

**ASSOCIATION OF  
PAEDIATRIC  
CHARTERED  
PHYSIOTHERAPISTS**

**JOURNAL**



**SEPTEMBER 2000**

**ISSUE  
NO. 96**

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The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence,  
and does not necessarily endorse courses advertised

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## EDITORIAL

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### DIANE COGGINGS

APCP Chairman

It is with some trepidation that I write this editorial. After being Vice-Chair for the last two years, the time seems to have gone so quickly, so that suddenly, here I am! I would like to take this opportunity to say a big thank you to Liz Hardy, not only from all other members of APCP, but especially from myself, for being such an excellent "teacher" over the last two years. I do hope I can live up to her high standards.

This edition contains the findings so far on the "Summaries of the evidence" of the topics we are investigating for clinical effectiveness. These were presented in May this year at our annual National Conference in Bristol, but as not all members were present, we felt it important that the results so far be published for all to see. Under the Education Liaison Officer's lead, we hope to complete these by Spring 2001, and present the completed reports at National Conference at Sheffield in April.

Writing an article for the Journal we all know is time consuming, especially when we are always so busy, but I would like to thank Julia Graham for allowing us to print such an excellent article on the Vulnerability of Children with Disabilities. You must take time to sit down and read this article.

Have you got an interesting Case History or audit completed? You may think that it is not interesting enough to others, but please do share it. The Editorial Board are always looking for new material, and with CPD now at the fore, send it Sally and add it to your "publication".

Finally, I would like to say a very big thank you to Sally, our new Editor, for taking on such an arduous task. She really does deserve a round of applause. Our Journal now goes out to over 1,600 members, and as well as collecting material, editing, putting it together, sending it to the Publishers and proof reading, she also works full time for the NHS, and we all know how time consuming that is!!

I hope you continue to enjoy reading your Journal at much as I do. Thank you to all our members, with your help and support, APCP will carry on to grow and prosper in the years to come.

Copy for the  
**DECEMBER 2000 JOURNAL**  
must be with the editor by  
**1<sup>st</sup> NOVEMBER 2000**

The editorial board reserve the right to edit all material submitted

## LETTERS

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Sue Booth  
Senior Paediatric Physiotherapist  
129 Rutherford Drive  
Over Hulton  
Bolton  
BL5 1DW

Dear Sally,

I have a few items to include in your letters page for the next edition of the journal.

Firstly, a colleague has asked me to enquire if any other members have noticed children showing paradoxical breathing patterns as a result of the introduction of tummy pegs for supplemental feeding; as we have noted this phenomenon occurring in two of our patients.

Secondly, on the topic of hydrotherapy, I would like to ask if any members have had experience of working in special schools that have opened their facilities to a wider clientele during nons-school hours i.e. twilight, weekends and holidays, in an effort to ensure that the facility is well used. If this has occurred could members say how it has been approached from a health and safety point of view e.g. if the health and safety policy has had a section added to take account of this. Some examples of possible users would be current school pupils accompanied by parents, but without the physio present; ex-pupils or members of local disabled groups.

I have been attempting to find out if there are national operating guidelines for hydrotherapy pools in special schools, in preparation for a new pool being built in our area. In reply to my query the Dfee stated they have no national guidelines and believe that the D.O.H. do not either . . . they obviously have either not heard of the C.S.P. hydrotherapy clinical standards or they do not believe they constitute a national guideline. I am now contacting the local Health Authority to see if they have any contribution to make to the issue. Also to ask if anyone has known these pools leased out to local private physiotherapists in an effort to generate income, and the nature of any contracts/safety police drawn up.

Thirdly, do any members know of any hydrotherapy courses running which focus on the P.M.L.D. group of patients and which therefore include considerable input on the idea of a sensory pool and not just the more common therapeutic benefits, which we all know about.

Yours sincerely

Sue Booth

Lyn Hemmings  
96 Hill View  
Henleaze  
Bristol  
BS9 4QG

Dear Sally,

Please could the following notice be printed in the next APCP journal?

An International Support Group for Chartered Physiotherapists is currently being set up. This group is open to any chartered physiotherapists and student members of the CSP, who are working, have worked or are interested in working abroad. We hope to provide support and advice for members and will produce a Membership Directory to enhance networking. In the future we hope to provide study days.

## LETTERS

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For further information please contact myself at the above address or on Email: [lynhemmings@btinternet.com](mailto:lynhemmings@btinternet.com)

Many thanks

Lyn Hemmings

Chris Purdy  
Pam Austin  
Senior Physiotherapists  
Childrens Therapy Room  
Physiotherapy Dept.  
Poole Hospital NHS Trust  
Longfleet Road  
Poole  
BH15 2JB

Dear Sally

We are looking at setting up a 24 hour Postural Management package, including training for parents and carers and supply of equipment such as sleep systems.

We would be grateful to hear from any others who may have a similar project already established.

Also, any current research and evidence based work on this subject would be appreciated.

Yours sincerely

Chris Purdy  
Pam Austin

Suzanne Gibbons  
Senior Community Paediatric  
Physiotherapist  
Devonshire Road Hospital  
Devonshire Road  
Blackpool FY3 8AZ  
Tel: (01253) 306520

Dear Editor

My colleagues and I are currently working on written clinical guidelines for the following specific conditions :

Cerebral Palsy

Muscular Dystrophy

Spinal Cord Injuries

Spina Bifida

Juvenile Chronic Arthritis

We would be grateful to hear from anyone who already has these in place or can offer us any advice/guidance. Also, any information or evidence-based research/practice in the treatment of any of these condition would be gladly received.

Please could any information be sent to me at the above address.

Many thanks

Yours sincerely

Suzanne Gibbons

## LETTERS

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Physiotherapist  
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Dear Editor

### Re: Neonatal Subgroup of the APCP

As you will be aware the profile of Physiotherapy in the field of Neonatology both Nationally and Internationally of recent months has become more heightened although not always with positive results. We all know that the New Zealand enquiry has had huge impact on our input; quite rightly, ensuring not only the safety of the fragile infants that we treat, but the protection of the clinicians that work in this field also. This needs to be done by developing adequate competencies to practice the specialised techniques required for these infants treatments but also ensuring that the techniques are based on best research evidence available.

The recommendation of ongoing regular peer review of practice will also be important for the protection of us as clinicians.

Having myself been involved in this field for several years, including tutorial on two Joan Lacey courses, and running a very popular Introduction to Neonatal Physiotherapy Course last November, it has become obvious that there is an ever growing group of physiotherapists who need support, teaching, and a forum through which to liaise with colleagues.

I am proposing that those interested fill in the accompanying form and I will then organise an initial meeting to look at the following :

- Forming a committee.
- Forming a database/directory of colleagues working in this area.
- Address National Training needs.
- Look at National guidelines and Standards for Physiotherapists working on neonatal units and in follow-up.
- Ultimately establish Competencies.
- Provide peer support/liaison over difficult issues
- Peer review for those working in isolation.

Once I have everyone's replies I can organise a date to meet.

Looking forward to hearing from you.

Yours sincerely

Allie Carter

Superintendent Paediatric Physiotherapist

**PTO**

# LETTERS

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## NEONATAL SUB. GROUP

### DATABASE

Name: Title ..... First name ..... Surname .....

Mailing address .....

Post Code .....

CSP No: ..... Work Telephone Number: .....

Home Telephone Number: ..... Fax Number: .....

Email .....

Areas of responsibility

1. ....

2. ....

3. ....

4. ....

5. ....

Type of Unit .....

Specific Areas of Interest .....

Specific Training Needs .....

What you would like to gain from this group .....

Research/Audit being undertaken .....

Other information .....

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## LETTERS

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Caroline Wilson  
Senior Paediatric Physiotherapist  
Physiotherapy Dept.  
St. Johns Hospital  
Livingston  
EH54 6PP  
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Fax. 01506 460984

Dear Sally

I am currently working with an OT colleague on a talk to education staff (teaching, learning support and PE specialities), and our Medical staff on DCD and Dyspraxia.

We are looking into multiprofessional working in DCD, specifically between Physio and OT, and more generally, though just as important, joint working Health and Education.

I would be interested in members experiences in this area, or protocols that others have in place.

Yours sincerely

Caroline Wilson

Ruth Pimblett  
Paediatric Physiotherapy Services  
Sanderson Centre  
North Avenue  
Gosforth  
Newcastle upon Tyne  
NE3 4DT

Dear Mrs Braithwaite

Our Paediatric Service is currently reviewing the service we offer children with hemiplegia who attend mainstream schools. These children are seen regularly by the pre-school service, but once they are established within a mainstream school, they are seen less frequently with the emphasis on orthotics and problem solving, rather than "hands-on physiotherapy".

I would be interested to hear from other members if they had guidelines or protocols in place relating to this client group and would especially like information on outcomes relating to the acquisition of further motor skills. Also, is there an age, or level of ability, where hands-on therapy input is no longer of benefit.

Yours sincerely

Ruth Pimblett

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'PARTNERSHIP FOR CHANGE,

Summary of some of the lectures

at

APCP Conference 2000

in

Bristol

# APCP EVIDENCE BASED GUIDELINES PROJECT

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The evidence based guidelines project was launched in May 1999 with a study for 40 members who volunteered for the project. The day included an introduction to guidelines and the theory and practice of critical appraisal skills.

The topics selected for the project were Obstetric Brachial Plexus Palsy (Erb's Palsy), Hip Management in cerebral palsy and Developmental Co-ordination Disorder. Members were allocated to each group and have been appraising research papers over the past year. Overleaf the topic co-ordinators have summarised their findings so far. It is planned to produce and publish evidence based summaries for launch at the APCP conference 2000.

All the members who been involved in the project should be congratulated for producing such a high standard of reviews and thanked for the amount of time they have given to the project.

# EVIDENCE BASED SUMMARY OF HIP MANAGEMENT IN CEREBRAL PALSY

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TERRY POUNTNEY  
MCSP

Fifty papers have been reviewed for the project, 22 have been rejected and 28 accepted. The evidence has been divided into distinct categories which cover the evidence for incidence, surveillance, prevention, measurement, treatment and surgery. Areas requiring further research have also been identified.

## Size of the problem

Incidences have been cited at between 25% and 75% in various studies (Cornell 1995) but only one prospective study has firm figures for the incidence at 5 years (Scrutton & Baird 1997). They found an incidence of 35% in all children with bilateral cerebral palsy and 58% in children not walking independently at five years.

## Surveillance

X ray measures and physical ability were found to be the strongest indicators of possible hip subluxation/dislocation.

The acetabular index (see Measurement) is a measure of the amount of dysplasia present in the acetabulum. Cooke et al (1989) found that hip dysplasia was a pre-requisite for hip subluxation. Normal figures for the acetabular index have been identified (Tonnis 1976) and subluxation is unlikely if the acetabular index is close to normal values.

The migration percentage measures the area of the femoral head extending beyond the acetabulum. Several authors (Scrutton and Baird 1997 and Miller and Bagg 1995) have identified this measure as useful in predicting future risk of dislocation from X rays at 30 months, as a continuing indicator in older children of hip dislocation. The annual migration rate has been found to be an indicator of tendency to hip subluxation.

Several studies have found a link between a child's level of physical ability and the rates of hip subluxation/dislocation. Scrutton and Baird (1997) and Howard et al (1985) found a much higher incidence (58%) of hip problems in children not walking independently at 5 years. Young et al (1998) identified a link between children's tonal asymmetry and increased rates of hip subluxation.

Hiroshoma and Ono (1979) identified a link between muscle shortening and derangement of the hips. This study was not entirely rigorous but suggested that clinical evidence of muscle shortening should cause concern. Katz et al (1991) established ranges hip measures in normal infants as a basis for identifying hips at risk.

## Prevention

Positioning of preterm infants was found to affect hip position preventing muscle shortening and changes to the bone shape (Downs et al 1991 and Grenier).

# EVIDENCE BASED SUMMARY OF HIP MANAGEMENT IN CEREBRAL PALSY

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Postural management including positioning in lying, sitting and standing reduces the risk of hip subluxation (Stuberg 1992 and Phelps 1957) .

## Measurement

X ray measures provide the most reliable measures of hip subluxation and dislocation. The child should be positional with the hips and pelvis in a neutral for valid measurements to be taken. The acetabular index provides a reliable measure of acetabular dysplasia up to the age of 8 years when the tri-radiate cartilage begins to ossify. The migration percentage, measures the percentage of the femoral head lying beyond the acetabular continues to be a useful measure into adulthood. Normal values are available for the acetabular index and migration percentage (Eklof 1998, Tonnis 1976, Portinaro 1995, Reimers 1981 and Scrutton and Baird 1997).

The Windswept Index was developed by Goldsmith et al (1992) and provides a method of measuring the relationship between the pelvis and hip ranges. It has been tested for reliability.

Computer tomography has been used to identify deficiencies and may provide a safe, non invasive method of assessing the acetabulum prior to surgery (Buckley et al 1991) .

Katz et al (1991) established norms for the range of hip movement in preterm infants which provides a baseline measure for assessment.

## Treatment Interventions

Several approaches to treatment were reviewed in the literature, weightbearing and muscle tension, Selective Dorsal Rhizotomy (SDR) , Botulinum Toxin and surgery.

Two papers on SDR indicated there may be possible benefits from this procedure but length of follow up was inadequate for a definitive conclusion (Standt et al 1990 and Chicoine et al 1997) .

The evidence for Botulinum Toxin use in the management of hip dislocation was that further studies are required to evaluate its effectiveness (Forsberg and Tedroff 1997) .

The effects of standing and muscle tension were evaluated in two papers. Gudsjondottir et al 1997 and Lespargot et al 1994) . Gudsjondottir et al suggested weightbearing and muscle tension around the hip are essential for its development and Lespargot et al found lack of hip abduction was caused by adductor tendon contracture which with physiotherapy and 5-7 hours can prevent.

## Surgery

There was a wealth of papers in the literature about surgical management of hip dislocation. Many of these were not research studies and others had confusing methodologies and results with limited follow-up periods.

# EVIDENCE BASED SUMMARY OF HIP MANAGEMENT IN CEREBRAL PALSY

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Cornell et al (1997) reviewed children who had hip surgery and found children whose hips had migration percentage of over 40% or an acetabular index greater than 27° remained subluxated or dislocated following soft tissue surgery. Two studies found bony surgery to the femur and pelvis provided satisfactory reduction of the femoral head (Barrie & Galasko 1996 and Gamble et al 1990).

Barrie and Galasko (1996) recommended use of specialist centres for hip surgery to children with cerebral palsy.

Cornell et al (1997) found post operative bracing to be a factor in maintaining reduction of the femoral head.

## Areas of further research

The two main areas which require further research are the use of conservative approaches to hip management and the use of Botulinum Toxin. Currently both areas have trials being conducted in the UK.

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## EVIDENCE BASED SUMMARY OF HIP MANAGEMENT IN CEREBRAL PALSY

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# EVIDENCE BASED SUMMARY

## OBSTETRIC BRACHIAL PLEXUS PALSY (ERB'S PALSY)

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### ANNE WALKER

Superintendent  
Physiotherapist  
Royal Alexandra Hospital  
for Sick Children  
Bright  
and

### DIANE COGGINGS

Chairman APCP  
Paediatric Physiotherapy  
Manager  
Royal London Hospital

For this project papers were selected for review, if reference was made to any of the following :

- i) Physiotherapy management and / or treatment
- ii) Clear information was given on the return of function
- iii) A clear indication given of when to refer on to a specialist centre.

To date

36 papers have been selected  
20 have been, or are being reviewed  
7 have been accepted  
3 have been rejected  
3 have been re-allocated for further review  
The remainder are in the process of being collated

Obstetric Brachial Plexus Palsy (OBPP) has been known about for a long time. Paralysis of both arms following a difficult delivery was first reported by Smellie in 1768, and in 1872 Duchenne detailed several cases of upper plexus obstetric trauma. In the past twenty - twenty five years there has been an increase in interest in this condition, its treatment and management.

### Definition

It is generally accepted that Obstetric Brachial Plexus Palsy occurs as a result of extreme lateral traction on the head of the infant away from the shoulder during the last phase of delivery. (Clarke & Curtis 1995) The baby presents with reduced or absent movement, usually of one arm, but occasionally of both. The diagnosis is made when all other differential diagnoses have been excluded.

### Incidence

There are no accurate statistics about the true incidence of OBPP within the UK but the following incidences have been reported from the literature reviewed:-

UK -	0 - 5 per 1000 live births (G C Bennett, A J Arnold BMJ 1976)
Sweden -	0 - 5 per 1000 live births (I Sjoberg, L Erichs, I Bjerte 1988)
USA -	0.5 - 2.6 per live birth (C Eng, H Binder, P Getson, R O'Donell 1996)
New Zealand -	0.87 per live births (A E Hardy 1981)

# EVIDENCE BASED SUMMARY

## OBSTETRIC BRACHIAL PLEXUS PALSY (ERB'S PALSY)

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In one of these studies the male / female ratio was 49% / 51%

- Left arm involvement 45%
- Right arm involvement 51%
- Bilateral arm involvement 4%

### Prevalence & Classification

The two commonly occurring presentations are:-

- a) Cephalic presentation of overweight babies of above 4 kgs. This may result in a plexus injury most commonly affecting C5 and C6 and occasionally C7 nerve roots.
- b) Breech presentation usually of small babies below 3kgs. One study by Geutjens, Gilbert and Helsen in 1996 showed that this group had a different pattern of injury, and a far worse prognosis for shoulder function. These babies may have required excessive extension of the head and often manipulation of the upper limb, exerting traction on the whole plexus, causing rupture or avulsion of many and occasionally all the nerve roots C5 - T1.

L Duclos and A Gilbert (1995) report 2 basic types

- 1) Erb - Duchenne type of paralysis - with C5 and C6 nerve roots or C5 and C6 and part of C7 roots involved - accounting for 75.5% of cases.
- 2) Total Paralysis - with C5 - T1 nerve roots affected and this accounts for 24.5% of cases.

Narakas (1987) classified OBPP into 4 groups based on examination at two - three weeks of age

Group 1 C5 - C6 injury. The new born child presents with a typical Erb - Duchenne palsy with paralysis of shoulder abductors and external rotators, elbow flexors, forearm supinators and wrist extensors. The fingers and wrist have normal flexors and the intrinsic muscles of the hand are not affected. The arm is held in the typical position of internal rotation and adduction of the shoulder, forearm pronation, elbow extension and wrist flexion. Recovery usually starts before the end of the first month, and by four - six months more than 90% have a normal upper limb.

Group 11 - C5, C6 injury C7 partial injury. This group shows the same presentation as group 1, but active elbow extension is weaker due to the C7 involvement. This group shows a slower recovery and may develop a contracture into internal rotation and adduction at the shoulder by eight months of age, and shortening of the humerus by six years. The child may require surgery to release these contractures.

# EVIDENCE BASED SUMMARY

## OBSTETRIC BRACHIAL PLEXUS PALSY (ERB'S PALSY)

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Group 111 - C5 - T1 injury. This shows a complete paralysis of the affected limb. At one month the shoulder is flail with no active rotation, there is no elbow flexion and only weak extension. The wrist is flexed and the fist tightly closed. There is no Horner Sign. The hand will improve slowly, with 50% of the group recovering good / normal hand function. However, flexion contracture at the elbow is common, and shoulder recovery may take a year or more to show any improvement in function, which often remains poor.

Group 1V - C5 - T1 injury. This like group 111 shows complete paralysis plus Horner's Syndrome - (The signs seen typically in Horner's Syndrome are a ptosis, enophthalmosis and anhydrosis on an ipsilateral face), caused by the avulsion of the T1 nerve root. (Clarke & Curtis 1995). The child may recover some finger function at around one year, otherwise recovery is poor and the arm will be six - eight cms shorter by adolescence. The shoulder will be held internally rotated, and can dislocate posteriorly, the elbow is usually fixed at forty five degrees with no active extension, but active flexion. The forearm is fixed in supination, the wrist is ulnar deviated, and a claw deformity of the hand develops.

### Physiotherapy

There is very little evidence so far with reference to Physiotherapy, apart from :-

- Refer at an early age - children who have not got active biceps by the end of three months of age should be referred to a peripheral nerve centre that specialises in nerve grafting on children with OBPP.
- Stretching and positioning for the affected arm should be taught to parents/carers, and monitored regularly, particularly in the early stages, that is under one year of age.
- When the child is old enough, weightbearing and strengthening exercises should be carried out as much as possible.
- Treatment should be continued until growth stops. The indication is that secondary deformities develop, particularly in the shoulder, inhibiting function, and therefore reviews should be carried out by a Physiotherapist, with appropriate advice.

### Measurement

Various standardised tests have been found for measuring :-

- Mallet Scale :  
looks at shoulder function - Tassin,  
Hertz &  
Meyer.
- Functional Scale :  
looks at hand function - Raimondi,  
Duclos  
& Gilbert.

# EVIDENCE BASED SUMMARY

## OBSTETRIC BRACHIAL PLEXUS PALSY (ERB'S PALSY)

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- Injury Scale :  
looks at the amount of damage - Tachdjian.
- Active Movement Scale :  
Assesses movement with a score, used for surgery intervention - Clarke & Curtis.
- Oxford Scale :  
Tests muscle power.
- McNemar's Test of symmetry :  
Compares initial examination and outcome.

### Assessment

When assessing a child with OBPP, the following should always be considered :-

- Other associated conditions :  
A fractured clavicle and/or humerus.  
Another diagnosis, such as Cerebral Palsy.  
Torticollis.
- Bilateral Cases :  
These occur in 5% of cases.
- Early assessment  
Look for indicators for primary and secondary problems.
- Surgery :  
Early nerve graft surgery should be carried out between three and six months, and selection criteria should be used.
- Common deformities :  
Internal rotation of shoulder.  
Fixed shoulder adduction.  
Elbow flexion.  
Pronation.
- Later Disabilities :  
As discussed previously, later deformities are not uncommon, particularly in the shoulder.

### Research Areas

There is very little research been done with respect to Physiotherapy, and it is felt that what is needed is :-

- A Standardised initial Physiotherapy Assessment.
- User friendly standardised classification for Physiotherapists.
- Standardised positioning for muscle charting.
- A clear indication as to when to start passive treatment.
- An indication as to the frequency of treatment.
- ? Standard exercise programmes.

# EVIDENCE BASED SUMMARY

## OBSTETRIC BRACHIAL PLEXUS PALSY (ERB'S PALSY)

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We still have more papers to collate and are in the process of sending out a questionnaire with regards to Physiotherapy treatment in different areas/centres.

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# DEVELOPMENTAL CO-ORDINATION DISORDER EVIDENCE BASED SUMMARY

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**JILL BROWNSON**

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and

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**The aim of this project has been :**

To achieve a consensus of expert opinion which is based on the findings from scientific papers

The most acceptable source of evidence was deemed to be published scientific papers. A literature search produced a comprehensive selection of papers, but retrospectively not perhaps entirely as anticipated.

We knew that justification for evidence may come from accepted practice amongst experts in the field.

Intuition may also be important, with the experience and knowledge of experts enabling them to make judgements based on apparently little evidence.

Informal enquiries into Clinical Practice suggest that most centres practise in similar ways.

We hoped to find that we could establish from evidence from scientific papers :

- an agreed definition of DCD
- a well defined list of difficulties and features

This would enable treatment/intervention to be reliably recorded, measured and evaluated.

We also hoped to be able to summarise similar clinical pictures, treatment approaches and successful treatments.

The current difficulties in the physiotherapy management of DCD arise from the number of variables:

- treatment options
- groups vs individuals
- criteria for selection of children to be offered treatment
- differing presentations of the 'symptoms'

These all contribute to a difficulty in measuring outcomes and a poverty of evidence available for intervention in Developmental Co-ordination Disorder.

Initially we were fairly clear that our anticipated recommendations would be :

- A clear definition
- Clearly defined treatment goals to be established before intervention
- Outcome measures to assess intervention

# DEVELOPMENTAL CO-ORDINATION DISORDER EVIDENCE BASED SUMMARY

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There are additional factors which complicate the project :

- The insistence of other professional groups to merge common features in other conditions and to question whether they are a manifestation of DCD (for example children with Autism or ADHD commonly display features which could be classed as DCD, some children with a moderate learning disability display co-ordination difficulties).
- Variable pattern of referral to either physiotherapists or occupational therapists, or jointly where joint working is known to take place.

Models of care have been developed and published both by Michele Lee and the Thameside and Glossop physiotherapists and occupational therapists. In both instances a definition was taken which enabled children to be identified for whom treatment was deemed suitable. These package have been adopted by other services.

- Sensory Integration is a treatment approach offered by some services (most commonly OTs) but not others.

The greatest hurdle to developing a Clinical Guideline is the production of evidence for the adoption of a definition of children for whom we consider treatment is appropriate. Intrinsic within that is the need to have scientifically based evidence in order for the diagnosis to come within the acknowledged remit of the therapist not the medical profession.

## Process

The initial literature search produced almost 100 articles (that was after selecting appropriately from the entire literature search).

At first, articles were randomly selected from that number for critical appraisal - using the premise that it was not the role of the core members of the group to evaluate articles before critical appraisal techniques were used.

Articles had predominantly been published in journals such as Developmental Medicine and Child Neurology, or various American, Australian or New Zealand physical and occupational therapy journals.

To date 28 articles have been reviewed.

## Results so far

Appraisers have identified that useful papers are those concerned with definitions of :

- Developmental Co-ordination Disorder
- Differential diagnosis
- Remediation

# DEVELOPMENTAL CO-ORDINATION DISORDER EVIDENCE BASED SUMMARY

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For example :

Sydney Chu 'Developmental Dyspraxia - the diagnosis' appraisers describe this as a key article on differential diagnosis which also defines a lack of standardised tests.

Willoughby & Polatejko - 'Motor Problems in children with DCD. A Review of the Literature'. Despite a lack of conclusions this article reinforces that the eclectic approach can work but that accurate diagnosis is essential before any intervention occurs. There is reference also to the need to understand the uni and multi sensory nature of DCD.

Sugden and Chambers are proving to be interesting authors in that they state that they know that intervention works but not how. They also write about diagnostic criteria and cultural aspects.

Sydney Chu - 'Do they grow out of it?'. Despite not being a true research paper this is identified as being a good article - clear and helpful. Comments have been: 'should this be one of our key papers to date?'

Controversially, Sigmundsson et al 'We can cure your child's clumsiness - a review of intervention methods' is also interesting, it asks whether the 'teacher' of the method has just as much influence as the method taught. It also suggests that initiating an intervention programme is as important as the actual programme itself.

## Conclusion to date

Collation of the responses from appraisal of articles so far has prompted the conclusion that the emphasis must be on the need for accurate diagnosis and classification i.e. if clumsiness is identified as a problem then it must be classified within boundaries of

- MLD
- True Dyspraxia
- Neurological symptoms
- Behaviour disorder

Our current needs must be to :

- Share current practice
- Write about and publish it
- Audit current treatments with standardised tests
- Agree outcome measures

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# DEVELOPMENTAL CO-ORDINATION DISORDER EVIDENCE BASED SUMMARY

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## DEVELOPMENTAL CO-ORDINATION DISORDER EVIDENCE BASED SUMMARY

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# INTEGRATING CHILDREN'S SERVICES (OR . . . THE TRUE CONFESSIONS OF A CHILD HEALTH MANAGEMENT INTEGRATOR)

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## PETER KOHN

Chief Executive  
of Cotswold PCG

The lecture split into 4 parts:

### Part 1 : Integrated Children's Services

This is an abridged version of the final lecture of the conference given by Peter Kohn.

- Integrated children's services
- Organising special needs services
- Multi-agency assessment of children with complex/severe special needs
- The development of a multi-agency children's centre

These were chosen to reflect four aspects of the subject. In the lecture these were linked by three small exercises chosen to illuminate the succeeding section.

I have been responsible for two integrated children's services, Greenwich and West Herts. The Greenwich service was created by amalgamating all the children's services from the health authority under one unit of management. This incorporated everything from continuing care for special needs children to special care babies. The West Herts service was formed by bringing together children's services from two acute and one community trust.

The organisational chart of the West Herts children's service was used as an example of what such a service could look like. The work of the total services divided into programmes of care; pre-school, school health, special needs, children in need, in-patient paediatrics, ambulatory paediatrics, support to the newborn and child mental health. These were split into areas, each under an associate director; one for community services, acute services and child mental health, and supported by a triumvirate of the Clinical Director, Manager and Clinical Nurse Manager. Each of the associate directors was responsible for the strategic development of the programmes of care under their responsibility, and supported in the day to day operational management by the Manager and Clinical Nurse Manager. In time the Therapy Head for all children's therapies was added into the structure along with all children's therapies. This is a great leap forward in being able to develop services for children with special needs in particular. While it was possible to make developments with the therapeutic disciplines being managed separately, there is no doubt that having to address separate lines of management added a complication into planning which was absent when all the players were part of the same management structure.

In looking at the question of why it was important that children's services were provided on an integrated basis, the difference between children's and other services were highlighted. Children are different from other health service users in that they each come with parents, they need to grow and develop to reach their full potential, and the secondary health sector

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retains a continuing responsibility for children's development which is absent in most other services. To provide children's services effectively, co-ordination and co-operation are absolutely essential. Even something relatively straightforward like an immunisation campaign for measles requires intense planning by several agencies and several parts of those agencies.

The integrated approach also makes a clear difference to the co-ordination with other agencies who find these structures in the Health Service impenetrable and confusing. An integrated service provides a single point of access which is a great advantage both in operational and strategic terms.

There are, however, some dangers with an integrated approach which needs to be carefully managed. Foremost amongst these are personalities or groups coming with their own agendas or fixed receptions. The ability for turf wars to break out is increased if boundaries between services are reduced and previously held positions become exposed to new ways of working. A second source of difficulty can arise if there is no support from the top. The children's service in West Herts was always well supported by a steering group consisting of the chief executives of each of the trusts and the health authority. This high level of exposure was due in part to the experimental nature of joining together services from three trusts and in part to the key position which children's services had in the configuration of hospital services in West Herts. A very senior level of support was important in maintaining momentum of development.

Two necessary conditions were set out for making such an organisational arrangement a success. Firstly to set up the system with checks and balances to prevent domination by any one group; secondly, and probably more important, to pay attention to the relationships within the group, fostering team work and open lines of communication.

The Conference were asked to write down quickly the words they immediately associated with a list of professions which was read out. They were asked to write down the first word or phrase that came into their mind without stopping to think. The words were : teacher, policeman, physio, doctor, OT, social worker and manager. I asked them to look down the list and look out which had positive and negative connotations. It was clear from the very vocal feedback from the floor that many of the words carried stereotypes. I asked the Conference to consider what part these stereotypes played in making integration more or less successful. I suggested that if people were aware of stereotypes that they brought as mental baggage when coming to work with other disciplines, this was the first step to understanding and developing a better working relationship.

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**Part II :** This part dealt with organising services for children with special needs.

I set out a series of definitions of multidisciplinary working as a way of clarifying this term which has so many meanings for different people. The classification here had three levels:

- Multidisciplinary where a team in which professionals from different disciplines work independently of each other. The child being assessed is evaluated by each team member only in his/her area of specialisation. Upon completion of the assessment the team members develop the part of the management plan related to their own discipline.
- Inter-disciplinary where representatives of various professional disciplines separately assess the child but the team comes together at some point to discuss the results of their individual assessments and develop a plan for intervention. Interdisciplinary teams are characterised by formal channels of communication that encourage team members to share their information and discuss individual results.
- Transdisciplinary, where a team composed of professionals who cross disciplinary boundaries and thereby maximise communication, interaction and co-operation among team members. Families are part of the team and are involved in setting goals and making programmatic decisions for themselves and their child. All decisions regarding the assessment, evaluation and the development of the management plan are made through team consensus.

Of these definitions the first is characterised by a report which has many different sections completed by different people and the multidisciplinary bit is the staple in the corner holding them together. The second is good for some circumstances where less intensive work is needed. The third is the gold standard, but extremely resource intensive.

I set out the child development team organisation by referral/assessment and treatment pathways chart from West Herts which envisaged three streams of workload going into the team. The first was referral to a single discipline where the assessment was carried out and treatment offered by a single discipline. The second, and most common, pathway was a referral into the child development team which was evaluated at the weekly team meeting. If this required assessment by more than one discipline, then a co-ordinator was agreed who would then sort out the assessment process and sequence, co-ordinate a report and action plan, ensuring that the child then went into the correct treatment package. This could be characterised as an interdisciplinary approach. The third referral route was for children who were complex or severe where a multi-agency process or assessment was required. This would follow a transdisciplinary approach, also including other agencies, and was the subject of part III of the talk.

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I outlined the process by which this comprehensive approach to special needs had been developed and the number of drafts through which it had gone to reach its current shape. I was able to report that the process was beginning to work well in West Herts, although certainly had not reached full fruition yet.

**Conference delegates found the next exercise easy to fulfil. I posed the question - 'You are a parent of a child with severe cerebral palsy with all the complications - who are you likely to see?' The Conference identified about 25 different professionals from different agencies with ease. I pointed out that what tended to happen was that the child and family were the communication route between each of these professionals and the next. They were the only people with whom all of the different professionals communicated. Apart from presenting the child and family with an enormous communication and co-ordination problem, this also meant that all of the various professionals both created duplications and gaps in services. How was it possible to create a system where services work together in a co-ordinated way?**

## Part III

I suggested that the area of complex and severe special needs was one of the most complicated areas in the NHS. It required three main agencies and multiple parts of those agencies to work together in a co-ordinated fashion and was rarely achieved for the most vulnerable children.

I described the process of developing an inter-agency assessment of children with special needs in Hertfordshire. A small like-minded group of professionals from three agencies had met over the period of two years to devise this process set out in detail in the accompanying handouts. The process had three elements; identification of children meeting the criteria for inter-agency assessment, a process of history taking and an assessment process leading to an action plan.

This process was currently being tested in two pilots in Hertfordshire, one with a child development centre, the other without. The achievement of such a system required great persistence by the professionals engaged in its development but was capable of answering many of the criticisms of services voiced so often by parents of children with complex and severe special needs.

**I explained the difference between wicked and tame problems, a distinction first noted by H. Rittel, a German physicist, in the early '70s. Rittel saw tame problems as those with known algorithms for arriving at a correct solution, whereas wicked problems are very complex, were often difficult to define and there is no right answer for their solution. The Conference were asked to identify problems that occurred at work which were then classified into either the wicked**

# INTEGRATING CHILDREN'S SERVICES (OR . . . THE TRUE CONFESSIONS OF A CHILD HEALTH MANAGEMENT INTEGRATOR)

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or tame problem category. Most of the problems highlighted by the Conference were wicked in nature. Delegates were not entirely sure what the problem was, the problem kept changing, the consequences of actions were unknown and there were many potential different solutions to the problem. I suggested that the only way of effectively dealing with wicked problems was to engage individuals, employ a consistent approach, be persistent, build up pressure for change and have a bit of luck.

## Part IV

Finally I described the development of a Children's Centre in St Alban's which had services from the three main agencies and voluntary sector. I described that when I first started at West Herts I was given what I thought was a tame problem of trying to relocate a child development centre, which turned out to be the king of wicked problems. I described my first tentative contacts with education to see whether there was a joint approach which was possible with a local nursery school, and the same approach was made to the family centre.

Over time, a possible site for the centre in an old disused cottage hospital was found. There was plenty of enthusiasm from the school and social services to try and find a solution which was both possible in capital and revenue terms. This exposed huge differences between the financing system of local authority and the health service which needed to be circumvented to allow the scheme to go forward.

Then came the bit of luck. The new incoming government decided that it would like to develop early years centres of excellence into which this sort of bid fitted quite well. A bid was made to the Department for Education and Employment which failed in the first instance, but allowed a dialogue to be opened with the Department to engage them in the ideas of the planning team.

I described all of the different agencies, key people, external people, workers, funders and health authority who needed to be lined up to point in the same direction to allow this scheme to succeed and described it as 'like the proverbial herding of cats'. At some point each party wandered off and needed to be brought back into the fold. I described how 80% of the parties would be lined up facing the same direction, then someone would get cold feet. Finally, once sufficient people were all lined up then it began to feel as if the tide was flowing in the direction of a position decision. I was able to report that two weeks after I left the West Herts job the funding for the children's centre was approved. As somebody wryly pointed out 'you should leave more often'!

I rounded up the session by pointing out that it was a wicked problem that had no easy single solution but that had been eventually solved by persistence, engaging all partners in the process and a little bit of good luck.

# GOLDSMITH INDEX OF BODY SYMMETRY

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## JOHN AND LIZ GOLDSMITH

### Symmetrikit

### Introduction

This assessment is designed to identify body symmetry and quantify asymmetry. It has been validated in a study published in "Physiotherapy" (Goldsmith et al 1992). It is expected that the procedure will be used in conjunction with other measurement techniques and will :-

- Provide the therapist with a simple and reliable method of measuring and recording body symmetry.
- Enable the therapist to give feedback to those providing postural care for the individual.
- Increase the therapist's sensitivity to the early signs of asymmetry, and raise awareness of the processes of its development.
- Enable the therapist to plan postural care on the basis of objective measurements.
- Provide data essential for the scientific evaluation of the effects of postural care.

### The Measurement Procedures

Each of these procedures is carried out four times and the mean of these four measures is calculated so that both the average result and the range of readings provide a depth of understanding of clinical information and an indication of intra-rater reliability.

- 1i Measurement in crook lying of the angle of the pelvis when the knees are upright, and
- 1ii If the angle of the pelvis is not level, the angle to which the knees must be taken to bring the pelvis level.
- 2 Measurement in crook lying of symmetry of rotation of the pelvis, as influenced by movement of the flexed knees together in an arc right to left, with the shoulders and feet fixed.

### Description of roles (*italics within the text indicates instructions*)

#### *The Measurer* (A therapist, trained in the procedure)

- Ensures that all measurements are accurate, carried out gently and according to the instructions. Explains the procedures and directs the patient and assistants.
- After the measurements have been taken, wipes off all pen marks that have been made on the patient. Records the angles and measurements on the record forms.
- Interprets these findings and explains implications of the results for postural care.

#### *Assistant 1* (Ideally, the parent or main carer)

- Places the patient correctly and comfortably in the starting position.
- Talks to and reassures the patient, keeping the measurer and assistant 2 informed about the patient's immediate emotional and physical needs.
- Holds the patient's limbs when required and makes the patient comfortable after each procedure has been completed.



# GOLDSMITH INDEX OF BODY SYMMETRY

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*Assistant 2* (A trained individual with handling skills)

- Places the patient correctly and comfortably in the starting position.
- Adjusts the pendulum goniometer to bridge the pelvis and uses it to identify the various angles adopted by the pelvis. Holds the pelvis flat during Procedure 3
- Holds the patient's limbs when required and makes the patient comfortable after each procedure has been completed.

## Equipment needed

1-A measuring board 2-A pendulum or electronic goniometer  
3-A standard goniometer 4-water soluble pens and chalk 5-wipes

## Starting positions

Before carrying out any of the measuring procedures outlined in this manual it is essential to spend time getting the patient into a good starting position, which is marked on the board, along with the position of the foot supports and measuring rod. This ensures that the measurements taken are recorded from a consistent starting position.

The optimum starting position (OSP)

This is the position to be used if the patient is able to fulfil all the criteria listed below. If existing problems with muscle tone or body shape prevent the OSP from being used, adapted starting positions (ASP1 and ASP2) have been devised, which are described within the text. It must be noted however that reliability of the measures will be compromised if the OSP cannot be attained.

Criteria for obtaining the (OSP)

- Supine crook lying on the board
- As straight as possible over the mid line marked on the board
- Buttocks in line with the edge of the board
- Both knees upright and flexed to an angle of 70 degrees
- Pelvis level
- Feet stabilised in the sandals
- Arms slightly abducted by the sides

## Attaining the starting position

There may be many physical or behavioural difficulties that will require adaptations to the OSP and where a compromise will have to be reached. Record all such adaptations and be aware of their effect on reliability. Looking at the range of results within the four measures taken can help when assessing reliability. A small range will suggest reliable measures, whereas a large range will reduce confidence in the results.

*Assistant 1*

Take up a position at the patient's head, talk to him and reassure him.

*Measurer and Assistant 2*

Place the patient on the measuring board so that the criteria listed for the OSP are met as closely as possible. Using the standard goniometer check

# GOLDSMITH INDEX OF BODY SYMMETRY

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that the knees are flexed to an angle of 70 degrees and stabilise each foot in the fur-lined sandals.

If joint restriction, spasm or any other reason prevents one or both knees being placed at 70 degrees record the angle formed by each knee on the record sheet.

This position becomes adapted starting position 1 (ASP1)

Mark the position of the trunk, shoulders and head on the measuring board and mark the position of the fixing bracket of the each of the sandals.

## Marking of reference points

### *Measurer*

Surface mark the most medial point on the joint line of each knee. Connect the measuring rod to the rotating bar and clamp it into the upright position. Move the rod along the rotating bar so that it comes in line with the surface mark made on the right knee. Fix the rod in this position and make a mark on the right side of the rotating bar to identify this point (position "x"). Repeat this procedure for the left knee, making a mark on the left side of the rotating bar (position "y"). If "x" and "y" are not opposite each other, measure a point mid way between the two marks and make a third mark to identify the point "z" on the rotating bar.

## Measurement procedure 1

This forms the starting position from which all other measurements are taken and in itself gives an assessment of the structural symmetry or otherwise of the pelvis.

- li Measurement in crook lying on the angle of the pelvis when the knees are upright, and
- lii If the pelvis is not level, the angle to which the knees must be taken to bring the pelvis level. This position becomes adapted starting position 2

### *Assistant 1*

Support the patient's head in mid line with the shoulders flat.

### *Measurer*

Stand at the patient's feet and support the knees and feet.

### *Assistant 2*

Adjust the bridge of the pendulum goniometer so that the pillars rest on the anterior superior iliac spines (ASISs)

### *Measurer*

With the measuring rod clamped into the upright position at the position "x" if the knees are level with each other and at "z" if they are not, bring the knees together until they are in contact with the rod.

# GOLDSMITH INDEX OF BODY SYMMETRY

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## *Assistant 2*

Place the pendulum goniometer on the ASISs taking care not to alter the angle formed by exerting too much pressure or by pressing down unevenly. Read the angle of the pelvis as indicated by the pendulum goniometer and tell the measurer the result.

## *Measurer*

If the pelvis is level make a record on the record sheet (in the space marked 1/1). If the pelvis is not level, release the clamp to allow the rod to rotate and move the knees away from the upright until the pelvis becomes level. Press the indicator button to read the angle of the rod and record both the level of the pelvis when the knees were upright (in the space marked 1/1) and the level to which the knees were taken to bring the pelvis level (in the space marked 1/2).

If the pelvis is level when the knees are upright, the knees are flexed to 70 degrees and all the other OSP criteria are fulfilled, record that the OSP has been used.

If the knees must be taken to one side to bring the pelvis level record that ASP2 has been used. The acute angle will indicate the side to which the knees must be taken and these angles will replace the upright position of the knees in the starting position.

## **Measuring procedure 2**

Measurement in crook lying of symmetry of rotation of the pelvis; as influenced by movement of flexed knees together in an arc, right to left, with the shoulders and feet fixed.

This measurement indicates symmetry of the trunk; pelvis and legs as the knees are moved from side to side. When individuals become asymmetric, changes in body shape involve the whole structure and therefore effective interventions need to control all the component parts of those changes. Measurement is designed to capture these overall changes, alerting therapists and carers to analyse any development of asymmetry and debate the appropriate therapeutic response. In a symmetrical individual, as the knees are taken to one side the pelvis rises on the contra-lateral side. The relationship between the angle of the legs and the resultant angle to which the pelvis lifts can be calculated. This angle is known as the "Angle between legs and pelvis". If an individual is perfectly symmetrical and perfect measurements are taken the (ABLAP) when the knees are taken to the right will be exactly the same as when the knees are taken to the left. However, as an individual becomes asymmetric changes occur in this relationship and by measuring and comparing the ABLAP, knees to the right, with the ABLAP, knees to the left, the clinician and carers can analyse component parts of the early stages of departure from symmetry.

# GOLDSMITH INDEX OF BODY SYMMETRY

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2/1 Pelvic rotation with knees to the right

*Assistants 1, 2 and Measurer*

Ensure the patient is in the OSP/ASP as previously devised. Gently bring the patient's knees together until they are in contact with the rod.

*Assistant 1*

Hold the patients's head in midline and the shoulders firm and flat to prevent lifting.

*Measurer*

Explain to the patient that their knees are going to be moved to the right and gently take the knees as far as possible towards the floor, allowing the pelvis to rotate and allowing the feet to rotate within the confines of their stabilised position. When the limit of comfortable movement is reached, apply gentle pressure to the lateral border of the left knee to ensure that the left leg is in contact with the ruler.

*Assistant 2*

When the measurer indicates that the posture to be measured has been achieved, gently place the pendulum goniometer on the ASISs, taking care not to influence the angle of the pelvis by exerting too much pressure or by pressing down unevenly. Note the angle formed.

*Measurer*

Simultaneously with reading of the pelvis angle, press the angle indicator for the leg angle.

2/2 Pelvic rotation with knees to the left. *Repeat the procedure with knees taken to the left.*

## **Calculating the Goldsmith Index and range of results**

Calculate the average leg and pelvic angle from each of the four sets of measurements. Work out the ABLAPs by subtracting the pelvic angle from the leg angle for each of the sets of measurements and the mean of these. This will give the average ABLAP with knees to the right and the average ABLAP with knees to the left. Many subjects develop the classic form of "windswept body shape" in which the legs fall down towards one side and the pelvis rotates backwards on the contralateral side. In these cases a useful illustrative device can be used by subtracting one ABLAP from another. The ABLAP when the subject is taken to the side to which they prefer will be greater than when they are taken to the other side. Thus the figure resulting from subtracting one from another, with the higher number representing the side to which the subject is windswept, can be said to represent the degree of symmetry or otherwise. In these cases no difference, or 0, represents symmetry and increasing difference represents increasing asymmetry. This figure can be known as the Goldsmith Index.

# GOLDSMITH INDEX OF BODY SYMMETRY

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**Range of results “Highest right/lowest left” “Highest left/lowest right”**

With four measures being taken to each side a range of results can be studied by comparing the extremes of result. If it is suggested that only one measure was taken and it was the highest to the right and the lowest to the left the result will illustrate the most to the right that the subject could be said to be windswept. Alternatively if the same calculation was made using the lowest to the right and the highest to the left the result will illustrate the most to the left that the subject could be said to be windswept. This set of calculations, illustrated on a record sheet, gives a range of possible results, which is useful for two main reasons.

- 1) Identification of intra - rater reliability  
Confidence in accuracy of the measures can be extracted from the size of the band of results. A small band illustrates a more reliable measure whereas a large band illustrates either poor technique on the part of the measurer or extreme difficulty inherent in the subject's condition.
- 2) Strong identification of symmetry  
It can be seen that if an individual is symmetrical the results will span the mid line, with a tendency to become windswept amply signalled by a tendency for results to move to one side.

**Reference**

Goldsmith, E. Golding, R.M., Garstang, R.A. MacRae, A.W. “A Technique to Measure Windswept Deformity” (1992) *Physiotherapy* vol 78, no 4, p 235-242.

## PERSPECTIVES ON INCLUSION

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Many paediatric physiotherapists are now finding themselves working in local authority contexts where policy directions are pointing towards greater inclusion of children with special educational needs in mainstream educational settings. The purpose of this article is to summarise some of the national and international perspectives which are driving this change, and then to describe some of the ways in which local authorities are approaching the issue.

Inclusion is a relatively new word for many of us. As recently as three or four years ago, integration was the term used. One of the first steps many local authorities have had to take is to define what they mean by inclusion. This is the definition we have adopted in Bristol, in our Inclusive Education Policy:

*Inclusive Education means all children, young people and adults - disabled, non-disabled and disaffected - being able to learn together in ordinary pre-school provisions, schools and community education settings, with appropriate networks of support.*

On its own, this definition carries a meaning no different to that we attribute to integration. It is necessary to add, in any policy, an explanation of how inclusion differs from earlier concepts. We have defined the differences as follows :

*Inclusive education is different from Integration. Many schools "integrate" disabled children by bringing them into their premises - but on the school's terms. The pupil can stay if she/he can benefit from what is already on offer; the school does not in this case expect to change to accommodate and support diverse needs.*

*Inclusive education, by comparison, seeks to adapt systems and structures to meet needs. Adaptations to the school curriculum, to buildings, to attitudes and values, to language, images and role models are some of the changes required if we are to move from integration to real inclusion.*

Inclusion, then, is about **changes** in mainstream schools to enable them to meet a wider range of needs, rather than about closing special schools or arranging for a special school child to spend a few days a week in his or her local school, with a support assistant attached. Integration, on the other hand, "allows a few more children, who might once have been in a segregated school, to attend an unchanged mainstream school as long as they can manage with a ramp, a little bit of untrained support and their mother on permanent stand-by" (Mason, M., 2000)

Inclusion as a concept has an international pedigree going back many years. It was defined as a basic entitlement for all children in the 1989

## PERSPECTIVES ON INCLUSION

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UN Convention on the Rights of the Child. In 1994, ninety-two governments (including the UK) were signatories to the Salamanca agreement, in which they made a commitment to a set of key principles:

- *Every child has unique characteristics, interests, abilities and learning needs.*
- *Educational systems should be designed and educational programmes implemented to take into account the wide diversity of these characteristics and needs.*
- *Those with special educational needs must have access to regular schools who should accommodate them within a child-centred pedagogy capable of meeting these needs.*
- *Regular schools with this inclusive orientation are the most effective means of combatting discriminatory attitudes, creating welcoming communities, building an inclusive society, and achieving education for all: moreover, they provide an effective education to the majority of children and improve the efficiency and ultimately the cost-effectiveness of the entire educational system.*

(Salamanca Statement, 1994)

Little happened at national level in the UK, however, until 1997, when a new government produced a consultation paper on SEN, setting out its stall on inclusion:

*The ultimate purpose of SEN provision is to enable young people to flourish in adult life. There are therefore strong educational, as well as social and moral, grounds for educating children with SEN with their peers. We aim to increase the level and quality of inclusion within mainstream schools, while protecting and enhancing specialist provision for those who need it. We will redefine the role of special schools to bring out their contribution in working with mainstream schools to support greater inclusion.*

Excellence for All Children  
DfEE, 1997

Responses to the consultation paper were varied, spanning the whole range of strongly-held views on inclusion, both for and against. The final DfEE policy statement was more pragmatic than the original, and emphasised parental choice:

*Promoting inclusion within mainstream schools, where parents want it and appropriate support can be provided, remains a cornerstone of our strategy. But our approach will be practical, not dogmatic, and will put the needs of the individual children first. We confirm that specialist*

## PERSPECTIVES ON INCLUSION

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*provision - including special schools - will continue to play a vital role.*  
Programme of Action  
DfEE, 1998

Parental choice similarly figures in the most recent DfEE statement, this time in the shape of draft legislation:

*A child with SEN shall be educated within a mainstream setting unless:*

*a) this is incompatible with the wishes of his or her parents*

*b) a school or local authority cannot take reasonable steps to adapt its provision to secure a place for them in mainstream without:*

*i) prejudicing the efficient education of the children with whom he or she will be educated;*

*or*

*ii) incurring unreasonable public expenditure*

SEN and Disability Rights in Education Bill Consultation Document,  
DfEE 2000

The stated intention of this draft legislation is to give "... a clear signal that a mainstream place should only be refused in the small minority of cases where it cannot be demonstrated that the interests of all children cannot be safeguarded (DfEE, 2000). However, it poses some interesting problems for local authorities. On the one hand, they are being asked to make sure that any child whose parents chose a mainstream placement will be able to access this, with additional support and some adaptations to the curriculum, buildings and staff skills. On the other hand, they are being asked also to maintain a healthy special school sector for "those who need it" (or those whose parents choose it).

In cost terms, this is going to be a difficult trick to pull off. At worst, it might be seen to be based on a frustrating circular argument: "special schools must be kept because mainstream schools cannot cope because they do not have the resources that are in special schools" (Mason, M. 2000).

Some special schools, however, are finding their own ways out of this circular argument. Working with their LEAs, they are redefining a role for themselves, which may involve



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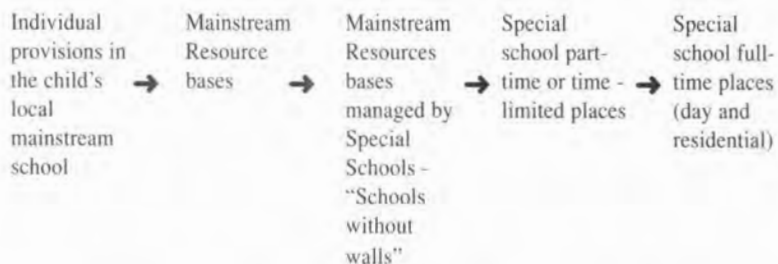
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- providing outreach support to children who attend their local mainstream school
- providing time-limited places (particularly, in relation to physical impairment, when children are young and in need of a focused period of intensive, specialist support) which end in a return to mainstream
- relocating whole groups (a whole class, or a whole department - such as a primary or secondary department) **with** their special school staff to a partner mainstream school.

This last model is sometimes called 'schools without walls'. What it means is that a special school remains as a school, with its own Headteacher, governing body and staff, and with a full complement of children on its roll - but with some or all of those children located elsewhere, on mainstream sites.

It is a model most appropriate where children continue to require specialist facilities (hydrotherapy, for example, or sensory rooms) which would within current financial resources be impossible to provide in every mainstream school. As a way of increasing opportunities for inclusion for children already in special schools, whilst re-assuring parents that specialist teaching, therapies and facilities will remain unchanged, it is a model which has much to offer.

Physiotherapists, then, are likely to see this as one of a range of models, and a continuum of provision, developing in their LEAs. The continuum is likely to look something like this:



The challenge for therapy services is to be able to identify the different types of provision on this continuum which are operating in their LEA, to make sure they are informed about types of provision which may be developing, and then to map a path which will re-configure the way they deliver services to match the re-configured LEA provision.

In many cases, this may mean systematic gathering of information on the impact on work patterns of supporting children in a multiplicity of settings

rather than one special school, and putting a clear case on the consequent resource implications to the relevant health authority.

The outcomes have to deliver on two counts. They have to ensure the children - wherever they are - can continue to access the very special skills which they need in order to make academic and physical progress. But they also have to do this in a way which ensures that children's other prime needs - their social needs - can be met.

As one parent puts it, when describing her own child (a child with cerebral palsy, who began in a special school but has now moved into a mainstream setting):

*She's never going to be a doctor or whatever . . . if she gets a job that's good; if she doesn't, that's life - but she can't do without friends. All children like to be liked and need to be with their peers. That's why I want her to go to her local school with the children she's grown up with.*

Our job is to work in 'joined-up' ways, across education, health and other services, to help this to happen. It isn't always easy, and it does require us to be adaptable and forceful in our arguments for the level of resource required - but it is worth doing.

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This paper will briefly look at partnership for change. The focus will be on the who, the what and the how of partnership. The aim will be to discuss the holistic framework of health care delivery as it is related to an ethnic minority group.

**PARTNERSHIP** - Amongst the many meanings I have selected those most appropriate to health care workers: alliance, co-operation, joint ownership, participation and teamwork: Relationship between two or more persons carrying out a joint venture.

To work in partnership for change as health care professionals we must look at our individual attitudes, some we may need to change. We must understand our strengths and limitations, understand our colleagues and their strengths and weaknesses. The White Paper (D.O.H. 1997) encourages the breakdown of our professional and or territorial barriers and to put the patient's needs first. We can only truly put our patient's needs first if we are culturally and ethnically sensitive. Where such knowledge is lacking, we should get advice from our colleagues who know. A strategy to include the particular needs of ethnic minority group should be sought.

Bahl, (1993) stated that the health needs of ethnic minority have been widely reported to be little understood, therefore are unmet and classed as low priority. Consequently service delivery is handicapped. In partnership professionals can influence and raise the standard of care they give to patients/clients by being involved in multi-professional policies, and evidence-based practice.

The government White Paper, Modern and Dependable (D.O.H. 1997) wants health care professionals to create a service which is patient centred, which will look and feel different at the patients level. According to the White Paper, this performance framework is about the quality of service delivery which must be supported by evidence-based practice.

The Acheson Report, (1998) calls for health workers to be trained in trans-cultural competencies, to develop cultural norms or practices which related to particular ethnic groups. These include knowledge of lifestyle, religion, kinship, social relationship, history of migration, language communication and diet. Lack of awareness of cultural expectations and beliefs is an obstacle to sensitive and effective health care. Working in partnership where the patient/client is a part of the decision making process, enriches professional knowledge with the resulting increase in job satisfaction.

Partnership for change must not just change the theoretical framework of professional practice but most important is our attitude at the practical level. If healthcare delivery is depicted as a wheel the professionals must

# HEALTH NEEDS - WORKING WITHIN A MULTI-ETHNIC AREA

see the patient as the centre of the wheel. The spokes of the wheel (*figure 1*) will be lines of communication connecting each professional to the patient/client. The more competent the communication the more culturally sensitive the information exchange and co-operation between every one. The less competent the communication the more communication barriers and lack of co-operation and partnership. If on the other hand the patient/client is excluded from active participation in the healthcare activity a lack of respect and non-compliance with treatment may result.

I will use the Bangladeshi (People from Bangladesh) as my example of an ethnic minority group. The Bangladeshi health beliefs and expectations are interwoven with religion and tradition. Eighty-five per cent of the population are Muslim and the laws of Islam are followed in every aspect of life (Baker, 1994; Horrie and Chippindale, 1990). Islam is a complete way of life with clearly defined moral and practical codes governing the spiritual, personal, social and economic behaviour of individuals.

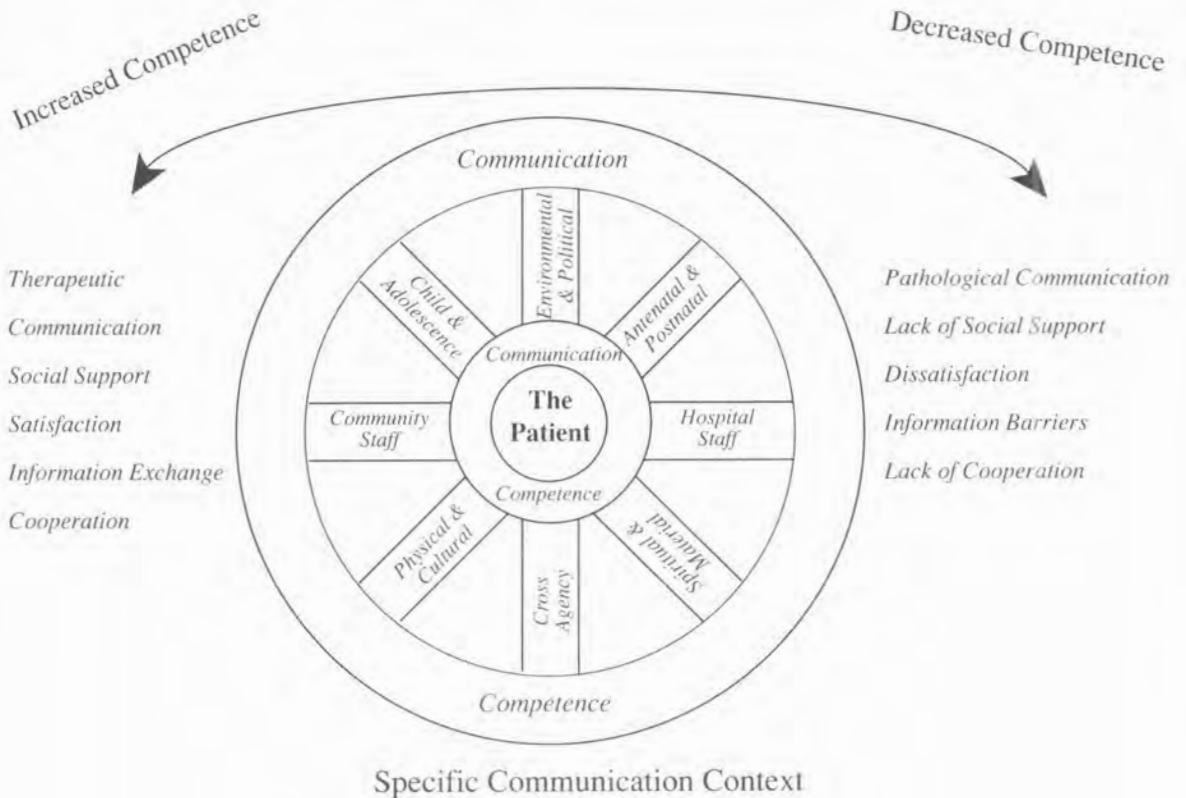


Fig. 1

The Muslim's attitude to health is that it is the duty of everyone to actively maintain their health by eating the correct foods and living a life free of excesses. This duty to maintain health may cause the Bangladeshi to go to their doctor for minor complaints such as a cold in the belief that the doctor will find a cure.

When ill, that person is expected to make demands and the family is expected to play a major part in caring and supporting. For example, in most hospitals in Bangladesh most of the bedside care such as washing and feeding is done by a relative. A relative also constantly stays with the sick who are never left alone. Visiting a relative during their illness is one of the most binding obligations, (Henley, 1999). These obligations may make it unlikely for a Bangladeshi to fully appreciate the practical and medical reasons for restricting visiting hours in a British hospital, particularly when for them their relative is ill and lonely.

In the Bangladeshi's health belief the concept of mental illness and neurosis are generally unknown and all forms of mental illnesses are stigmatised, also diseases such as eczema, tuberculosis, asthma and epilepsy, (Henley, 1979). These are believed to be inherited and infectious with stigma affecting the whole family not just individuals. For this reason family may reject diagnosis or keep it a secret.

Healthcare professionals then, need to be aware of the likely distress and sensitivity when giving information about diagnosis, family's wishes or secret should be respected. At the same time professionals need to be aware of the need to give information for reassurance and understanding of the prognosis of any disease.

Lack of awareness of the cultural expectation and beliefs of the Bangladeshi population is a great obstacle to sensitive and effective health care. For these reasons it is important to give a brief insight into the social reality on which the Bangladeshi belief system is based. Using Laungani's (1994) theoretical model. The health care professional's culture will be called Western and that of the Bangladeshi Eastern.

**Western ..... Eastern**

Individualism .....	Communalism (Collectivism)
Cognitivism .....	Emotionalism
Freewill .....	Determinism
Materialism .....	Spiritualism

Laungani, (1994) suggested that each of these cultural factors should be understood along a continuum and not dichotomously. Factors may even move from one end to the other along the continuum causing a shift in individual position in either direction.

A. Individualism . . . Communalism (Collectivism). In Western societies individualism is emphasised. There is emphasis on self reliance as being responsible for one's success or failure which creates a strong sense of identity, Rogers, (1961, 1980); Erikson, (1993); Maslow, (1970) which reflects one's true inner being and leads to fulfilment and realisation of one's potential. Individualism ensures that each individual is held responsible for his or her own problems with any failure and the feeling of guilt explained in individualistic terms. There is respect for privacy of individual physical and psychological space. Respect for privacy defines boundaries, which separates the self from others.

In Communalism (Collectivism) the emphasis is on collective responsibility, achievement and the extended family.

The Bangladeshi society is community based as most individuals grow up and live in extended families. Individuality is subordinated to collective solidarity and one's ego is suppressed into collective ego of the family and community.

Consequently any problem whether financial, medical, psychological affects the entire family. Seldom does one see personalised private problems. Members of the Bangladeshi community generally function in a ranking or hierarchical system, (Laungani, 1994). Elders (older people) have special status within the community. On important issues group decisions are taken and the decisions are binding on all members.

B. Cognitivism . . . Emotionalism. This is concern in the way in which the private and social world are construed and the way in which social relations are formed; in broad terms the philosophy of western society is work and activity centred. The Bangladeshi society is relationship centred, Laungani, (1994). In a work and activity centred society individuals operate on a cognitive mode where the emphasis is on rationality of feeling and emotions are often frowned on, and the expression of feelings cause embarrassment. Work identifies one's sense of worth and one's working life includes one's private life, which is organised around time. To waste time is unacceptable.

In Bangladeshi society time is conceptualised in circular terms. It is more flexible and relaxed. Feelings and emotions are expressed freely. There is emphasis on feelings, intuition and relationships that is caste and family

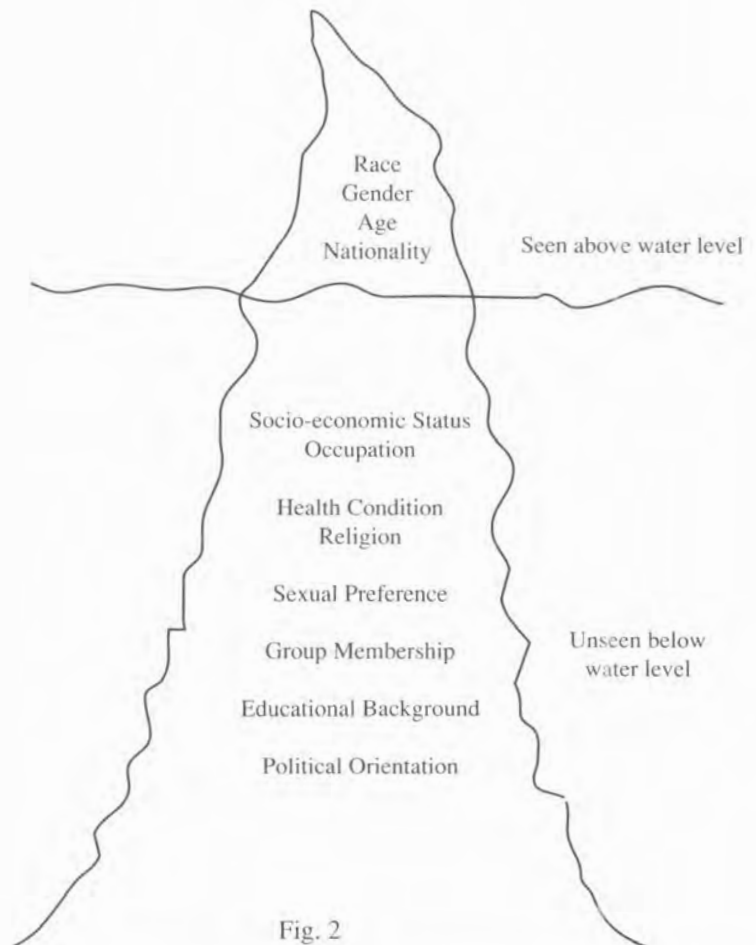
# HEALTH NEEDS - WORKING WITHIN A MULTI-ETHNIC AREA

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based. Because the family is hierarchical individuals soon learn the normative expression what is of emotionally permissible to the persons concern. Also individuals are forced into relationships from which opting out is difficult without sanctions.

C. Free will . . . Determinism. Free will allows an individual to do what he or she wills and in so doing takes credit for his or her successes, thus one is responsible for the consequences of one's action.

Free will concept explains individual's action in terms of internal control, which is a feature of western societies. The concept of determinism shapes the Bangladeshi view of life. In this concept freedom of choice is limited. Things happen because they were destined to happen, no guilt attached to failure, no blame to the victim, although effort is important success or failure is related to destiny.



D. Materialism . . . Spiritualism. Materialism refers to the belief in the existence of a material world. Knowledge of the world is external to one self (positivism), reality is 'out there', understanding the world can only be obtained through objectivity or scientific enterprise.

In Bangladeshi society the notion of Materialism is relatively unimportant. The external world is believed to be illusory, reality is internal to the individual and is perceived through inner reflection.

All relationships, then, are embedded in a large framework created by each dyad partner's separate cultural and communication network. Knowledge about each other can reduce uncertainty. Whilst the understanding (and respect) of the cultural views that influence the way people think and act will aid effective participation in all healthcare delivery.

Healthcare professionals need to be aware that culture influences are not always apparent (*figure 2*) but that awareness of the hidden influences can affect the way they professionals relate to each other and the patient.

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# THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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Although there is much evidence available on the subject of childhood abuse there is little information about "special populations" such as children with disabilities. Epidemiological studies are difficult to carry out due to the wide variation in the nature of the disabilities of the children and the problems with utilising control groups.

## **Introduction**

Existing theory regarding children with disabilities is therefore, built upon the experiences of non-disabled children.

Westcott and Cross (1996) in their description of societal beliefs about the abuse of children with disabilities included the following examples:

*'Nobody would do that - i.e. no-one would harm anyone so 'unfortunate' as to be disabled.'*  
*'It is OK to abuse a disabled child- they are damaged, unfeeling, stupid anyway - what will it matter?'*  
*'Disabled children are less human because of their disability, therefore it is not inhumane to abuse them'*

There is a broad scope of abusive practice which includes : sexual, physical, emotional and psychological abuse and neglect.

Abuse being an act of commission and neglect being an act of omission.

It is not known to what extent children with disabilities may be at a differential risk of abuse or neglect when compared to non-disabled children or if the characteristics of their disabilities make them more vulnerable to perpetrators of abuse or neglect.

## **Background**

In their retrospective study of a population of sixty-one children with chronic illnesses in the United States of America, Jaudes and Diamond (1986) described neglect as being the most prevalent form of maltreatment among children with disabilities. They defined medical care, educational, emotional and physical neglect and abandonment as the five major categories of maltreatment. The majority of the children (65%) were found to have experienced medical care neglect, 8% educational neglect, 4% emotional neglect, 9% physical neglect and 14% were abandoned, with some of the children experiencing more than one aspect of neglect.

This view is supported in a more recent study by Westcott and Cross (1996) who describe neglect and emotional abuse as the most prevalent forms of abuse amongst disabled children.

Kennedy (1993) describes other forms of abuse or infringement of disabled children's rights as force feeding, medical photography, physical restraint, misuse of medication, deprivation of visitors, listening to telephone calls

## THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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and financial and property abuse. She believes these are oppressive practices which may be considered abusive.

Benedict et al. (1990) believe that children with chronic diseases or disabilities often place high emotional, physical, economic and social demands on their families. Many other authors support this view (Starr et al. 1984, White et al. 1987) and believe that these proven factors may be a plausible link to an increase in vulnerability of children with disabilities and abusive practice but exactly how and if functional or developmental factors associated with disabilities influence susceptibility to maltreatment is unknown.

Although sexual abuse is not the main focus of this critique it is worth noting that Marchant (In Westcott and Cross 1996) has documented her conclusions that there are five myths about sexual abuse and children with disabilities which reflect the common beliefs held by society as a whole; and questions whether they could extend to other forms of abuse and neglect:

1. Myth ~ disabled children aren't vulnerable to child sexual abuse
2. Myth ~ sexual abuse of disabled children is OK - or at least not as harmful as sexual abuse of other children
3. Myth ~ preventing the sexual abuse of disabled children is impossible
4. Myth ~ disabled children are even more likely than other children to make false allegations of abuse
5. Myth ~ if a disabled child has been abused it is best to leave well alone once the child is safe

There are many questions which beg answers . . . are these children exposed to unique situations making them vulnerable? Should one lay the blame on the individual (victim blaming)? - making an exception for that individual amongst all others (exceptionalistic view). Is it something the individual (internal focus) has done to cause this or has something happened within the environment (external focus)? How has the wider environment i.e. the systems surrounding the child, treated the child (universalistic focus)? (Westcott and Cross 1996)

Members of society are conditioned by myths, stereotypes and prejudices about other groups and these are likely to perpetuate the systems that hold them in their present positions. (Morris 1991)

An oppressive society, by definition, mistreats a group - i.e. one group has the power to make decisions affecting the lives of others - in this case children with disabilities ('Adults know best belief' - Kitching 1998).

# THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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A society which systematically suppresses any group - i.e. the mistreatment is contained within the systems that exist in that society e.g. education system, housing system, health system, welfare system, - is structured in such a way as to render that group vulnerable to abuse. It gives tacit permission to perpetrators to mistreat individuals from the group. (Westcott and Cross 1996)

It could be said that there is an unwritten licence to abuse children with disabilities in a society in which they are constantly 'stigmatised'. For example when children are 'labelled' as disabled, are perpetrators given the message that they are worth less than non-disabled children?

There is no evidence or reason to believe that abuse should have any less of an impact on a disabled child compared to a non-disabled child.

Westcott and Cross (1996) believe that the vulnerability of children with disabilities is a "socially constructed" phenomenon i.e. how we the members of society put these children at risk through our attitudes and beliefs towards them and the treatment, education and care we give them. This view is strongly supported by O'Hagan and Smith (1998) who state "The way in which society perceives children has great bearing on the way that society treats children. i.e. social construct".

## Historical Perspective

Historically the Victorians believed children were supposed to be '*seen and not heard*' - a phrase many parents continue to use.

There has always been a power imbalance between adults and children, making children vulnerable. They have less physical strength than adults and less knowledge of how things should be. Children are less likely to be believed and hold a lower status in society. (Kitching 1998)

Children's Rights, almost non-existent in the early part of the twentieth century, are now becoming more important and indeed recognised by Law.

In 1923 Eglantyne Jebb (founder of the Save the Children Fund) drafted the *Charter of Rights of the Child*. This was the basis for the origins of the *Convention on the Rights of the Child* which was voted on in 1989, by the United Nations member states and ratified by UK Government in 1991. (Thompson 1990)

Previous to this the only universal text which existed on Children's Rights was the 1959 *Declaration of the Rights of the Child*. This was a statement of general principles, accepted by governments but carrying no legally binding obligations.

## THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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The *Convention on the Rights of the Child* once ratified by governments became law, thus ensuring a legal obligation to meet the 'gold' standards it set. (Shield 1994)

The rights identified in the Convention are grouped by UNICEF into the following categories:

- **provision** - the right to process, receive or to have access to certain services, e.g.: a name and a nationality; health care; education; rest and play; care for disabled and parentless children.
- **protection** - the right to be shielded from harmful acts and practices, e.g.: separation from parents; commercial or sexual exploitation; physical and mental abuse; neglect; fear; pain; loneliness; from too many medical interventions; neglect of being denied necessary treatment; from engagement in warfare.
- **participation** - the child's right to be heard on decisions affecting his or her life; to have increasing opportunities to take part in the activities of society, as preparation for responsible adulthood; the right to self-determination; respect; dignity; integrity; non-interference. (Thompson 1990)

In line with this Convention and reflecting many of its principles, in 1989, *The Children Act* was implemented by the UK government.

*The Children Act* brings together both public and private law relating to children and young people changing the emphasis in the handling of children from a directional and paternalistic way to one which attempts to seek out the best interests of the child.

This should ensure universal standards of service for children and families; providing proper training for professionals dealing with children; and reforming judicial and administrative systems to take into account children's needs and rights. (APCP 1992)

The Act prohibits the use of physical punishment by child care workers in all social service, hospital and educational facilities and sets new standards of respect for the child's autonomy. (Pound 1994)

In 1993 the European Association for Children in Hospital (EACH) met in Austria to promote the *Charter for Children in Hospital throughout Europe*. This charter, which has ten points, offers an ethical foundation for the care of children in hospital. EACH believes that the right to the best possible medical treatment is a fundamental right, especially for children. EACH state that taking the charter seriously alongside the UN

# THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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Convention 1989 means informing children and actively involving children who have views in making decisions about their care. It also means overcoming age-assumptions of children's ability to understand explanations or who do not mind their privacy and dignity being disregarded. (Alderson 1993)

With this background of empowerment for children through the legal system an examination of epidemiological studies and more recently, evidence-based practice research demonstrates that there are mixed views amongst authors as to the practical application of this theoretical basis and an urgent need for much wider investigation into this 'special population'.

## The Emerging Themes

Several authors have documented evidence which suggests that the predisposition to vulnerability of children with disabilities, begins long before they are even born! (Jaudes and Diamond 1985, Fomufod et al 1975, Lynch 1975, Pasamanick 1975, Starr et al 1984, Zirpoli 1986) Abnormalities and problems during pregnancy, labour and delivery increase parental stress before the child is even present and may affect bonding and parent - child attachment relationships, when the child is eventually born.

Parents may be unable to recognise distress signals or calm the crying child who may be less responsive to their comforting efforts. Abnormal attachment may result in parents dealing with irritable behaviours in an abusive manner in the future. (Zirpoli 1986)

Prematurity, low birth weight and peri-natal stress factors such as separation from the parents due to the need for intensive care or increased hospitalisation have been shown in some studies (Lynch and Roberts 1982, Benedict and White 1990 Nesbitt and Karaginis 1982, White et al 1987, Zirpoli 1986) to be variables which increase the vulnerability of a child to maltreatment but these are not confirmed by others. (Egeland and Vaughan 1981) It may be the case that a number of abused children are premature but the majority of premature children are not subsequently abused.

A child who is 'born too soon' is unexpected and may be the cause of increased parental anxiety. Parents may be overwhelmed by their caretaking responsibilities for children who may not provide the desired or expected gratification.

Often premature babies or those babies who have severe cerebral palsy, have difficulty feeding - an experience which should provide an opportunity for mother-child bonding, then becomes highly stressful for the mother and may even be life threatening for the child if they are unable to suck and swallow effectively.

## THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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Benedict and White (1990) reported that parents who were unmarried, with fewer years of formal education and in unstable employment were more likely to have substantiated reports of abuse than those who were married, better educated and in stable employment. In this particular study some demographic factors were examined although there was a wealth of information unaccounted for, thus reducing its validity. However, the hypothesis that levels of parental education are relevant to the vulnerability of children to abuse is examined in other studies (Starr et al 1984, Zirpoli 1986) where unwanted pregnancies, young mothers, single parent families, social isolation, poor parenting skills, lack of experience and knowledge of child development, and anxiousness, were found to be factors which increased the vulnerability of children to abuse.

In their review Starr et al. identified child characteristics which were significantly different between maltreated and non-maltreated infants.

These included:

- Cuddliness
- Predominant state
- Muscle tone
- Motor maturity
- Defensive movements

In an earlier study Nesbitt and Karaginis (1982) included many more characteristics which they felt were associated with child abuse:

- Prematurity
- Low birth weight
- Difficult temperament
- Behaviour disorders
- Mental disabilities
- High pitched crying
- Frequent crying
- Poor eating habits
- Messy eating habits
- Unresponsiveness
- Sleeping problems
- Toileting problems

These characteristics can often be associated to children with disabilities. The nature of their impairment may influence muscle tone, the children are often difficult to hold or cuddle - children with increased muscle tone may be difficult to curl up and contain and those with very low muscle tone will be floppy and unresponsive. Those who are medically unstable or very premature are not handled by parents thus reducing parent-child bonding opportunities. (Zirpoli 1986)

## THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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Babies with Cerebral Palsy may not develop routine sleep patterns for a long time. They often have a high pitched cry and cry a great deal, thus increasing disturbance, irritation and annoyance in parents.

The severity of the disability will affect the responsiveness of the child and their behaviour will affect how the parents respond to them. If the child has sensory defensiveness they will withdraw from touch or contact and may not meet the expectations of the parent. If they are hypersensitive their responses to parents may be exaggerated and extreme. (Westcott 1991)

Toilet training is often delayed and parents may have to face ongoing problems of disturbed sleep, the child bedwetting and endless piles of laundry.

The level of impairment is a factor which many authors refer to as a potential variable in maltreatment cases (Benedict and White 1990, Glaser and Bentovim 1979, Martin 1982, White et al 1987, Zirpoli 1986) although there is some disagreement at which end of the severity spectrum a child is most vulnerable.

Zirpoli believes that it is not the child's condition which causes the maltreatment as this is only one factor amongst others e.g. parental, socio-cultural and environmental, all of which contribute in some way to the abuse - a view similarly shared by Bittner and Newberger (1981) who believe that stresses may be caused by the child, the parent or by social-situational consequences or a combination of all three.

Glaser and Bentovim (1979) in their study, although somewhat dated now, concluded that the severity of the disability measured by functional status or impact on the caretaking abilities of the parents, by inference, could be important in differentiating maltreatment risk levels among the disabled population.

This approach, which may be useful for future research, was supported in a later study by Diamond and Jaudes (1983) who identified samples of children diagnosed as having Cerebral Palsy before maltreatment took place (consequently high care needs) and compared them to a group in whom Cerebral Palsy occurred as a result of maltreatment (previously low care needs).

Abuse, in the form of neglect, occurred at a later stage in the pre-existing Cerebral Palsied group.

The study reinforced the findings of Glaser and Bentovim that different types of maltreatment were more likely in disabled than non-disabled

## THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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populations and an outcome was to identify that a child with a long-term or permanent disability presented a long term family crisis, therefore the child was 'at greater risk' for a longer period of time.

Parents of a child with a severe disability at birth have different expectations of their child than those of a minimally disabled child or one who is not identified as disabled at birth but later develops problems. They are often more accepting and resigned to the condition because the outcome is more definite and they do not expect any improvement in level of functioning from the child. They are also likely to have a high level of support from services from an early stage. (Gath 1985)

Others who have a child with a more subtle developmental abnormality - which is not easily detectable by professionals are often at greater risk. There is more scope for disparity between expectations and performance. When a disability is not noticed, deviations from 'normal' behaviour are often attributed to the child and not the disability. Parents often perceive the child as 'difficult' and stress factors within the family unit are usually increased. (Gath 1985)

Coping strategies adopted by families will affect the stress levels within the unit and if positive, will reduce the likelihood of abuse occurring. An inability to adapt in stressful situations will lead to a failure to cope. (Elliot 1991, Jaudes and Diamond 1985, White et al 1987) On initial diagnosis many parents experience the beginnings of a grief process whereby they mourn the loss of a 'normal' child. The family will be affected socially and economically and many couples experience individual and marital problems. If adjustment does not occur and a parent becomes fixed at one level of the grieving process problems can then arise. (Gath 1985) Sibling rivalry and breakdown of relationships can develop and once again lead to an increase in stress for all concerned in the family unit.

Social influences on parental-child rearing behaviours e.g. the willingness of adults to inflict physical punishment upon children is the most significant determinant of child abuse according to Zirpoli (1986). Where physical punishment of children is not common practice e.g. in China, the incidence of child abuse is significantly lower. Physical punishment is a negative form of reinforcement and abusive parents use less positive reinforcement with their children.

Children with disabilities are often placed in segregated education establishments for many reasons - usually that local provision is inadequate to meet their needs. This in itself may lead to increased vulnerability to abuse. (Rosenthal et al 1991, NHS Executive 1998)

Whether in an out-of-home residential placement or travelling on a daily

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# THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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basis in 'special transport', the child may be introduced into new situations whereby they are placed more at risk than non-disabled children. Segregation may lead to feelings of isolation and rejection. Institutions and procedures within, may take away the element of choice over how, when, where and by whom personal or intimate care routines are carried out on the child.

The level of care a child requires can also be a factor in the vulnerability of that child. If a child needs high levels of intimate care and has a number of different carers to carry out these tasks then they are open to increased risk. The carer may exploit the situation to behave inappropriately. How adults handle this process of intimate care will affect how the child perceives it should always be handled. If adults do not protect the child's privacy and dignity and teach the child what is and is not, appropriate and acceptable touch, then, if abused by a perpetrator they may just accept this a 'normal' practice and not report it. Thus allowing the perpetrator to continue the abuse.

Children in residential care establishments depend on staff for their well being and may be unable or afraid to speak up or communicate problems for fear of repercussion.

Communication in itself may be the issue as children using augmentative communication equipment depend on adults to supply them with the vocabulary to describe their experiences - an example of the adult/child power imbalance which reinforces the social construct theory.

Jaudes and Diamond (1985) believe that abuse occurs due to the malfunction of the systems designed to protect the child. Openings occur for perpetrators when communication between the state, education, legal system, foster care, social care, financial systems and health care systems, fail; leaving the child with inadequate, fragmented care, lack of stability and vulnerable to abuse.

Views which support the social construct theory.

Low socio-economic status of the family is the most consistently reported demographic factor (White et al 1987). This may be measured by income, education or occupation. Maltreatment, therefore vulnerability, is present in all socio-economic groups but is more likely to be reported in the lower groups because of increased contact and interactions with public welfare and health support systems.

## Conclusions

While the association between abuse and neglect seems clear cut, the complexity of the phenomenon and the large number of interacting variables make any cause and effect conclusions tenuous.

## THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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Studies support but do not confirm the links between disability and abuse. The limited research available which has non-comparable methodology, uses differing definitions (which are not always interchangeable) and vastly different study samples, demonstrates the complexity of the subject area.

Suggestions are made for further study to include the impact on vulnerability of children with disabilities, of the demands of care; the impact of the timing of the disability in the child's life and the functional or developmental status of the child rather than the diagnosis. One needs to identify which factors signify the risk and the different types of maltreatment that occur.

Most previous studies have been retrospective and are therefore only as reliable as the data collected and used. Figures obtained for maltreatment of children with disabilities may be disproportionately represented. One view is that children with special needs tend to have more contact with professionals therefore more cases may be identified when compared to non-disabled children. Conversely the figures obtained are only those reported or seeking medical attention and these may be an under-estimation. The undetected cases are an unknown quantity.

Parents may take the child to different medical establishments so that no unexplained injury pattern can be established. Families are highly mobile nowadays and may move from one district to another without warning. Systems within society may be perpetuating the problems of vulnerability (social construct).

The medicalisation of disability, supported by the mass media - constantly promoting the 'miracle cures' or 'magical treatment', carried out by the medical experts reinforce the non-disabled persons need to 'normalise' the disabled individual. (Morris 1991, Swain et al 1993)

Differences are an important part of the individual's identity. (Cross 1998)

The disabled role and dependency are defined by non-disabled people.

The disabled population view independence not in physical terms but in terms of control. (French 1994)

Disabled children are vulnerable.

To reduce that vulnerability one must examine the world in which we live.

Carers may have little training in disability issues and may be more influenced by institutional practice and attitudes.

Carers must learn to see beyond the disability to the child themselves.

# THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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There must be a readjustment of the balance of power.

The child must be listened to, given recognition accepted and treated as a child first, in line with the supporting legislation.

Societal views are changing. There is less stigma now associated with disability. The old asylums and institutions are closing and children with disabilities are more often included in mainstream education.

There is more public scrutiny of establishments and agencies working with disabled young people (Goodinge 1998, Ball 1998, Morris 1998a,b,c.)

People are more willing to discuss the issues of the mistreatment of children - within the past year there has been a graphic television campaign by the NSPCC aimed at raising awareness of child abuse, bringing it into the domain of people's homes.

This review has highlighted the potential vulnerability of children with disabilities to perpetrators of neglect in its many forms.

It has suggested that a minor deviation in child behaviour rather than a major disability is more likely to predispose to abuse but further study needs to be undertaken comparing families with disabled children to those with non-disabled children.

The following table (adapted from Zirpoli 1986) indicates just some of the interacting factors that need to be taken into account.

<u>Parent Factors</u>	<u>Socio-cultural Factors</u>
Abused as children	Acceptance of physical punishment
Poor parenting skills	Children not provided equal constitutional protection
Unrealistic expectations	Inadequate child protection resources
Low self esteem	Vague child abuse laws
Depression	Cultural beliefs
Stress	Prejudices
Frequent use of physical punishment	Social class
Infrequent use of positive reinforcement	
Social isolation	
Understanding of disability	

## Parental Physical Child Abuse

<u>Environmental Factors</u>	<u>Child Factors</u>
Conflict between spouses	Mental Disabilities
Conflict between parent and child	Physical Disabilities
Impact on siblings	Emotional/Behavioural Disabilities
Substance abuse	Prematurity/Low Birth Weight
Unemployment	Functional/Developmental Level
Housing	
Education	
Transport	

# THE VULNERABILITY OF CHILDREN WITH DISABILITIES - A SOCIALLY CONSTRUCTED PHENOMENON: FACT OR FICTION?

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Professionals must learn to:

“*Listen to children – they will have to live with the decision*” (Shield 1994) and only then may we realise that there is much about the way we as a society treat, care for, transport and educate disabled children that increases their vulnerability which does suggest that the social construct is fact and much could be done to improve the situation.

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# APCP MATTERS

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## EDITORIAL NOTICE

Your journal will in future be distributed in the second week of the month in which it is published. I am sorry for any inconvenience this may cause you but it will help considerably with its production, because it is usually due to be at the printers over a bank holiday, which is not always possible to do.

We are also looking at the possibility of starting a personal column for APCP members to keep in contact with friends and colleagues and share their news. The success of this will depend on your response - it will be FREE!!!

Sally Braithwaite

## PRO NOTICE

Sue Whitby now has a list of child development centres throughout the country and knows that they have paediatric physiotherapists based within them. However in the interests of setting up a full data base of where we are found she would greatly appreciate it if you could contact her with the address of your workplace and any other establishments that you may provide a service to.

## PUBLICATIONS NOTICE

### Tests and Measures Resource Pack

As you are probably aware this pack reviews a range of both standardised and non-standardised measures of motor function. It is produced in a loose leaf format in order to allow additional tests and information to be added.

We are happy to receive ideas from members on any additional tests not described in the pack which they have found useful and would like us to consider for inclusion.

### Leaflets

As you will read in the Summary of the July National Committee Meeting we are proposing to look at producing information leaflets in addition to our current publications. If members have ideas for, or examples of leaflets that would be of interest, please contact me.

We are no longer selling the Serial Splinting booklet.

Eileen Kinley

# APCP CONFERENCE 2001 A MIXED BAG



26TH - 28TH APRIL  
SHEFFIELD POST HOUSE



# APCP MATTERS

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## **A MIXED BAG** (DRAFT PROGRAMME) **APCP INTO THE 21ST CENTURY**

### **Thursday 26th April 2001**

- 0830 hrs National Committee Meeting
- 1130 hrs Registration
- Onwards
- 1230 hrs APCP Into the 21st Century  
Keynote Speaker : Di Coggings
- 1315 hrs **Gait Analysis - From Beginning to End**  
Wendy Dickens  
Senior I Physiotherapist, Sheffield Children's Hospital
- 1430 hrs TEA  
Served in the exhibition hall
- 1500 hrs **Botulinum Toxin - With research in Mind**    **Research Aspects**  
Dawn Simpson Research Physiotherapist, St James' Hospital, Leeds  
**Clinical Implications**  
Mary Harrison Superintendent Physiotherapist
- 1600 hrs **Presentation of Evidence Based Practice Findings**  
**Hip Management in Cerebral Palsy**  
Terry Pountney  
**Developmental Co-ordination Disorder**  
Jill Brownson/Sue Walmsley  
**Erbs Palsy**  
Di Coggings
- 1715 hrs Cheese and Wine Tasting served in the exhibition hall

### **Friday 27th April 2001**

- 0830 hrs Registration
- 0900 hrs **Cystic Fibrosis, Baby to Adolescence.**  
Dave Threlfall, Superintendent Physiotherapist, Sheffield Children's Hospital
- 1015 hrs The Jenx Award
- 1030 hrs Coffee and Exhibitions in the exhibition hall
- 1130 hrs AGM for APCP  
Members only
-

## APCP MATTERS

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- 1215 hrs Lunch and Exhibitions
- 1330 hrs **Evidence Based Practice. The straightforward approach.**  
To include case reports of practical ongoing research.  
Anne Simpson. Research Physiotherapist, Sheffield Children's Hospital
- 1500 hrs TEA
- 1515 hrs Travel to satellite workshops
- 1530 hrs **SATELLITE WORKSHOPS**
- Neurology**  
**Practical use of video for treatment and assessment**  
Lucy Lecount. Senior I Physiotherapist, Sheffield Children's Hospital
- Cystic Fibrosis**  
**Exercise Tolerance Testing, practical workshop.**  
Dave Threlfall. Superintendent Physiotherapist, Sheffield Children's Hospital.  
**Gait Analysis : Hip surgery for Children with Cerebral Palsy.**  
Wendy Dickens. Senior I Physiotherapist, Sheffield Children's Hospital
- Orthopaedic Pain Relief**  
Suzanne Davis. Senior I Physiotherapist, Sheffield Children's Hospital  
Clare Wagstaff. Senior I Physiotherapist, Sheffield Children's Hospital
- PICU and Neonate simplified**  
Fiona Roberts. Senior I Physiotherapist, Sheffield Children's Hospital  
Anna Simpson. Research Physiotherapist, Sheffield Children's Hospital
- 1730 hrs End of Day
- 1900 hrs Conference Dinner
- Saturday 28th April 2001**
- 0900 hrs Registration
- 0930 hrs **Osteogenesis Imperfecta. The Move Forward.**  
Professor Nick Bishop. Professor of Metabolic Bone Disease.  
Clare Wagstaff. Senior I Physiotherapist  
Shelley Brooks. Senior I Occupational Therapist, Sheffield Children's Hospital
- 1045 hrs COFFEE
- 1115 hrs **Muscle imbalance. The Paediatric Approach.**  
Liz Mackay. Private Practitioner.
- 1230 hrs Close of Conference  
Di Coggings - Chairman APCP
-

# APCP MATTERS

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS  
A MIXED BAG  
SHEFFIELD POST HOUSE - 26th - 28th APRIL 2001

Name : ..... Discipline : .....  
Home ..... Work .....  
Address : ..... Address : .....  
.....  
Post Code : ..... Post Code : .....  
Tel. (Home): ..... Tel. (Work): .....  
APCP No. and Region: .....

### Conference Packages

Full package with accommodation to include :

All lectures (Thurs. pm  
Fri. am & pm, Sat. am)  
- tea and coffee.

Lunch - Fri.  
Evening Meal - Thurs. & Fri.  
Bed & Breakfast  
-Thurs. & Fri.

(single room with en-suite included)  
Use of sports facilities.

*Please tick where appropriate*

	Member		Non Member
£200	<input type="checkbox"/>		£250 <input type="checkbox"/>

Full Package without accommodation to include :

All lectures (Thurs. pm  
Fri. am & pm, Sat. am)  
- tea and coffee.  
Lunch - Fri.

Thursday Evening Entertainment.  
Please indicate if you plan to attend.

	Member		Non Member
£150	<input type="checkbox"/>		£185 <input type="checkbox"/>
	<input type="checkbox"/>		

### Optional Possibilities

Thurs. (pm) half day

Fri. all day with lunch

Sat. (am) half day

Conference Dinner

	Member		Non Member
£50	<input type="checkbox"/>		£60 <input type="checkbox"/>
£100	<input type="checkbox"/>		£120 <input type="checkbox"/>
£50	<input type="checkbox"/>		£60 <input type="checkbox"/>
		£17.50	<input type="checkbox"/>

Do you have any dietary/special requirements. If YES please detail.

Are you a member of the National Committee

Y / N

# APCP MATTERS

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## Workshops

Name : .....

Delegates will only have the opportunity to attend one workshop session. Please indicate your preference in order 1 - 5.

- |    |   |                          |
|----|---|--------------------------|
| a) | Neurology.<br>Practical use of video for treatment and assessment.  | <input type="checkbox"/> |
| b) | Cystic Fibrosis.<br>Exercise Tolerance Testing, practical workshop. | <input type="checkbox"/> |
| c) | Gait Analysis.<br>Hip surgery for Children with Cerebral Palsy.     | <input type="checkbox"/> |
| d) | Orthopaedic.<br>The ups and downs of Pain Relief.                   | <input type="checkbox"/> |
| e) | Acute.<br>PICU and Neonate simplified.                              | <input type="checkbox"/> |

Cheques should be made payable to "APCP Conference 2001"

Application forms (including payment) should be sent to Claire Wagstaff/Angela Karck. Physiotherapy Department, Sheffield Children's Hospital, Western Bank, Sheffield, S10 2TH.

Closing Date : 23rd March 2001.

## OBITUARY

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### JENNY MCKINLAY (1948-2000)

Jenny, formerly head of paediatric physio services in Croydon, has died of multiple sclerosis aged 52. She was born in Glasgow but was taken to Dunrossness, Shetland, aged 3 weeks and lived there with few mod cons with her parents and older twin brothers for several years. Her secondary schooling was at Boroughmuir School in Edinburgh. She was a keen pianist, hockey player, cyclist and hill climber. She moved to London, where she trained as a physio at King's.

At first she practised as an adult physio, taking a while to see the light and move to paediatrics. However having two sons influenced her to change and most of her career was with children. She worked at the Phoenix Centre in Bromley, Queen Mary's Carshalton and in Croydon where she was appointed Superintendent for hospital and community paediatric physio. As with many contemporaries, she was a lively, enthusiastic therapist but a somewhat reluctant administrator.

Nonetheless she became a member of APCP national committee and for 4 years was Editor of the forerunner to this Journal. After she was forced to retire in 1993 because of her MS, the first symptoms of which appeared over 20 years ago, she became APCP membership secretary. She developed the computerisation of the membership database and updated the data continuously. Contact with the membership was enjoyed thoroughly. When she retired from this, with increasing effects of her condition taking hold, she was made an Honorary Member which delighted her. The last meeting she was able to attend, however, was the Easter 1998 meeting in Birmingham. She had become dependent on her wheelchair by then.

At first, MS hit her in acute, fairly short-lived, infrequent episodes with good recovery. It was hoped that the condition would remain at the mild end of the spectrum. In 1986 she began to show the earliest signs of paraplegia. She climbed Snowdon slowly and with great effort. In 1989, recovering from an

episode of optic neuritis, she climbed Goatfell (2860 ft) albeit in 5 hours and was proud to have done so. She played golf and was active on her bicycle. By 1993 she needed a stick but could walk a couple of miles on the flat. Two years later she needed 2 sticks and could only manage short distances. After a further 2 years she could hardly walk and experienced increasing personal care problems. As a fastidious person she found this mortifying.

By spring 1998 ambulance crew were being called to help her off the floor at home with increasing frequency. In June she was admitted for rehabilitation but had a further acute relapse and was never able to return home to live. Her 50th birthday garden party was memorable with personal firework displays at dusk but she tired quickly. There were to be 3 nursing home placements and a further long hospital admission. As her paraplegia extended and her arms became ataxic, she developed increasing dysphasia, eventually virtual aphasia. Her Korsakov psychosis became severe - recent events were lost to her in minutes. Her feeding and drinking became problematical but she refused a tube steadfastly. She lost over 7 stone in weight and became almost unrecognisable. Eventually she died of pneumonia.

Why some people with MS have such a remorseless form like Jacqueline du Pre and Jenny and others have a more gradual form is not known. Some friends and former colleagues meant to keep in touch with Jenny but found they couldn't bear to see what was happening to her. She was sustained through her illness by her husband, Robin, her sons, Kenneth and Alastair and by a loyal core of family and friends. Jenny remained peaceful and dignified, though at times she was sick of her disablement. It is strange how hard it can be for those of us who treat children with severe disablement to cope with its evolution in a friend or family member. Any day I felt inclined to complain, Jenny came to mind. She has been an inspiration.

**Ian McKinlay**

## REGIONAL REPRESENTATIVES

---

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### OVERSEAS

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Hail Weston  
Huntingdon PE19 4JG

## REGIONAL REPORTS

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### EAST ANGLIA

On the 1st July at Cambridge, Veronica Bastow from King's Lynn, and Dr. Richard Isles of Addenbrooke's Hospital, Cambridge, gave a fully in-depth, up-date Study Day on C.F. It was well attended and all agreed an excellent day.

The application forms, with an information package, for the S.C.B.U. Course on 22nd. & 23rd. September in Cambridge are now with Fiona Down, 01480 415203. It is proving very popular, so do apply soon to guarantee a place. The main speakers are; Judy Hough on acute respiratory care and positioning; and Chris Howbury on 'setting up a follow-up service'.

The next course in the pipe-line is on Serial - Casting. Sue Edwards will be leading this, and it is to be held at Clare School, Norwich, on the 11th November.

We look forward to seeing you at these courses.

TRICIA BROSNAN

### WEST MIDLANDS

We have an excellent programme set up for autumn 2000

Thursday 21 September Wendy Browne  
Respiratory Update  
7.00.p.m. Education Centre  
Birmingham Children's Hospital

Thursday 19 October  
Elen Wright and Susan Rideout  
Spasticity Management 'A Bite from the Big Apple'  
7.00.p.m. Physiotherapy Department  
Birmingham Children's Hospital

Wednesday 15 November Kathy Baines  
Developmental Gait Disorders  
7.00.p.m Education Centre  
Birmingham Children's Hospital

We have been really thinking hard about how to encourage more members to attend the meetings, and are starting to plan the programme for 2001 and welcome any suggestions about the venues or content that may be included in this. Please ring me on 0121 333 9480 at Birmingham Children's Hospital with any ideas. We look forward to seeing you and please let me encourage your feedback to me if you are someone that will be willing to keep others informed of forthcoming events

FIONA NICHOLSON

### SCOTLAND

There is no new direct APCP information at this time however I thought you would like to know that since June 99 a Scottish Clinical Network Group has been established.

This has been started by Jane Hedley from Royal Aberdeen Children's Hospital and has many past and present APCP Committee as its membership.

The composition of the group is made up of "Paediatric Physiotherapists" who are responsible for the provision/ management of paediatric services (PIMMS) and its purpose is to form a clinical network looking specifically at common issues, clinical effectiveness, standards etc.

Conscious that there could be areas of overlap with work already underway by APCP it is good that so many of this committee have shared knowledge and dual function.

Hopefully duplication of effort and work will not take place.

I hope you have had a good summer and look forward to seeing you in the Autumn.

LESLEY SMITH

## REGIONAL REPORTS

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### NORTH EAST

At the last local Committee Meeting, we elected Georgina Keighley as Chairperson and Penny Sherlock as Secretary. Emma Graham will be the Course Organiser allowing Jane Howland to concentrate solely on the demanding task of being the Treasurer which she does exceedingly well. Also a warm welcome to Suzanne Carter and Alex Thompson as new members to the Committee.

The Study Day in June, on JCA, was a success. It was informative and brought us up to date with the latest drug therapy. It is anticipated that we will have an extremely good response to the Neurophysiology Study Day on the 10th November (tutor - Margaret Mayston) so do apply early to secure a place as these will be limited. The venue at Wakefield is ideally situated just off the motorways linking north, south, east and west.

The Committee have provisionally arranged study Days for the coming year i.e.

MARCH 2001 - Postural Management (Liz Goldsmith) + AGM

JUNE 2001 - Recreation for the Young Disabled

OCT/NOV 2001 - Workshop on Soft Foot Orthoses

MARY HARRISON

### NORTHERN IRELAND

The committee have been busy organising next year's programme of evening meetings. The first meeting will be on Monday 11th September 2000, "A Pharmacology Update", the speaker is Dr E Hicks and the venue will be Fleming Fulton school at 7.30 p.m. The final programme containing the times and dates of all the evening meetings will be forwarded to all the members during August.

We are in the process of organising a Paediatric Manual Handling Course, hopefully in November, once the details are finalised, application forms will be sent out.

We look forward to seeing everyone at the forthcoming evening meetings.

JUDITH MORRISON

### WALES

Can you believe it's September already? Where did the Summer go?! Not much to say this time except that the plans for the "Introduction to Paediatrics Cymru 2000 Course" are going well - it will soon be here! So make sure if you are interested that you get your application forms in ASAP! Details on the advert in the journal.

There was positive feedback following the Study Day on Neuromuscular Disorders in June. And as for next year's programme, we hope to arrange study days on the following topics: Hydrotherapy, Erb's Palsy, NTS and Talkdown techniques. We will also rerun the Manual Handling Day for those who missed out this year. And if you're all good and remember to renew your membership, it may be free of charge again!

Finally, just for your information, we decided as a committee to write a letter to the Welsh Stewards, expressing our concern as a CIG that they did not contact APCP, locally or nationally, for advice on the issue of banning baby walkers.

Hopefully, I'll see some of you in November (I'll be the one consuming a large gin and tonic!) Hwyl!

SIAN HOWELLS

### SOUTH WEST

There is very little news to report from the region this time as unfortunately two of the committee have been out of action due to injury and our treasurer has been on maternity leave. Therefore we have been unable to plan any study days or workshops recently but hope to meet shortly to rectify the situation. Please look in the SIGS section of Frontline for details of future study days. The



## REGIONAL REPORTS

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Wessex area CP Workshop scheduled for July had to be cancelled but we hope this can be rearranged for next term. (It was on the differential diagnosis of cerebral palsy). Please keep sending me your news and views and I do apologise for any delay in replying to anyone who contacted me this term.

PAM EVANS

### SOUTH EAST

Our next study days on November 10-11, will be on 'Paediatric gait analysis and orthotic management'. This will be held at The Children's Trust, Tadworth Court, Tadworth, Surrey. Our lecturer is Elaine Owen MCSP. Fee is £90 for APCP members and £100 for non-members. Applications to Anne Finlayson, The Oast House, Pristling Lane, Staplehurst, Kent TN12 0HH. (Tel. 01580 891693). Please support your region as I am sure this will be an interesting and informative course.

Next year we are planning to run another course on the GMFM and on neuroplasticity, spasticity and splinting from a Bobath tutor. Any ideas for courses please let your committee know. Look forward to seeing many of you in November.

SARAH CROMBIE

### LONDON

A successful study day was held on "Complementary Therapies" at our AGM on March 2nd, 1999.

The next study day will be "An Evidence Based Approach to Infant Orthopaedics" at Guy's Hospital, London on September 15th 2000. Future plans include looking at outcome measures and an evening lecture from Dr. Min Mehta on scoliosis. We are continuing to investigate the possibility of a paediatric muscle imbalance course - but no definite plans yet.

KATE BEATTIE

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# APPLICATION FORM FOR APCP PUBLICATIONS

TITLE	PRICE	QUANTITY									
The Children Act 1989 'A Synopsis for Paediatric Physiotherapists'	£2.50										
Dyspraxia - A Handbook for Therapists by Michelle Lee and Jenny French	£5.50										
Guidelines for Calculating Caseloads (to be updated)											
Baby Massage	£1.00										
Standards of Practice for Paediatric Physiotherapy (to be updated)											
Statutory Assessment of Children and Special Educational Needs	£4.00										
Tests and Measures Resources Pack (2nd Edition)	£3.50										
Haemophilia Booklet	£3.50										
Human Postural Reactions - Lessons from Purdon Martin by Dr. John Foley	£5.00 (incl. of P&P)										
Manual Handling Booklet	£10.00 (incl. of P&P)										
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**SEND ORDERS - WITH PAYMENT to :**

**Eileen Kinley, Superintendent Physiotherapist,  
Royal Liverpool Children's NHS Trust, Alder Hey Hospital,  
Child Development Centre - Physiotherapy Department, Eaton Road, Liverpool L12 2AP**

Name and Address for delivery: .....

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.....

## HERE AND THERE

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### YORKSHIRE NORTHERN REGION NEUROMUSCULAR FORUM IN PAEDIATRICS

This group was established in Halifax in 1999 by physiotherapists Sue Robinson and Helen Dowden. The group was developed following visits to nationally recognised centres, which led to changes in working practice in Calderdale. The aim of the group was to improve regional links, and ensure effective clinical practice.

A steering group was set up including therapists from the Clarendon Wing, Leeds General Infirmary, who worked together to produce a standardised method of assessment or physiotherapy and occupational therapy for neuromuscular conditions. These were presented at a study day in March 1999 to therapists from West, East and North Yorkshire.

The study day launched the assessment forms which are now used throughout the region. It also instigated the Neuromuscular Forum which has since held study days on :-

- Static and wheelchair seating.
- Respiratory management in neuromuscular conditions.
- Equipment and adaptations for children with neuromuscular disease.
- Medical management of Muscular Dystrophy.

All study days have been well attended by professionals from North, West and East Yorkshire.

The Forum aims to assist in continuing professional development and reviewing clinical practice for therapists. Our speakers have, and will continue to be, experts within this field, on all aspects of care, with plans for three study days per year. Following on from the study days the forum is looking to further develop protocols, to take part in research programmes, and to develop consistency of treatment across the region.

There is currently a group of four who plan and arrange the study days, which includes Sarah Hibbert, Sue Robinson physiotherapists, Liz Keogh, occupational therapist from Calderdale and Helen Dowden physiotherapist from Leeds Community Trust.

We are always looking for new ideas and speakers, so please feel free to volunteer to talk to us, or if you would like information on the study days, we can be contacted at the Child Development Unit, Halifax General Hospital - Hx 01422 224156 (direct line).

SARAH HIBBERT  
SUE ROBINSON

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### EQUIPMENT FUNDING

Variety Club, the greatest children's charity in the world, welcomes applications to its Easy Riders Scheme, for assistance with funding mobility aids, such as wheelchairs, buggies and trikes, on behalf of children with special needs under 19 years of age.

To apply, please contact the Wheelchairs Co-ordinator at Variety Club, 93 Bayham Street, London NW1 0AG. Tel. 020 7428 8100. Fax 020 7248 8111, Email: [wheelchairs@varietyclub.org.uk](mailto:wheelchairs@varietyclub.org.uk)

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## HERE AND THERE

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THE CHARTERED SOCIETY OF PHYSIOTHERAPY

### **Travel Scholarship**

#### **Baroness Robson Travel Scholarship**

The Baroness Robson Travel Scholarship Fund has been established by the Charitable Trust of the Charter Society of Physiotherapy in memory of Baroness Robson, Vice-President of the CSP.

It supports chartered physiotherapists who are travelling overseas for educational or research purposes to develop their practice. This includes :

- Evaluation of physiotherapeutic methods or skills
- Study of alternate methods of patient care
- Collaborative research with centres of excellence
- Development of specific skills/knowledge relevant to research degree in another institution
- Gaining teaching experience

Five awards of up to £3000 each will be made annually.

The Baroness Robson Travel Scholarship is administered by the Society's Educational Awards Panel.

The next closing date for applications is 1st October 2000.

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CHURCHILL LIVINGSTONE

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

### **UK Presentation Fund**

**Are you presenting a paper at a conference?**

**Do you need help with funding?**

**If so, this fund may benefit you.**

The UK Presentation Fund has been set up by Churchill Livingstone and the Chartered Society of Physiotherapy to support chartered physiotherapists presenting at conferences held in the UK. These include :

- physiotherapy or interdisciplinary international conferences;
- national conferences relevant to, but outside of physiotherapy.

It also supports physiotherapists presenting papers for the first time at physiotherapy national and international conferences held in the UK which includes the CSP annual congress.

To be eligible for consideration for an award, chartered physiotherapists should be:

- (a) invited as lecturers, keynote speakers or clinical demonstrators but only part-funded or unfunded by their hosts.
- or**
- (b) those who have had papers accepted for presentation but are only part-funded or unfunded by their employer/institution/other sources.

The UK Presentation Fund is administered by the Society's Educational Awards Panel. The next closing date for applications is 1st October 2000.

**Further details and application forms for both the above are available from Elaine Venables in the Education Department at the CSP on 020 7306 6610 or Email: [venablese@csphysio.org.uk](mailto:venablese@csphysio.org.uk)**

THE CHARTERED SOCIETY OF PHYSIOTHERAPY  
14 BEDFORD ROW, LONDON WC1R 4ED

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**ST. JAMES'S UNIVERSITY HOSPITAL**  
**Regional Child Development Centre**  
**CHILD DEVELOPMENT AND NEUROLOGY SERVICE**  
**UPDATE ON BOTULINUM TOXIN**

Increasingly Botulinum toxin (type A) is being used as a treatment for spasticity in children with cerebral palsy. Botulinum toxin in the form of Dysport, from Ipsen, has recently gained approval, and now boasts a licence to treat dynamic equinus foot deformity in ambulant children with cerebral palsy.

The implications of gaining this license are vast, and will inevitably see many more centres setting up a service. Botulinum toxin has been called a 'promising medical treatment' and will no doubt prove an exciting and useful adjunct to those therapies which we already employ.

Look out for the randomised control trial performed at St James's Regional Child Development Centre, in support of this license, due to be published in Archives of Childhood Diseases September 2000.

For more information please contact Dawn Simpson, Research Physiotherapist at the RCDC, St James's University Hospital, Leeds, LS9 7TF or on 0113 2065894.

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***Is anyone out there interested?***

We are considering running a one day introductory course on Motivational Interviewing using the cycle of change model. This approach is increasingly being used as part of the management of patients with chronic pain.

The course would be specifically geared towards physiotherapists.

If you are interested in attending or just want further details please contact :

Alex Bairstow  
Physiotherapy Department,  
The Thistle Foundation,  
Niddrie Mains Road,  
Edinburgh, EH16 4EA

Tel: 0131 661 4253  
Fax: 0131 661 4879  
Email: [abairstow@thistle.org.uk](mailto:abairstow@thistle.org.uk)

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## HERE AND THERE

CAPT believes the standard is in need of revision. However because of work being done at a European level a new British Standard cannot be introduced.

### A new European Standard

A new European standard is in preparation (currently it is in draft form prEN1273). This has recently been redrafted because there were concerns that the draft standard did not adequately address the key safety issues of mobility and access to hazards.

A new draft will be voted on soon in Europe.

A much needed part of the new European standard is the requirements on manufacturers to use clearer and more stringent safety warning labels and information.

### BABY-WALKER IMPROVEMENTS

In response to the fact that many children have accidents in baby-walkers some manufacturers have been changing their designs to meet some of the safety concerns.

#### These changes include

- A slowing mechanism in the wheels to limit the speed a baby can reach.
  - Rubber pads on the base to detect changes in level and restrict movement if an uneven surface is detected.
  - A wider base to stop walkers getting through door ways.
- These changes address some of the safety issues but not all of them, for example the increased height of the baby and increased access to potential dangers. Making baby walkers harder to move put more pressure on baby's hips.

These changes are just coming into effect in some makes and models of baby-walker. It is too early to say whether these changes will be effective in reducing accidents. In addition there are many older style baby-walkers still on the market and many more are being used by parents and carers.

### CAPT'S ADVICE

With this in mind the *Child Accident Prevention Trust still recommends that at present babies and young children should not be placed in a baby-walker.*

### BABY-WALKERS ADVICE FOR PARENTS

*Many parents often use baby-walkers completely unaware of the potential dangers. We should work to raise awareness of the dangers and encourage them not to use*

*baby-walkers. However use remains high and so perhaps it is important to offer advice to parents who are using them.*

- Check the baby-walker to see that it is solid and in good condition.
- Check the fastenings every time you see the baby-walker.
- Make sure fire guards and safety gates are in place and there are no hazards for baby to reach in the baby-walker.
- Baby-walkers should only be used for short periods of time - no more than 20 minutes in any session.
- Children must be closely supervised, that is within eye contact and arm's reach, at all times.
- Don't relax your supervision for a minute - it only takes a second for baby to come to harm.

### References:

- Play it Safe; A complete guide to child accident prevention, Levene, S, BBC Books 1992
- Making a Safer Choice. (Leaflet for parents and carers) CAPT 1998
- 'Safety of baby-walkers', a research report, International Testing 1997
- "Are baby-walkers a safe and effective way of promoting mobility in infants?" Graham, J. Association of Paediatric Chartered Physiotherapists Journal, June 1999.
- "Patterns of Walker Use and Walker Injury", Rieder et al, 1986 Paediatrics Vol 78 No. 3 September p488 - 493.
- "Babywalkers: prevalence of use and relationship with other safety practices", Kendrick D and Marsh P, Injury Prevention 4, p295-298 December 1998.
- "Parental Decisions to use Infant Walkers" Bar-on et al Inj. Prev. 4 December 1998 p299-301.

### Acknowledgements

CAPT is grateful for the assistance of Julia Graham and Sue Whitby of the CSP; Anne Smith; Dr Sara Levene; Andrea Forbes Westlake of the CPHVA in preparing this factsheet.

### Further information:

- Royal Society for the Prevention of Accidents: 0121-248-2000
- Chartered Society of Physiotherapy: 0171-306-6666
- Community Practitioner and Health Visitors' Association: 0171-717-4000

The Child Accident Prevention Trust (CAPT) is the only national organisation concerned solely with preventing injury to children and young people. CAPT carries out research, provides information, training and consultancy, and gives safety advice to parents, carers, those working for children's safety and the children themselves.

This is one of a series of factsheets on child safety issues produced by the Child Accident Prevention Trust. You are free to copy this factsheet for educational purposes but not for financial gain. The Child Accident Prevention Trust retains copyright. We welcome any requests for further information from parents, children, practitioners and students about this or any other aspect of child safety.

Child Accident Prevention Trust, 4th Floor, Clerk's Court, 18-20 Farringdon Lane, London EC1R 3HA  
Tel. 0171-608-3828, fax: 0171-608-3674. Email: [info@capt.demon.co.uk](mailto:info@capt.demon.co.uk)

### **HANDBOOK OF MOBILISATION IN THE MANAGEMENT OF CHILDREN WITH NEUROLOGICAL DISORDERS**

SANDRA BROOKS-SCOTT Ed, PPT, PCS

BUTTERWORTH HEINEMANN - USA

FIRST PUBLISHED 1999

ISBN 0 706 7025 8999 100 PAGES £35

This compact hardback book is written for paediatric physiotherapists trying to find an effective way to help their young patients to learn to move as efficiently as possible and to improve function. It describes combining joint mobilisation with the traditional neurological modes of treatment.

It is suggested that mobilisation could sometimes put off the need for orthopaedic intervention for some children.

It is written in seven chapters, starting with a historical perspective describing various methods of treatment and moving on to more recent research based theory.

Discussion follows on the contribution of biomechanics and musculoskeletal development on motor control. There is a chapter on techniques of mobilisation, which includes clear photographs showing the actual treatments shown on a skeleton and on a child.

Whether stretching or strengthening are appropriate is included in the section on assessment protocols. This section also includes tables for range of movement of children related to age.

Seven case examples are used throughout the book and treatments related to them.

The final chapter discusses the vexed question of when to start and when to stop treatment for this group of children, remembering that children's needs change as they mature. Goals change – sometimes they are reached and sometimes they are no longer relevant.

There are eight pages of references, many of which are American.

The first four chapters of the book have been written for American paediatric physiotherapy students to use. The fifth and sixth chapters for the recently graduated paediatric physiotherapist and the

complete book will give food for thought to all experienced paediatric physiotherapists.

The paper is good quality and the size of the book makes it easy to handle. It would be a useful addition to a paediatric physiotherapy department library.

**Mrs Sue Whitby MCSP**

### **FINGERS AND THUMBS**

ROMA LEAR

BUTTERWORTH HEINEMANN - UK

FIRST PUBLISHED 1999

ISBN 0 7506 2524 4 134 PAGES PRICE £9.99

'Fingers and Thumbs' is the second book in the 'Play can Help' series. It is written for children with hand function problems.

All the toys are home made and have been 'invented' by lots of different people. Roma Lear is now retired, having worked for many years as a teacher and toy maker. She has collected the ideas throughout her career, which included setting up one of the first Toy Libraries for children with special needs. Many of the toys can be used by children with special needs but could be used by all children who want something to play with.

The actual toys can be made by most adults and use simple materials. The level of difficulty is graded, including instant, quick and long lasting. The reader is introduced to materials and techniques to make toys. This includes advice on safety. Addresses, including mail order suppliers are given with a description of the materials needed.

The toys are categorised under common hand movements. Each section has a list of contents with the easiest ideas first. There are lots of wonderful ideas throughout the book, which is written like a recipe book.

The book is illustrated with sketches showing some of the ideas. Some of the singing rhymes include actual music for those who really want to get the tune right, although the children don't seem to mind - as long as you are willing to have a go and make singing fun.

This soft back book is pleasant to use. The pages turn easily and the text is well written. This book



would be a delightful addition to a paediatric therapy department library. It would also be useful for anyone involved with children as a parent or carer. It would allow everyone to have a bit of fun, with therapy as a bonus.

**Mrs Sue Whitby MCSP**

### **DECISION MAKING IN PEDIATRIC NEUROLOGIC PHYSICAL THERAPY**

CHURCHILL LIVINGSTONE

PHILADELPHIA 1999

(ISBN 0-443-07923-4) 341 pages Price £32.95

Edited by Suzann K. Campbell PT, PhD, FAPTA.

This easy to read book is divided into seven chapters, each very fully referenced. The book's editor, Suzann Campbell has written the first and last chapters, with intervening chapters written by a range of contributors.

There is a distinct North American flavour to the start of some chapters, that on traumatic brain injury quoting detailed figures and costs within the US., which may not be meaningful to European readers. Chapter one takes the reader through models for decision making; the steps involved are clearly stated, and are a springboard for more specific discussion in subsequent chapters. Professor Campbell gives a brief overview of some of the more commonly used treatment strategies. She emphasises the need for proponents of the strategies to provide well-designed research on outcomes, and for clinicians to choose and engage in effective evidence-based practice. She also expresses the importance of families being "empowered with full knowledge of their child's condition", to enable them to be part of the ongoing decision making process.

Each of the following chapters start with a succinct overview of the topics - cerebral palsy, traumatic brain injury, multiple disabilities, spina bifida, brachial plexus injury and the at-risk infant. Assessment, problem analysis, goal setting, and possible outcome measures are then discussed in relation to a variety of case studies, clearly illustrated throughout with photographs and tables. The interdisciplinary team was referred to by some

authors but in the section on traumatic brain injury, no reference is made to liaison with speech and language therapists regarding eating and drinking difficulties.

The chapter on children with multiple disabilities focused on children with "mental retardation" (sic); possible visual problems were not addressed. It was also disappointing that the importance of head and neck alignment was not mentioned. Ms. Lunnen's brief resumé of neuro-development treatment is out of date and very misleading (Bobath & Bobath 1967). Other authors in this book have found more recent references: Mayston 1992, Bobath & Bobath 1984. In the section on brachial plexus injury, somewhat prescriptive therapeutic management is described. Prof. Shepherd emphasizes that successful outcome of practised tasks is dependent on concrete meaningful goals. This would have been enhanced with a discussion of appropriate outcome measures. Changing goals and issues around the transition from adolescence to adulthood are touched upon in the chapter on spina bifida, and hardly mentioned elsewhere.

Prof. Campbell reinforces the book's theme in her final excellent chapter on the infant at risk with a five point guide to decision making, several case studies with recommendations and points for reflection.

I think this book will aid decision making and encourage reflective practice in both physiotherapy graduates and undergraduates. Other disciplines would also find it useful. I have no hesitation in recommending it.

#### **References :**

Bobath K & Bobath B. The neurodevelopmental treatment. In Scrutton D (ed): Management of the Motor Disorders of Children with C.P. Clinics in Developmental Medicine 90. J B Lippincot, Philadelphia 1984.

Mayston MJ: The Bobath Concept - Evolution and Application. In Forsberg H; Hirschfeld H (eds). Movement Disorders in children. Med.Sport/ci vol 36 Karger Basel 1992.

**Gillian Stern M.C.S.P.**

## COURSES

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**APCP**

### **INTRODUCTION TO PAEDIATRICS COURSE**

**CYMRU 2000**

**6 - 10th November 2000**

**Cardiff Jury's Hotel**

This five day course is for physiotherapists who are interested in or who have recently commenced their first paediatric post.

It aims to give an overview of the main aspects of paediatrics. Topics will include Child Development, Neurodevelopmental and Neuromuscular Conditions, Orthopaedics, Respiratory Care and Legal Aspects.

Each participant will be expected to complete a Multiple Choice Questionnaire and a Case Study in order to obtain a certificate from APCP.

**The cost will be £250 APCP Members, £285 Non Members**

For further information please contact : Sian Howells, 17 Carlton Close, Thornhill, Cardiff CF14 9EF

Work: (029) 207 15591. Home : (029) 207 58293

For application form (with accommodation details) please send S.A.E. to: Julie Williams, 42 Portreeve Close, Llantrisant, Mid Glamorgan CF72 8DU (01443) 222685

### **APCP REGIONAL STUDY DAY NORTH EAST REGION**

### **UPDATE IN NEUROPHYSIOLOGY**

**Friday 10th November 2000**

**Course Tutor : Dr Margaret Mayston, Bobath Centre**

**Venue : Postgraduate Centre, Pinderfields Hospital, West Yorkshire**

**Fee : APCP members £50, non-members £75, including coffee and lunch**

Please make cheques payable to APCP - NE

Send to : Mrs Emma Graham, 16 Albert Road, Eaglescliffe, Stockton on Tees, Cleveland, TS16 0DD Tel. 01642 889420

### **APCP SOUTH EAST REGION**

### **TWO DAY PAEDIATRIC GAIT ANALYSIS AND ORTHOTIC MANAGEMENT**

**Friday 10th and Saturday 11th November 2000**

**Speaker : Elaine Owen MCSP**

**Venue : The Children's Trust, Tadworth Court Hospital, Surrey**

**Cost : APCP Members £90 - Non-members £100**

Course Contents : Biomechanics, Normal Gait, Pathological Gait, Video Kinematic Analysis Technique, Aims of Orthotic Prescription

For further details and/or Application Form, please contact :

Anne Finlayson, Mainstream Schools Therapy Team, Foster Street Clinic, Foster Street, Maidstone, ME15 6NH. Tel. 01622 226084.

S.A.E. & Cheque with application form please

## COURSES

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### YORKSHIRE NORTHERN REGION

Date : Wednesday 8th November 2000,

9.00 a.m. - 12.30 p.m.

### NEUROMUSCULAR FORUM

Venue : Post Graduate Centre, Halifax General Hospital,  
Godfrey Road, Halifax HX3 0PW

Feedback from Hammersmith on Practical Management of Children  
with Neuromuscular Disease, Care at Martin House.

Cost : £5.00 cheques made payable to Calderdale Healthcare NHS Trust

Please contact :

Sarah Hibbert, Physiotherapist, Child Development Unit,  
Halifax General Hospital, Godfrey Road, Halifax HX3 0PW

### CEREBRAL PALSY RESEARCH STUDY DAY

Date : Thursday October 12th 2000

Venue : Blair Bell Conference Room, Liverpool Women's Hospital

Cost : FREE

10.30 Welcome and introduction - Dr Philippa Hallam

10.45 Dr Lewis Rosenbloom

*Keynote lecture - Cerebral Palsy Research Update*

11.30 Professor Cliff Cunningham/Professor Sheila Glenn  
*Working with parents*

12.15 Professor Neil Marlow

*Evidence-based parental Support Strategies - The Bristol  
Experience*

1.00 - 2.00 LUNCH

2.00 Dr Peter Moore

*The Botulinum Trial Update*

2.45 Dr Ian Mckinlay

*Disclosure, diagnostic uncertainty and changing clinical  
patterns in CP*

3.30 Professor Mike Weindling

*Efficacy and effectiveness of physiotherapy and parent support  
for children with CP and their families*

4.00 - 4.30 DISCUSSION AND CLOSE

THIS MEETING HAS BEEN APPROVED BY THE RCPCH FOR 5  
CPD POINTS

RSVP for catering to Dr Philippa Hallam, 0151 708 9988 x 1021,  
x 4055

# COURSES

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## FORTHCOMING COURSES AT ORLAU, OSWESTRY

### RECIPROCAL WALKING ORTHOSES:

**Fundamental Principles  
and Overview of Currently  
Available Devices**

**Date : 2 - 3 November 2000**

This seminar will enable clinical practitioners (physiotherapists, orthotists and doctors) to make informed choices about the type of reciprocal walking orthosis most suited to their patients. Qualifies for 12 BAPO CPD points.

**Fee : £85 + VAT including buffet lunch**

### NEW 21st CENTURY ORTHOTICS AND MODERN CLINICAL PRACTICE - FOR TREATMENT OF WALKING DISABILITY

**Date : 24 November 2000**

This one day course will show how paralysis in the lower limbs can be treated orthotically to compensate for weakness and restore walking motion. Some cases of cerebral palsy spasticity in children require tuned AFOs. The methods of 'tuning' to optimise the biomechanics will be explained.

**Registration Fee : £95 including Lunch and refreshment breaks**

### A THERAPEUTIC ORTHOTIC SYSTEM FOR MANAGING KNEE CONTRACTURES

**Date : 8 - 9 February 2001**

The Contracture Correction Device (CCD) is a system of dynamic splinting that provides a low load constant stretch to soft tissue for the reduction of contractures. This is a one and a half day introduction to the CCD for teams of (preferably) orthotist/physiotherapist. Lectures/workshops from consultant, physiotherapy and engineering staff at ORLAU. History and development; anatomy; biomechanical and orthotic principles; fitting and application; commercial consideration and future development will be covered. Qualifies for 12 BAPO CPD points.

**Fee : £130 approx (TBA) + VAT**

**Advance notice of a major  
three day seminar with  
invited international  
speakers :**

### NEW MOBILITY STRATEGIES IN CEREBRAL PALSY

**Date : 28/29/30 November 2001**

A plethora of choice - a paucity of guidance  
(How we match treatment to the individual child)

Please contact us to register your interest - further details will be sent as soon as they become available.

For further details and application forms contact :

Karen Edwards, ORLAU, Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust Oswestry, Shropshire, SY10 7AG.  
[www.orlau.com](http://www.orlau.com)

Tel. 01691 404531, Fax: 01691 404058 Email: [edwarkj@aol.com](mailto:edwarkj@aol.com)

## COURSES

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### BRITISH ASSOCIATION OF BOBATH TRAINED THERAPISTS

### ANNUAL STUDY DAY and AGM/EDUCATION DAY

### "FIDGETY" INFANTS - HOW DO WE SEE THEIR NEXT MOVE?

**Date : Saturday 21st October 2000**

**Venue : Corpus Christi College, Cambridge**

Exploring the natural history of postural and visual development in children with cerebral palsy associated with prematurity

Various speakers on the subject with wide experience in the field including:  
**AM:**

**Dr Mijna Hadders-Algra** - University of Groningen, The Netherlands

*"Development of postural adjustments: effects of preterm birth and lesions of the periventricular white matter"*

**Prof. Giovanni Cioni** - University of Pisa, Florence

*"Observations of spontaneous movements and early diagnosis in CP"*

Dr Hadders-Algra and Prof. Cioni are internationally renowned speakers with vast experience in the field. They have undertaken extensive research in the field and have published widely in peer reviewed journals.

**PM:**

Development of the Visual system in preterm cerebral palsy including :  
Normal and abnormal development

Both ophthalmic & functional assessment of visual system

**Open to BABTT members (£40) and non-members (£50)**

Application forms available from Sue Bearne, 49 Efford Road,  
Higher Compton, Plymouth PL3 6NF. Tel. 01752 786497

Closing date : 2nd October 2000

### THE BOBATH CENTRE, LONDON

### SPECIALIST COURSE FOR THE TREATMENT OF ADULTS AND ADOLESCENTS WITH CEREBRAL PALSY

**Date : November 20th - 24th 2000**

**Cost : £395.00**

This course is designed to give participants practical experience of applying Bobath principles to the management and treatment of adults and adolescents with cerebral palsy, and to give the participants insight into the specific problems encountered by these client groups.

This course is open to therapists who are Bobath trained - either in paediatrics or adult neurology. For an application form please contact :

Abby Stopler, Course Organiser, The Bobath Centre, Bradbury House,  
250 East End Road, London N2 8AU

Tel: 020 8444 3355 / Fax. 020 8444 3399

Email: rach@bobathlondon.co.uk

## COURSES

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### THE BOBATH CENTRE

**Date : 30 November 2000**

**Cost : £60**

### 'OUTCOME MEASURES'

Outcome measures for children with cerebral palsy to include workshops and presentations on GMFM - PEDI - QUEST - SFA and Goal Setting.

### GROSS MOTOR FUNCTION MEASURE

**Date : 1st December 2000**

**Cost : £100 (this includes manual and testing)**

A validated test to measure motor function for children with cerebral palsy. The workshop will include training and criterion testing.

**Combined offer for both courses @ £150**

Further information and enrolment forms are available from :

Abby Stopler, Course Organiser, The Bobath Centre, Bradbury House,  
250 East End Road, London N2 8AU

Tel: 020 8444 3355 / Fax. 020 8444 3399

Email: rach@bobathlondon.co.uk

### THE BOBATH CENTRE

### PAEDIATRIC COURSES BEING RUN BY THE BOBATH CENTRE IN 2000-20001

Introduction to moving and handling (£75) 1st September 2000

3 Day Splinting Course (£200) 12th - 14th October 2000

A Course for Doctors (£300) 27th - 29th November 2000

Refresher Course, London (£345) 11th - 15th December 2000

Advanced Course (£395) 21st - 25th May 2001

Therapy Assistants Course (£80) 11th - 12th June 2001

Teachers Course (£40) 28th September 2001

Refresher Course (£345) 26th - 30th November 2001

Therapy Assistants Course (£80) 5th - 6th December 2001

Introductory Courses in 2001 (£175) 5th - 7th March 2001

4th - 6th June 2001

24th - 26th September 2001

8 Week Paediatric Courses in 2001 (£2350)

Winter Split 2001 Part 1 : 8th Jan. - 9th Feb.

Part 2 : 23rd April - 11th May

Spring 2001 19th February - 12th April

Summer 2001 18th June - 10th Aug.

Autumn 2001 1st Oct. - 23rd Nov.

From October 2000, the 8 week Bobath Course will form part of an MSc in neurophysiotherapy in conjunction with University College, London

Further information and enrolment forms are available from :

Abby Stopler, Course Organiser, The Bobath Centre, Bradbury House,  
250 East End Road, London N2 8AU

Tel: 020 8444 3355 / Fax. 020 8444 3399

Email: rach@bobathlondon.co.uk

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## COURSES

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### WHAT IS JUVENILE IDIOPATHIC ARTHRITIS?

**Date : Thursday 23rd November**

**Venue : Royal Victoria Infirmary, Newcastle upon Tyne**

This is an introductory course for therapists seeing small numbers of children with rheumatic diseases as part of a wider caseload. The aim is to provide an overview of childhood arthritis, along with its medical and physical management.

Tutors : Newcastle Paediatric Rheumatology Team

Apply with cheque to : Rachel Evans, Therapy Services, Royal Victoria Infirmary, Newcastle upon Tyne, NE1 4LP.

**Fee : £30** payable to "Newcastle upon Tyne Hospitals NHS Trust", lunch and refreshments included.

Closing date : 10.11.00

### PARTNERSHIP IN DEVELOPMENTAL CARE

### TODAY, TOMORROW AND BEYOND - CAN IT MAKE A DIFFERENCE?

**Date : 2nd and 3rd November 2000**

**Venue : The Edinburgh Conference Centre, Heriot Watt University, Riccarton campus, Edinburgh.**

This is a two-day conference providing a forum to discuss and debate the multi-professional approach to developmental care.

There will be plenary sessions, workshops and an exhibition.

Conference Organisers: the Scottish Neonatal Nurses Group, the Neonatal Unit, SMMP Edinburgh, and the Scottish Developmental Care Special Interest Group.

Speakers include :

a Developmental Specialist, Speech and Language therapists, Physiotherapists, Psychologists, Research Fellows, Midwives, Obstetricians and Neonatologists.

Topics include :

Antenatal influences on fetal development and outcome,  
Sensory system development and implications for behavioural development,  
Evidence for and against developmental care,  
Theoretical concepts underpinning developmental care,  
Clinical strategies utilised to support developmental care,  
Neurological assessment techniques of the preterm infant and  
Long term follow-up of babies discharged from the neonatal unit.

Application form available from : Frances Noble, Event Co-ordinator, c/o NNU (4th Floor) SMMP, Lauriston Place, Edinburgh, EH3 9YW. Tel. 0131 536 4387 Fax. 0131 536 4215.



**MOVE**  
EUROPE

A Disability Partnership Innovation in Inclusion

## Starting MOVE

**Two day Basic Provider training in London  
Monday 13 & Tuesday 14 November (9.00 a.m. - 4.30 p.m.)**

The MOVE Curriculum (**M**obility **O**pportunities **V**ia **E**ducation)<sup>®</sup> is an innovative teaching programme used by teachers, therapists, parents and carers to help children and adults with severe disabilities to sit, stand and walk. The programme teaches mobility skills which allow greater independence in adulthood and help children, young people and adults with disability to take some control over their own lives.

This two-day Basic Provider course will provide participants with an overview of the MOVE philosophy leading towards greater choice and opportunity for adults/children with disability. The course covers the six steps of MOVE, joint goal setting, planning individual programmes, monitoring and evaluating clients' progress and developing Team Work. MOVE teams include professionals, clients, carers and families who are trained together to help reinforce the team philosophy on which MOVE is built. The two-day course will allow participants to start using the MOVE Curriculum in their own school, centre or at home.

• **MOVE International Trainer<sup>®</sup>** • **Full introduction** • **Equipment session** • **New training material**

To reserve a place on the training course, please complete and return the slip below to: **MOVE Europe**, University of Wolverhampton, Gorway Road, Walsall, WS1 3BD. Tel: 01902-323066, Fax: 01902-322858, email: [move@disabilitypartnership.co.uk](mailto:move@disabilitypartnership.co.uk)

**To: MOVE Europe, University of Wolverhampton, Gorway Road, Walsall, West Midlands, WS1 3BD**

Please reserve ..... place(s) on the **Starting MOVE** course in London on 13 & 14 November 2000 @ **£150** per place. Please note that a MOVE Curriculum (price £50) is included in the course fee.

I enclose a cheque for ..... (made payable to 'The Disability Partnership')

or:  Please send me/my employer an invoice

(Note: To secure a place payment **must** be received before the course)

Name: .....

Job Title: .....

Address: .....

Postcode: .....

Telephone: ..... Email address: .....

Please attach names and details of all other participants for whom you are reserving places

**Please circulate this flyer**





## **LUTON & DUNSTABLE HOSPITAL NHS TRUST PAEDIATRIC PHYSIOTHERAPY**

Due to re-organisation and service developments we wish to recruit two community Paediatric Physiotherapists to join our friendly and dynamic team. As a member of the community team you will provide a physiotherapy service to children from 0-16 with a wide variety of paediatric conditions in children's centres, nurseries, mainstream schools and home visits. You will work alongside our existing experienced senior 1 physiotherapists and physiotherapy assistants in the community and the acute paediatric service within the hospital.

Personal and professional development is encouraged through individual development and performance review, inservice training and generous funding for external courses.

Car drivers are essential.

Luton is a popular commuter city 30 minutes train ride from the centre of London with easy access to the M1.

### **SENIOR 1 PAEDIATRIC PHYSIOTHERAPIST**

**FULL TIME 36 hours**

**£20,310 - £23,915 per annum**

We are looking for an enthusiastic and motivated experienced paediatric physiotherapist to assist in developing and co-ordinating our community paediatric service. The position will offer scope to develop both clinical and managerial skills with close support from our team. Funding is available for external courses for clinical and managerial skills.

### **SENIOR 2 PAEDIATRIC PHYSIOTHERAPIST**

**20 hrs**

**£17,090 - £20,310**

This 20 hr position with flexible hours working alongside our community team members may suit those wishing to reduce their commitment to a full time post or returning from a career break.

**To discuss these posts and/or arrange an informal visit please contact Lynda Gilmore, Senior 1 Physiotherapist on 01582 497350/01582 708141.**

**Application forms and job packs are available from the Recruitment Officer, Human Resources Dept. 01582 497284.**

## VACANCIES

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### **SENIOR 1 PAEDIATRIC PHYSIOTHERAPIST**

#### **36 HOURS PER WEEK**

Upon the retirement of the present post holder a unique opportunity is available for a special physiotherapist prepared to be dynamic, innovative and most of all flexible in the delivery of care to children attending the Cheyne Day Centre. They will also have a community paediatric caseload.

The Day Centre, based at Chelsea & Westminster Hospital, is a specialist nursery for children from two to seven years of age with cerebral palsy and other complex disabilities. The Centre has its own sensory based developmental curriculum from which individual timetables are devised and adopts an holistic approach to help each child reach their full potential. It offers an assessment, therapy, education and advice service to children and their families and has a multi-disciplinary team involved in the children's care.

You will be part of a cohesive team of 12 paediatric physiotherapists and will be fully supported by your superintendent.

The Chelsea & Westminster Physiotherapy Department is committed to continuing personal and professional development through well established in-service training programme and support for further post-graduate education.

This is an opportunity for a physiotherapist with specialist skills, which is not to be missed.

For an informal discussion or to arrange an informal visit please contact Jane Anderson, Superintendent Paediatric Physiotherapist on 0181 846 1615.

**Chelsea & Westminster Hospital, 369 Fulham Road, London SW10 9NH**

Closing date : 6th October 2000

## Notes for Contributors

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

Manuscripts should be sent to Mrs Sally Braithwaite, 531 Church Road, Yardley, Birmingham, B33 8PG.

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

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

**References** should be given in the Harvard System.

In text Author(s) name and initials followed by the date of publication. Use a,b, to indicate more than one publication in the same year. Where there are 3 or more authors use first name followed by et al.

For books Laszlo, J. & Bairstow, P. (1985) *Perpetual Motor Behaviour* (Rinehart and Winston)

For chapters within books

Morley, T.R. (1992) Spinal deformity in the physically handicapped child, in : G.T. McCarthy (Ed). *Physical Disability in Childhood* (Churchill Livingstone)

For articles Scott O.M., Hyde S.A., Goddard C.M., Dubowitz V., (1981a) Prevention of deformity in Duchenne muscular dystrophy. *Physiotherapy* 67(6), 177-80.

## Tables and Figures

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

Keys to symbols should be included.

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

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

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

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

Cover designed by John Soper

Printed and bound by

G. H. SMITH & SON, EASINGWOLD, YORK

ISSN 1368 - 7360



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