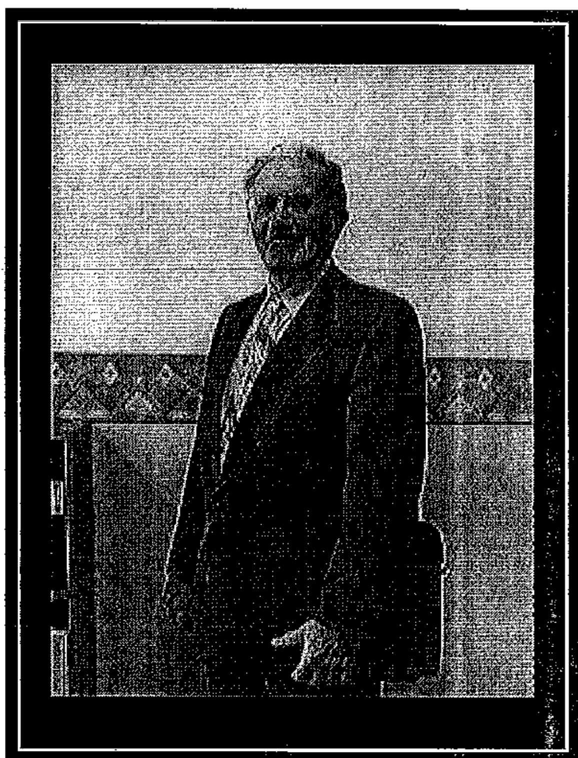
# A CHRONICLE OF THE ORIGIN OF THE CHILDREN'S REHABILITATION CENTRE - ALGOMA

## On Its Golden Anniversary... 1952 - 2002



*Dr. Alex Sinclair was instrumental in the creation of the "Rehabilitation Unit" which was the precursor to our present-day Centre. Dr. Sinclair was the unit's first medical director. He practiced as a well-respected surgeon in our community from 1950 to 1991. Dr. Sinclair retired in 1991.*

The celebration of a Golden Anniversary is a propitious time to pause in the day's occupation, to reflect upon all that has transpired in those fifty years. It was suggested, in regard to the Children's Rehabilitation Centre - Algoma, that it would be useful to review how it all began.

When our story begins in the early 1950's, in the aftermath of the rigours of World War II, the country was coming to grips with problems which had necessarily been deferred for the duration of that war. (A staggering statistic that surfaced was that there were some 10,500 educable children in this province who were physically handicapped. More than two hundred lived in this community.)

Who were they? They were the polio victims, the cerebral palsied, the muscular dystrophies, the congenital deformities (spina bifida, dislocated hips, club feet, etc), bone abnormalities (fragilitas osseum), the deaf and the blind.

Where did they come from? In regard to polio victims, many were saved by new methods of treatment particularly by Drinker's invention of the "iron lung". The mortality dropped, but the number who faced life partially crippled, increased. Cerebral palsy is recognized as the result of brain cell damage usually at birth, sometimes before, sometimes afterward, that gives a varying picture depending upon what cells are damage. Often there is a cogitation of symptoms.

In an unchallenged struggle for survival these children were early victims. The infectious diseases–diphtheria, scarlet fever, measles, and the rest whose epidemics left little white coffins in many a home, had a devastating effect on the subjects of cerebral palsy. As these epidemics were controlled for the general population the cerebral palsy children were spared too. And the advent of antibiotics starting in the late 1930's and rapidly developed during the war brought relief from respiratory diseases, kidney infection, etc.

However, this gratifying decline in infant mortality did make the challenge all the more urgent to serve the needs of the proportionate steadily growing number of handicapped children who then lived to attain school age. Our community was no exception to this trend.

To keep things in context, at that time there was no universal hospital insurance, no state-sponsored health insurance, no polio vaccine and no blanket drug benefit plan. But there were substantial other resources: Rotary–a dedicated service club, a keen local branch of the Ontario Medical Association, a visionary Board of Education, a helpful resource in the Ontario Society for Crippled Children, parental enthusiasm, community support (Cubs, Scouts, swimming at the Y.M.C.A.).

The Sault Ste. Marie Rotary Club (organized June 18, 1989) was particularly interested in the problems of crippled children. They underwrote the costs of out-of-town travel and hospitalization for the underprivileged. In Ontario, since 1922, coordination of the efforts of service clubs and the medical profession had been brought together by a group called The Ontario Society for Crippled Children (now known as the Easter Seal Society). They coordinated travelling clinics of groups of specialists to outlying areas such as the Sault–on the invitation of the doctors of the local branch of the Ontario Medical Association, who referred the patients for consultation. The Ontario Society also provided a resident nurse in each district to monitor the caseload.

This close liaison between the local doctors, the University Centres, the service clubs and the Ontario Society for Crippled Children facilitated crossconsultation and the designation of nominees by the local branch of the OMA to train at model Children's Rehab Centre such as that of Drs. Deaver and Rusk at Bellevue Hospital, New York, or attend the Boston university 3 month sabbatical tour of Rehab Centres in 9 countries of Western Europe. As a result, it was decided by the parties concerned that a Children's Rehabilitation Centre was required for this community. But what kind?

The passage of time had indicated that the primary care of the Blind and the Deaf had been well served by the highly specialized services available at their respective Residential Schools. This should be encouraged.

It was determined that there was a need for a special facility to provide physiotherapy, speech therapy, and schooling under circumstances where the handicapped could be taught a core curriculum with special consideration of their special needs. It was recommended to have this in a regular school so that the handicapped and those who were not could learn to live together. It was to embrace those of all religious persuasions. It was to have no means test because several instances were found where the students would have been deprived because their parents were not indigent. And it was to have an elastic admittance age. If it were restricted to the usual 5 years and over, many patterns would be set which could have been altered in early years. So they were taken in for physiotherapy and preschool training as soon as possible with the end in view of having them join their regular classes in their regular school as soon as possible. To accommodate these unusual and potentially sensitive modifications of the established procedure, it required the dedicated persuasion of a visionary Director of Education and an equally dedicated Board.

Thus, the Rehabilitation Unit in this community was a four room suite in the King George Public School. It consisted of a classroom, two physio rooms, one of which doubled as a dining room at lunch time, and a dormitory for a mid-day nap. There were four categories of staff:

<table>
<tr><td>occupation (a)</td><td>occupation (b)</td><td>funding source</td></tr>
<tr><td>Teacher</td><td>Speech Therapist</td><td>Board of Education</td></tr>
<tr><td>Physiotherapist</td><td>Occ Asst Physio</td><td rowspan="2">Rotary and Ontario Society for Crippled Children</td></tr>
<tr><td>Matron</td><td>Pre-school supervisor</td></tr>
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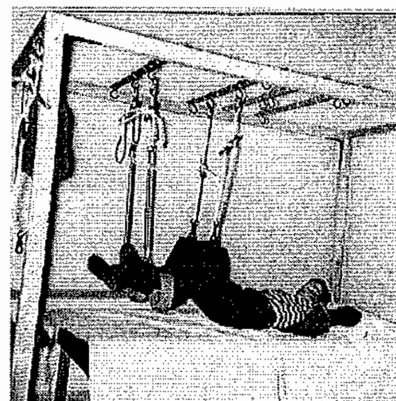
Medical Director and Associates were appointed pro bono by the local branch of Ontario Medical Association.

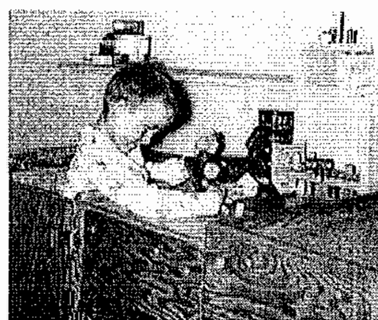
A wholesome, loving home, was thought to be the soundest starting point and staunchest ally of any realistic educational program. It was thought reasonable to assume that every handicapped child who could be retained in a community should stay there and attend a local school. The Rehabilitation Unit was intended for those who required concomitant medical treatment, physiotherapy, etc. or special teaching techniques. Of the 200 crippled children in the community, about 50 required the facilities of the centre, 13 were regular day pupils and the rest were outpatients.

CEREBRAL PALSY There was a premise that satisfactory voluntary movement required the elimination of extraneous movements. Thus relaxation was vital. Each child was first given a relaxation chair ▸

Relaxation was also taught on a mat routine and a suspensory Guthrie-Smith exercising frame. This last simulated hydrotherapy in that it permitted movement with minimal effort.



Hand movement was considered vital to develop. ▸



◂This is encouraged at the relaxation chair level and when the patient advances to the standing table.

The Standing Table is used to strengthen legs prior to the commencement of walking.▸

Walking first begins using the parallel bars. ▸

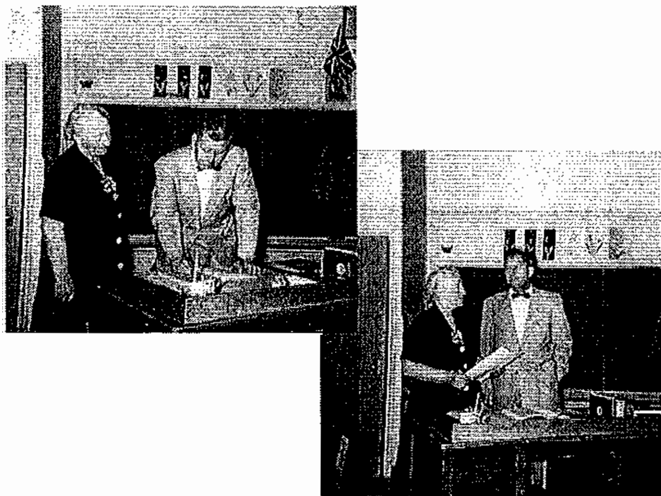
Other cases, such as spina bifida were treated. The stages of walking went through the phases of braces, standing table, walk with tripod canes

normal canes,

up steps,

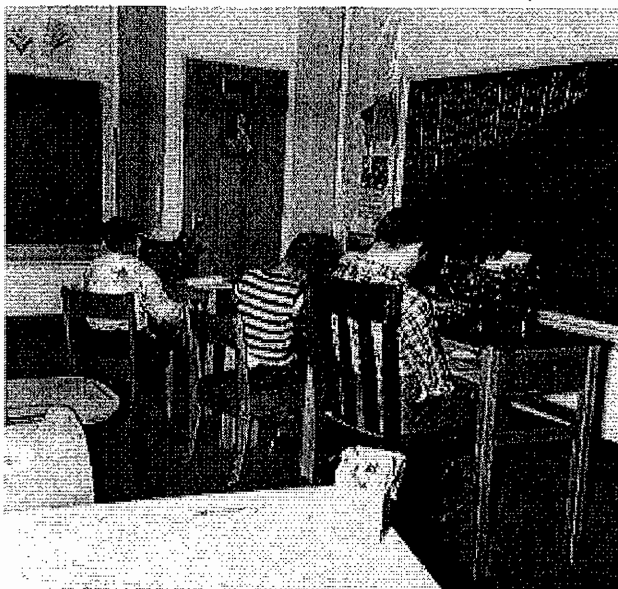
and finally, alone

The whole concept of rehabilitation was summed up by a little girl in Edinburgh who said– "Doctor, it isn't what you've got to what you haven't got, It's what you do with what you've got".



The classroom activities were under the direction of a teacher who brought the happy combination of the common sense of a country school teacher with one who had had special training in the field of handicapped children.

While teaching follows the usually syllabus, the teacher and her principal geared it toward the practical aspects of activities for daily living, manual training, sewing, etc. ▸



◂While the classroom looked almost like any other, it handled special problems like typing for those whose problems precluded writing.

Teaching too was directed to meet the problems of daily living– e.g. making change at the store. It included art courses and carpentry.▾

This unit was provided with a lunch room where the children ate at noon, and dormitory facilities were provided for their rest after lunch. The concentration time of these children was limited and they required adequate rest.

This unit was deliberately a part of a school for normal children. Thus the normal child learned to accept the handicapped one, and the handicapped child learned to live in a world of normal people.

At recess, and other get-togethers it was sometimes hard to know who was handicapped and who was not.▾

The prime reason for rehabilitation, helping children to help themselves, is to give handicapped children the opportunity to make the most of their abilities. This is a basic right of all children.▸