London

Access All Areas

This conference takes up the themes of our campaign, Access All Areas. It will: Highlight services where therapists and people with disabilities work together to provide services that disabled people want; look at the continuing campaign for civil rights; and consider wider issues in service planning.

The conference will also focus on factors likely to affect future service delivery and will conclude with a consensus statement, highlighting common ground and a way forward for therapists, clients, patients and carers.

The conference is aimed at therapists working at all levels with people with disabilities, managers in health and social services, people with disabilities and carers.



Camp Limited
30/32 Sovereign Road
Birmingham B30 3HN
Tel: 0121 451 3016
Fax: 0121 433 4906

THE NEURO-PHYSIOLOGICAL ORTHOTIC MANAGEMENT OF THE CEREBRAL PALSIED CHILD.

Camp Ltd. Manufacturing Division are proposing to sponsor a one-day seminar on the above. Among the subjects to be covered are:

The Neurophysiological and Neurodynamic Theory of Management in the C.P. Child Indications and Contra-Indications for the use of Neurophysiological Orthoses.

Probable Date: Within the school summer holidays

Likely location: English Midlands (additional locations dependent upon response)

**If you are interested in attending the above, write or 'phone
Graham Irons, Marketing Manager, Camp Manufacturing at the above address.**

COURSES

INTERNATIONAL CONFERENCE AND EXHIBITION

Scientific Basis of Health Services

2-4 OCTOBER 1995

Queen Elizabeth II Conference Centre, London

The theme of the Conference is the scientific basis of health services. For the very first time, a major international forum will attract the widest range of interests from the health professions and research.

The Conference will examine existing links between research and health services in the UK and other countries and explore ways in which they can be strengthened and extended, to improve health care and make better use of resources.

It is a unique opportunity for industry, academic and research institutions, and everyone involved in health services to meet and exchange views in a truly multi-disciplinary environment.

For Conference and Exhibition Enquiries Please contact:

RSVP Purchase point

Conference and Exhibition Organiser

P.O. Box 4124

Hall Green, Birmingham, B28 9HE, United Kingdom

Tel: +44 (0) 121 778 4070 Fax: +44 (0) 121 702 2886

UPDATE IN PAEDIATRIC RESPIRATORY MEDICINE

JUNE 26-27 '95 - Fee: £120

Course director: Dr. Robert Dinwiddie

This is an update on current paediatric topics: asthma, cystic fibrosis, acute infection, congenital malformations, gastro-oesophageal reflux, immunology, heart lung transplantation and new techniques of ventilatory support.

Aims and objectives:

To provide a review of recent research and its application to day to day practice.

Participants:

Registrars, senior registrars, consultants, physiotherapists, nurse practitioners.

Continuing Education Office, Institute of Child Health

30 Guildford Street, London WC1N 1EH

Tel: 0171 829 8692 Fax: 0171 831 0488

DERBYSHIRE ROYAL INFIRMARY NHS TRUST

THE NATIONAL TRAUMATIC BRAIN INJURY STUDY: RAISING ISSUES

DATE: THURSDAY 14th SEPTEMBER 1995

For: Multi-disciplinary Health Professionals and other interested people

Venue: Derby City General Hospital

Fee: £40 (including VAT) Lunch and refreshments provided.

Places 100 Ref: NDC/9/95

COURSES

NATIONAL DEMONSTRATION CENTRE IN REHABILITATION

FEEDING DIFFICULTIES IN CHILDREN WITH NEUROLOGICAL PROBLEMS: MULTI-DISCIPLINARY ASSESSMENT CONCENTRATING ON THE USE OF VIDEOFLUOROSCOPY.

Date: Friday, 22nd September 1995

For: Multi-Disciplinary Health Professionals

Venue: Post Graduate Education Centre, Derby City General
Hospital

Fee: £40 (including VAT) Lunch and refreshments provided.

Places 100 Ref: NDC/11/95

GAIT ANALYSIS - CLINICAL APPLICATIONS

DATE: WEDNESDAY, 27th SEPTEMBER 1995

For: Interested Health Professionals

Venue: Devonshire Hall and Orthotics & Disability Research
Centre, Derbyshire Royal Infirmary - Derby

Fee: £40 (including VAT) Lunch and refreshments provided.

Places: 40 Ref: NDC/12/95

UMBRELLA DISCUSSION DAY: THE SHORT GOODBYES

(A day of discussion, looking at different models of Short Term Care for
children with special needs and their parents' preferences)

DATE: THURSDAY, 5th OCTOBER 1995

For: Parents and Interested Professionals

Venue: Post Graduate Education Centre, Derby City General
Hospital

Fee: Parents £12 (including VAT) Professionals £20

(including VAT) Buffet Lunch and refreshments provided.

Places: 100 Ref: NDC/13/95

MANAGEMENT OF CHILDREN WITH ARTHRITIS

DATE: THURSDAY, 2nd NOVEMBER 1995

For: Multi-disciplinary Health Professionals

Venue: Lecture Theatre - Devonshire Hall, Derbyshire Royal Infirmary -
Derby

Fee: £40 (including VAT) Lunch and refreshments provided.

Places: 90 Ref: NDC/16/95

COURSES

ASSESSING AND MEASUREMENT OF PROGRESS AND OUTCOMES IN REHABILITATION

Date: Thursday, 30th November 1995

For: Multi-Disciplinary Health Professionals

Venue: Post Graduate Education Centre, Derby City General Hospital

Fee: £40 (including VAT) Lunch and refreshments provided.

Places: 100 Ref: NDC/18/95

Further details and registration forms are available from:

Mrs. P. D. Jones, National Demonstration Centre in Rehabilitation, Derbyshire Royal Infirmary NHS Trust, London Road, Derby, DE1 2QY
Telephone: 01 332 254679 - Direct Line (Answer machine if office unattended)

Telephone: 01 332 347141 ext 4679 - Through main switchboard

Fax 01 332 254934

PLAYTRAC TRAINING CONSULTANTS,

HORIZON NHS TRUST, HARPERBURY, HARPER LANE, RADLETT, HERTS. WD7 9HQ

TEL: 0923 854861 EXT. 4385

INTENSIVE INTERACTION/ AUGMENTED MOTHERING

FRI. 26th MAY 1995

This one day course will outline a method of working with people of any age who have severe or profound learning disabilities and/or challenging behaviour. The focus will be on developing communication skills creatively through play.

Tutor: Andy Battell Course no. 11/95

Fee £50.00 plus VAT

MOVEMENT

MON. 5th JUNE 1995

This is an experiential workshop where the use of Laban movement is explored in groups, pairs and individually. The session aims to demonstrate how movement derives from our inner creativity and how we are all natural dancers.

Participants are advised to wear trousers.

Tutor: Charlotte Wilmer Course No. 12/95

Fee: £50.00 plus VAT

'GALAXIES' A DRAMA EVENT

WEDS. 21st & THURS 22nd JUNE 1995

'Galaxies' aims to give people with profound multiple learning disabilities an experience of drama by taking them on an imaginary journey into outer-space. The first day is for participants to experience the drama and to make the props and environment. On the second day participants are asked to invite a friend with a learning disability or service user to join in the drama event.

Participants are advised to wear trousers.

Tutors: I. Mullins and A. Hammond Course No. 14/95

Fee £85.00 plus VAT

COURSES

THE VALUE OF PLAY AND LEISURE

TUES. 4th JULY 1995

Participants will consider the role of play and leisure in service users' lives and how opportunities can be extended or improved. There will be an opportunity to look at the practical difficulties which participants may face in their work.

Tutor: Irma Mullins Course No. 15/95
Fee: £50.00 plus VAT

BEREAVEMENT AND LOSS

WEDS. 12th JULY 1995

This course will examine issues around bereavement and loss. Participants will be encouraged to recognise areas of loss within the lives of people with learning disabilities and difficulties around these issues. The session will look at the different stages of the grief process and explore practical ways of providing support to service users. There will be an opportunity for discussion and to share personal experiences.

Tutor: Noelle Blackman Course No. 16/95
Fee: £50.00 plus VAT

RELAXATION

MON. 11th SEPTEMBER 1995

In this workshop participants will be encouraged to explore the possibilities of using relaxation, simple massage and body awareness exercises with people with learning disabilities. Time will be spent discussing relevant issues as well as experiencing the various exercises. Participants will work in pairs and activities will involve physical contact with another person.

Participants are advised to wear trousers and to bring a blanket, pillow and towel.

Tutor: Any Battell Course No. 18/95
Fee: £50.00 plus VAT.

NAPOT ANNUAL CONFERENCE CAERLEON '95

Children at Play - A creative approach **14-15 SEPTEMBER 1995**

The Conference will appeal to all Therapists working with children, their families and carers.

The programme will include:

- * Key note speakers
 - * Seminars and practical workshops
 - * Resource and Equipment Exhibition (open to public)
- (Accommodation available at a very reasonable price)

For further details:

**Sharon Drew, Senior Occupational Therapist, Eveswell Children's Centre,
St. John's Road, Newport, Gwent. Tel: 01633 274832**

Forest Healthcare is one of the largest NHS Trusts in the Country and provides an integrated health care service for residents in North East London

Senior I & II Community Paediatric Physiotherapists

***Senior I Physiotherapist 16 hours Part Time or 19 hours Term Time Only,
please quote ref AD/PHY/22/95***

We are looking for an enthusiastic and self-motivated Chartered Physiotherapist to join an established team of staff treating children of all ages and diagnoses at the Childrens Developmental Centre, in Special Schools, Mainstream Schools and in the Community.

You will have a specific area of responsibility where you will be able to develop your clinical management skills, and to assist in the future development of the service, along with other members of the multi-disciplinary team. The possible areas of responsibility are as follows:-

Mainstream schools, children under 5's either in the community, at the Child Developmental Centre or in nurseries, children in special schools of which we have five. These are a school for physically handicapped children (age 2-16), a primary and a secondary school for children with moderate to severe learning difficulties, a primary school for children with hearing impediments as well as physical difficulties, a combined primary, secondary school for children with visual impairments as well as physical difficulties. Another area of responsibility is Orthotics.

Previous paediatric experience is essential along with good handling and communication skills, with the ability to work alone, or as part of a team. Our treatment approaches are based around the Bobath principles, of which some knowledge would be useful, however in-house training is available.

Senior II Physiotherapist Full Time, please quote ref AD/PHV/23/95

We also have a vacancy for a Senior II Physiotherapist; the right candidate should have an interest in working with children. Although you will still have a specific area of responsibility you will remain working closely with experienced Senior I staff.

For further information on both posts contact the Superintendent Paediatric Physiotherapist - Jan Ridding at Brookfield House School, Alders Avenue, Woodford Green, Essex IG8 9PY. Telephone 0181 531 9484.

***Application form and job description available from Facilities Personnel
Department, Management Block, Whipps Cross Hospital, Whipps Cross Road,
Leytonstone, London, E11 1NR or Telephone: 0181 535 6619
(24 hour answerphone) Please quote appropriate ref no.***

Closing date 9th June 1995



*The Trust aims to be
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*We operate a no
smoking policy.*



CHAILEY HERITAGE

South Downs Health NHS Trust

WE HAVE A VACANCY FOR A FULL TIME SENIOR II PHYSIOTHERAPIST IN PAEDIATRICS.

We have a friendly physiotherapy team, who are managed by the District Physiotherapy Service, Brighton Health Care.

At Chailey Heritage, we have outpatient services that include specialist clinics for children with special needs. These include the assessment and provision of orthoses, and equipment for postural management.

We have a unit for up to 6 children for intensive rehabilitation following head injury.

We have a school for about 90 children from 2-18 years who have a wide range of disabilities, though mostly cerebral palsy. Both day and residential care facilities are provided. We have a nursery for babies and young children with special needs, where a limited number of children of staff can attend. We also have a large, heated pool.

The post involves working as a member of a multi-disciplinary team. Encouragement is given to postgraduate education. There will be the opportunity to gain experience in different areas of the centre's specialities.

For application form, job description or informal visit, please contact Teresa Fearn, Superintendent Physiotherapist, Chailey Heritage, North Chailey, East Sussex, BN8 4EF, 01825 722112 ext. 317 Monday, Wednesday, Friday 9.00 - 1.00 or answerphone.

BRIGHTON HEALTH CARE

SENIOR 1 PAEDIATRIC PHYSIOTHERAPIST

Full time post available - based at
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The paediatric physiotherapy team provides a service to inpatients, outpatients, child development centre and special schools. Caseloads include neurological, orthopaedic, developmental and respiratory patients.

For further information and/or informal visit please contact Chris Young or Anne Walker, Superintendent Physiotherapists, Brighton (01273) 328145 ext. 2155.

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.

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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.

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In this issue

**Measuring Motor Goals in Children
with Cerebral Palsy**

**Assessing Motor-skill Acquisition in Four Centres
for the Treatment of Children with Cerebral Palsy**

Disclosure of Developmental Disorders

Bobath Baby Course

Paediatric Physiotherapy in Cape Town

**Group Therapy for Children with
Co-ordination Problems**

Standards of Service for Children with Disability

Statements and Annual Reviews

Conference and AGM 1995

