**Editorial**

Neurodisability as a subspecialty
There is progress on recognition for neurodisability as a subspecialty of paediatrics (see page 2). This will potentially have important implications for trainers and trainees.

The CDDG Committee and Regional Representation
Also in this edition look for the notice of the meeting for regional representatives prior to the March 14th Meeting in Derby. If the STA approves neurodisability as a subspeciality this will inevitably lead to changes in committee structure of the groups representing disability in the RCPCH: please get involved in the developments. Anticipation of this evolution has meant that the current national CDDG committee has been relatively static and it is now time for change: Those interested should also come to this meeting.

Meetings:
March 14th 2003 Derby - "Disruptive behaviours in Childhood:Origins, interventions and outcome". See enclosed flyer. Paul Gringras and Val Harpin have organised another exciting and stimulating programme – so don’t miss out and book early.

April 10th, Thursday am York:
RCPCH meeting: The theme for the guest speakers will be the treatment of osteoporosis in childhood disability: reviewing the evidence and some good practical messages. Of course we hope you will also contribute by sending in abstracts of your recent disability research (BACCH / disability). After our session there will be a special symposium on disability: speech, language and hearing from 11.30 to 15.00.

EACD
The PISA meeting was a great success, with many highlights although with a huge attendance of more than 600, organisation proved a challenge. The next meeting will be in Oslo dates 2nd to 4th October 2003. Book through www.eacd2003.no

Website
Are you a keen website browser? Would you like to help develop, manage and update our website? Please contact Caroline Llewelyn. Any feedback and suggestions about the website would be welcome.

Membership Fees for CDDG
Remember you can become an individual or team member of the CDDG with a reduction in the annual meeting cost, access to all CDDG publications and also through your subscription help support the work of the group in promoting best practice in Childhood Disability. Membership applications are available from Caroline Llewelyn (caroline.llewelyn@rcpch.ac.uk) and have been sent with the meeting flyer. Feel free to photocopy a friend’s form and send it in.

Administrator
We welcome Caroline Llewelyn as the new CDDG Administrator (based at RCPCH) and thanks to Alison Saunders for her excellent work with us, wishing her well for the future.

National Service Framework for Children: External working group (EWG) on disabled children
Francine Bates (Director of Contact a Family) is the chair of this EWG. She gave an excellent talk and workshop at this September's BACCH ASM, summarizing the work of the group so far. The Acute services for children NSF will be published by early next year and all the other EWGs will publish documents describing 'emerging findings' at the same time. The final findings of these groups will then be published later next year.

The EWG on disabled children are particularly keen to consult widely and a preliminary document will be published on the DoH website soon. Comments are very welcome. A number of consultation meetings early next year are also planned, and will include a meeting with CDDG regional representatives planned for March 13th.

The overall aim of the EWG is to recommend Standards and Interventions that will:
Ensure that disabled children enjoy the highest quality of life possible, gain maximum life chance benefits from educational opportunities, health care and social care, and that their and their families needs are promptly and sensitively addressed and their choices respected.

Alison Salt

Ten key themes have emerged from the EWGs work:
1. Promoting inclusion
2. Partnership and participation
3. Co-ordinated and multiagency services
4. Early identification, diagnosis and assessment
5. Early intervention
6. Tackling inequalities and family support
7. Transitions
8. Therapies
9. Equipment and adaptations
10. Children with complex and continuous health needs and/or life-limiting conditions

Do watch the DoH website and contribute to this important work - at www.doh.gov.uk/nsf/children/externalwgddisabled.htm see page 6 of this newsletter for more 'work in progress'.

Alison Salt
The case for recognition of neurodisability as a subspecialty within Paediatrics

The recognition of neurodisability as a subspecialty in paediatrics has long been proposed, on the following basis. Neurodisability has become increasingly complex, and practitioners are expected to show competence in a very wide range of skills. In order to deliver a high quality service for children with disability some paediatricians are likely to require more detailed training than generic Community Child Health.

Approximately 2% of the child population have some level of special educational needs, implying 1,000 children in an average ‘old’ health district. The recent DIES document ‘Together from the Start’ highlights the complex multiagency work required to meet their needs from 0 to 2.

The majority of these children will be referred from primary surveillance. Community Paediatricians, with broad competencies in CCH, will manage those with less severe developmental problems. However those with more complex difficulties will require a higher level of expertise and competence.

There are currently 320 Child Development Teams in the United Kingdom, each seeing on average 200 new cases per year. These teams should have a lead Paediatrician to oversee more specialist neurodisability services, including initial assessment, diagnosis, and on-going management of children with severe learning disability and co-morbidity including epilepsy, moderate to severe cerebral palsy, autistic spectrum disorders, head injury rehabilitation, neurometabolic conditions and children with complex disability. Current lead paediatricians have often developed their expertise through CPD over many years, and work in close collaboration with regional Neurology and Neurodisability services.

There are also a number of paediatricians working in ‘tertiary’ level neurodisability. Some have specialist training in Neurology and others have learned from CPD and clinical experience. When jobs are advertised for these paediatricians there are few adequately qualified individuals as no dedicated specialist training is available.

Many posts are now advertised for a Community Paediatrician with a special interest in neurodevelopmental disability. In a survey of trainees in Community Child Health in 2000, 16 / 61 (26%) expressed an interest in developing a subspecialist interest in neurodisability. A current survey of 220 lead clinicians in CCH, which is not yet complete, found that of the 120 responses (60%) 45 centres could provide specialty training in neurodisability.

A syllabus, recommended training programme and competencies to be achieved for Neurodisability, with some suggested assessment tools, have been developed by the Education and Training subgroup of the Standing Committee on Disability for the RCPCH. This has been circulated for comment to the CDDG, BACCH, BPNA, Regional Advisers and the College Council, and final versions are being prepared following feedback.

Training in Community Child Health will of course continue, and generic Community paediatricians will continue to play an essential role in managing children with disability. Those with more detailed training will be those taking lead responsibility in neurodisability in a district, providing leadership for the service and seeing children with more complex/severe disability.

With this level of evidence for the case for subspeciality recognition the proposal has been accepted by all those consulted in particular by the RCPCH Executive Committee and Council. The next step will be to submit this to the Specialist Training Authority of DoH.

Alison Salt (Chair CDDG)
New publications on fathers, genetics and education rights

Contact a Family has recently produced two new factsheets: one is for fathers of disabled children and the other is about genetic conditions in the family. The “Fathers” factsheet was written by Clare Gibson, the former Library and Information Officer in association with Keith Bowen, the Wales Development Manager. It draws on the experiences of a number of fathers who attended workshops held in Swansea and Bridgend. We thank them for their insight, wisdom and help.

The other factsheet is called “A Genetic Condition in the Family” and is written by the Directory Researcher, Lucy Arnold, who has a Masters degree in Molecular Genetics with Counselling. The factsheet gives a brief introduction to genetics, explores what counselling involves and tries to address many of the worries and concerns that surround it.

Contact a Family has also published a guide to education rights for disabled children in England from pre-school to university. This guide was produced in conjunction with Network 81 and Skill and includes information on new rights around disability discrimination, which apply to schools from the autumn onwards.

The new edition of the Contact a Family Directory – Specific Conditions, Rare Disorders and UK Family Support Groups 2003 is now available.

The above publications, and many more, can be viewed on the Contact a Family website at www.cafamily.org.uk.

For more information, including costs, and to order copies of any Contact a Family publications please tel: 020 7608 8700 or email info@cafamily.org.uk.

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**Featured team: the first team subscribers to CDDG**

Social Services Team Paediatric Directorate
Royal Belfast Hospital for Sick Children (RBHSC)

The RBHSC is a regional hospital providing specialist paediatric services to the whole of Northern Ireland for children up to the age of 13. It also has a busy local accident and emergency unit. The main specialisms are Children’s Haematology and Cancer, Cystic Fibrosis, Nephrology, Neurology, Neurosurgery, Burns and Cardiology. The social work team is made up of one Senior Social Worker and 7 social workers. There are 4 specialist posts with regional outreach responsibilities, 2 for children with cancer or leukaemia, 1 for cystic fibrosis and one part time renal post. A dedicated post has recently been developed for neurosciences leaving 2 generic posts for medical and surgical wards.

The team offers a highly skilled service to children, young people and parents as inpatients or outpatients who are experiencing difficulties following admission to hospital or coming to terms with a diagnosis or life limiting condition. The social workers provide information, advice, counselling and support, practical assistance with finances, employment, education, housing, play an integral part in the multi disciplinary team and have an important role communicating between parents and professionals both in the hospital and the local community.

Increasingly, with technological advances, more children are surviving but with significantly more complex problems. Parents want to be able to care for their children at home and these children are requiring 24 hour care. This has required entirely new approaches to children’s care and management. Assessment, planning, funding and multi-disciplinary working between hospital and community professionals have had to develop amidst pressures to safely enable children with complex problems to be at home. Pressures include the need to free-up intensive care beds, and to find adequate funding and staffing to provide safe and effective levels of homecare. It also highlighted the need to network with other areas throughout the UK to find out how other regions are dealing with these issues and developments and the team expressed interest in the Child Development and Disability Group to network and liaise with other professionals working in the same field and with the same issues.

Irene Montgomery, Team Leader
Irene.Montgomery@nwb.n-i.nhs.uk

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Familial dysautonomia (FD) is an autosomal recessive condition affecting autonomic, sensory and motor functions. Cardinal features of this condition include decreased pain and temperature perception, diminished or absent patellar reflexes, absent fungiform papillae, signs of autonomic dysfunction and lack of overflow tears. Formerly known as the Riley-Day syndrome, this condition was first described in 1949 by Riley et al., when 5 children with ‘undue reaction to mild anxiety’ manifest by excessive sweating and salivation, red blotching of the skin and transient arterial hypertension were reported. Almost exclusively found in individuals of Ashkenazi Jewish origin, the recent discovery of two FD mutations (the IKAP gene in the region of 9q31) has allowed an estimation of carrier frequency of 1 in 32 in that population. Antenatal diagnosis is possible in families where the specific gene in the 9q31 region has been identified in an affected child.

Presenting features and diagnosis Poor feeding in infancy is often the first symptom of FD. There are difficulties with sucking and swallowing, and breastfeeding is usually impossible. High fluid and calorie requirements result in failure to thrive. Distinctive features are excessive sweating, skin blotching, cold red hands and feet and absent overflow tears. Recurrent chest symptoms feature due to frequent aspiration. Diagnosis rests with the recognition of the disease pattern in an individual of Ashkenazi Jewish descent and is supported by the absence of an axon flare in response to intradermal histamine, Table 1.

Table 1
Diagnostic features of familial dysautonomia

- Diminished tear production
- Lack of lingual fungiform papilla
- Decreased deep tendon reflexes
- Lack of an axon flare after intradermal histamine (consistent with a sensory neuropathy)

Developmental concerns in FD
In the early years, motor milestones are delayed, the average child walking at 26 months. While receptive language is often normal, expressive language is delayed due to oromotor incoordination. On average, the first word appears at 30 months. Drooling and persistent swallowing difficulties are predominant and gastrostomy feeding is usually accompanied by gastric fundoplication.

The combined involvement of autonomic, sensory and motor nerves presents multisystem involvement. Table 2. An insight into the pathological processes in FD is useful in understanding the acute and chronic phenomena and further reading is recommended, Axelrod FB, 1998.

Table 2
The multisystem involvement in familial dysautonomia

<table>
<thead>
<tr>
<th>System</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>Increased fluid and calorie requirements combined with feeding difficulties and abdominal distension with large boluses</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Oropharyngeal incoordination, oesophageal dysmotility, delayed gastric emptying, increased acidity, constipation</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Recurrent pneumonia, hyperactive airways, chronic lung disease, decreased CO2 sensitivity, restrictive lung disease due to kyphoscoliosis</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Scoliosis, kyphosis, lordosis; neuropathic joints, aseptic necrosis, fractures, osteoporosis</td>
</tr>
<tr>
<td>Ophthalmological</td>
<td>No overflow tears, corneal ulceration, decreased sensation to foreign bodies, optic atrophy later in life</td>
</tr>
<tr>
<td>Neurological</td>
<td>Developmental delay, reduced taste, pain, temperature, joint position and vibration senses, ?deep tendon and corneal reflexes</td>
</tr>
<tr>
<td>Cardiac</td>
<td>Hypotension, hypertension, coronal spasm, arrhythmias</td>
</tr>
<tr>
<td>Renal</td>
<td>Progressive glomerulosclerosis (ischaemic), decreased renal function with age</td>
</tr>
<tr>
<td>Dermatological</td>
<td>Burns, pressure sores, Seborrheic dermatitis in infants</td>
</tr>
<tr>
<td>Dental</td>
<td>Malocclusion, teeth grinding, dental abscesses (dental hygiene poorly tolerated), cavities rare (perhaps due to copious saliva)</td>
</tr>
<tr>
<td>Psychological/Emotional</td>
<td>Poor concentration, emotionally labile, prone to withdrawal and irritability</td>
</tr>
</tbody>
</table>

Special considerations in the management of the child with FD
There are particular clinical considerations through each stage of childhood and adolescence for the individual with FD, Table 3. Knowledge of other specific acute and chronic features is essential.

- Acute FD crises occur frequently, with an apparently cyclical pattern in 40%. These are episodes of protracted vomiting and retching associated with tachycardia, hypertension and skin blotching. Precipitating factors are often not clear and possible triggers, such as pain, should be considered. Diazepam and clonidine are used in the treatment of these crises and particular attention must be given to fluid replacement.

- Episodes of weakness are common, due to drops in blood pressure, which may be associated with sudden postural change, straining at stool or an over distended bladder. A male with FD may need to use a urinal in bed for passing urine in the morning.

- While individuals with FD can identify visceral pain, reduced pain sensation in skin and bones puts them at risk for unrecognised injury, including fractures, and unidentified sources of fever, such as dental abscesses or osteomyelitis.

Swimming is encouraged but must be closely supervised. Underwater swimming and diving are hazardous due to decreased sensitivity to rising CO2 levels.

The difficulties in dealing with a chronic condition may be compounded by withdrawal and emotional lability. The early involvement of a supportive counselling service is an important consideration.
Management and prognosis
The management of FD depends on addressing multiple discrete and complex needs. This is a major challenge to our principles of multidisciplinary work, with necessary input from paediatric medical specialists and therapists. The importance of identifying a key worker within that team is paramount, Figure 1. Either a physician or therapist, this should be a person with a special interest in FD or with whom the parents and child have a particularly good relationship.

Through improved understanding of disease progression and treatment of acute crises, survival has improved over the past 50 years. In the 1950’s, 50% of affected individuals survived to 20 years. Currently, 80% are surviving to 30 years, many in successful employment and long term relationships.

Acknowledgement:
We would like to thank Dr R Dinwiddie, Consultant Respiratory Paediatrician and Ms Martina Ryan, Speech and Language Therapist, at Great Ormond Street Hospital for their contribution.

### Table 3
The evolution of clinical problems through childhood

<table>
<thead>
<tr>
<th>Infant</th>
<th>Poor feeding, failure to thrive, skin changes, tongue ulcers, lack of tears, respiratory infections/hypersecretion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school</td>
<td>Delayed motor milestones, speech and toileting; coordination problems, dysautonomic crises, breathing (63%), febrile convulsions (22%)</td>
</tr>
<tr>
<td>School-age (5-12yrs)</td>
<td>Short attention, perceptual problems, poor speech articulation, scoliosis (in 85% by 10 years), episodes of weakness, reduced pain and temperature sensation</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Increased self awareness, emotional stress, delayed sexual maturation, persistent chest infections, kyphoscoliosis (scoliosis does not progress beyond puberty, kyphosis may), need for daily exercise programme to maintain muscle tone</td>
</tr>
</tbody>
</table>

### ‘Distruptive behaviours in childhood: Origins, interventions and outcome’
Derby Assembly Rooms, Friday 14th March 2003.

As paediatric and child mental health services become increasingly experienced in the management of many ‘pure’ developmental and neuro-psychiatric disorders, it is often those children with challenging, disruptive behaviours that cause major problems for health, education and social services. Many of these children may have core diagnoses of ADHD, Autism or learning difficulties, but their associated behaviours lead to a much poorer prognosis than would be expected.

This conference will explore biological origins, outcomes and a range of management strategies that will be of interest to a wide range of professionals and parents working in fields of child development, child psychiatry, schools and social services.

Genes for ‘aggressive behaviours’ have demonstrated the nature/nurture paradigm better than ever before, and neuroimaging studies are beginning to give vital clues about the origins of many disruptive behaviours. There is an increasingly robust evidence-base both for parent training programmes and direct interventions with the children, as part of this rapidly expanding field the role of medication is changing. Recent studies for core ADHD show that well-prescribed and monitored stimulants are more beneficial than any of the ‘talking therapies’. When looked at carefully however, it seems that for some subsets of children, additional non-medication therapies are not only helpful but should be first line treatments.

This conference will be one of the first to try and link all these approaches in a true multidisciplinary forum.

Paul Gringras

### Reference
Inclusive education since 1988

An inclusive education policy has been established in Newham in east London since 1988. By 2001, all but one special school were closed, and almost all children with special needs are placed in mainstream schools. Like many other districts, the Local Education Authority has initiated much of the changes, and the health providers have found it difficult to keep up.

Health workers often described themselves as ‘being carried along’ by the changes.

An exercise long overdue

In early 2002, the health service to Newham school aged children with special needs was reviewed, as commissioned by the recently established borough-wide interagency strategic partnership group for children and young people. This long-overdue exercise generated much interest amongst local professionals and parents. Their views were obtained through individual interviews, meetings, focus groups and consultation by correspondence. Over 100 individuals from health, education, social services, voluntary organisations and parent groups participated.

The findings: a lot of consensus and very few surprises

Much enthusiasm to make inclusive education work was evident. Despite the potential differences between the participants, there is good consensus of what constitutes good practice. Good working relationship, good communication and appropriate training can mean success. There are strong desires for improved information systems and record keeping. The importance of maintaining clear health care-plans in school was stressed. Many of the suspected challenges to health service provision were confirmed. With more sites to cover and more education staff to train, the demand on health service far out-stretched the available resources. Many education staff expressed feelings of vulnerability in managing children with unfamiliar conditions. Areas of potential breakdown in service coordination, such as transitional stages, were elicited. Not surprisingly, some parents wished for more specialised placements, and debate on this contentious issue is expected to continue.

Much more work to be done

Recommendations to commissioning priorities, operational policies, training strategy, and information systems were made. Some operational policy changes had already taken place, and interagency service development bids have been put forward too. Progress is being monitored by two interagency committees, and there will be a formal review in June 2003.

We are in it together

The findings and recommendations are expected to have strong influence on commissioning and service planning, as they represent the consensus of local professionals and parents. However, the most important benefit of the project is the opportunity for workers and parents from different backgrounds to meet and get to know each other, thus breaking down many barriers and lifting many misunderstandings. ‘It is reassuring to see that therapists do talk to each other’ a teacher commented. Although the project participants had not agreed on everything, a feeling of ‘we are in it together’ was created. Hopefully this will lead to a culture of improved communication and commitment in collaboration for the benefit of our local children

For a copy of the full report of the project please visit www.newhampt.nhs.uk/schoolhealthreview02 or email to ben.ko@newhampt.nhs.uk

NATIONAL SERVICE FRAMEWORK FOR CHILDREN:

External Working Group on Disabled Children: Work in Progress

As readers of the editorial will have seen, the NSF External Working Group on Disabled Children has recently published a report on ‘Work in Progress’. The report summarises key themes and invites comments from interested readers. The document can be accessed through the NSF website on:


Your views are warmly invited on some challenging issues (and opportunities) in the development of services for disabled children. A number of consultation events around this strand of the NSF are also being organised by the Council for Disabled Children on behalf of the Department of Health. Contact Philippa Russell for further information on: Prussell @ ncb.org.uk
Call for Reviewers!

Any one wishing to review either of these two publications please contact Caroline Llewelyn

- Disabled People and European Human Rights Law by Luke Clements and Janet Reed
- Disabled People in refugee and asylum seeking communities by Keri Roberts and Jennifer Harris

Regional Representatives meeting - 13th March 2003, Derby

On the afternoon prior to the March 14th CDDG meeting in Derby we would like to invite a representative from each ‘old region’ to attend a meeting with three AIMS:

1. To hear about the emerging findings of the NSF EWG on disability
2. To discuss the future structure and development of the CDDG
3. To share and discuss any important relevant local issues

We are looking for nominations from each old region. Ideally the representative would be elected by a local regional group, but if such structures do not exist a volunteer would be very welcome. The representative could come from any profession. Those interested in national CDDG involvement could also attend Please contact Caroline Llewelyn at RCPCH for further details

Letters to the Editor

Dear Editor,

Charles Essex has misunderstood the National Initiative on Autism: Screening and Assessment recommendations, when he reduces the NIASA message to ‘more must be better’, and criticises the recommendation for a multi-disciplinary, multi-agency approach to children with autistic spectrum disorder. (Autumn 2002 Issue, CDDG Newsletter)

Many professionals and parents could agree that for some children with an ASD the diagnosis itself is not difficult. However, that is not the issue. Firstly, for many children there is genuine diagnostic uncertainty. Experience and a broad multi-disciplinary view is needed. Secondly, co-morbidity is very common, and early identification may help. Thirdly, the assessment of a child’s needs does not begin or end with the diagnosis alone. It is helpful if the assessment which confirms ASD also highlights the child’s abilities and areas of difficulty. Multidisciplinary teams can give advice on management, addressing the child’s communication needs, behaviour, social well-being and learning abilities in an individual care plan.

Fourthly, we do not practice in a cocoon. Good practice needs to be shared, discussed and developed. On occasions, for some professionals up and down the land, the diagnosis may be evident as the child walks into clinic. However, that does not explain the child’s needs nor guarantee that they are met. Up and down the same land, there are varied standards of services, very uneven resourcing, long waiting lists and delayed diagnosis and service provision.

NIASA offers a model of assessment and a framework whereby each district ASD assessment service would deliver the core assessment. For the children where the diagnosis is clear, they still need an...
Forthcoming meetings

Jan 2003

22nd  Mental Health and People with Learning Disabilities
London, Pavilion in association with the Estia Centre

24th  Risk Management in Physical interventions
Edinburgh, BILD, (see below for contact details)

Feb 2003

5th - 7th  Introduction to TEACCH
Edinburgh, The National Autistic Society,
conference@nas.org.uk, 0115 911 3387

12th  Supporting people with Asperger syndrome
Nottingham, The National Autistic Society,
Conferences@nas.org.uk, 0115 911 3387

13th  Attentional Deficits in people with learning disabilities
The Royal Society of Medicine,
learning.disability@rsm.ac.uk, tel 020 7290 2989

Mar 2003

Developing PSHE: A safe environment for learning
National Children’s Bureau, training@ncb.org.uk, tel 020 7843 6441

11th - 17th  Brain Awareness Week
London, European Dana Alliance for the Brain,
edab@which.net, tel 020 7937 8771
Nottingham, Headway - The Brain Injury Association,
enquiries@headway.org.uk, tel 0115 947 1917

**14th**  Disruptive behaviours in Childhood: Origins, interventions and outcomes
Derby; CDDG Annual Conference;
cddg@rcpch.ac.uk; tel 020 7307 5625

Mar 2003

20th - 21st  Assessment & Management of Children with Severe Visual Disability
London, ICH; (see below for contact details)

26th  Living with Asperger Syndrome
London, The National Autistic Society,
Conferences@nas.org.uk, 0115 911 3387

Apr 2003

1st  Autism Spectrum Disorders: What we know and What to do: A Practitioner Masterclass
London, Mole Conferences -(see below for contact details)

7th - 10th  Royal College of Paediatrics and Child Health
7th Spring Meeting
York, tel: 020 7307 5633, aaron.barham@rcpch.ac.uk

May 2003

8th  Learning disability and mental health: the dual diagnosis
The Royal Society of Medicine,
learningdisability@rsm.ac.uk, tel 020 7290 2989

17th  Spinal Injuries Association Awareness Day
London, Spinal Injuries Association, sia@spinal.co.uk,
tel 020 8444 2121

19th - 23rd  Training courses on Griffiths Scales
North Wales, A.R.I.C.D, sarah.horrocks@virgin.net,
tel 01745 443215

20th  Meeting the Mental Health Needs of Children & Young People with Learning Disabilities who have Mental Health Problems
London, Mole Conferences -(see below for contact details)

The above information is provided from a variety of sources. We cannot provide further information regarding conferences. Please contact the organisers if you require further information.

In the next Issue:

Cross Cultural Issues in Child Disability

Please feel free to copy and distribute this newsletter within your team.

We welcome offers of articles, ideas, letters and meetings to publicise. Please send editorial copy in duplicate to Dr Tom Allport, Donald Winnicott Centre, Coate Street, London E2 9AG; allportt@gn.apc.org, and the CDDG Administrator, 50 Hallam St, London W1 6DE, e-mail cddg@rcpch.ac.uk.