

Wales L; Waite C (2005) Children in Vegetative State and Minimally Conscious State: a Survey of Sensory and Cognitive Intervention. *British Journal of Occupational Therapy* 68: 486-494.

April 2009 - Sara Carlsson

This summary is written for occupational therapists that are working with children in vegetative state (VS) and/or minimally conscious state (MCS). This summary aims to inform the reader about the research article and the strengths and limitations of it. The aim of the article is to investigate the current working practices of occupational therapists and to identify whether current assessment and intervention tools meet the needs of this paediatric group.

Background

VS and MCS occur following brain damage. A Multi-Society Task Force has broken down the clinical features of both VS and MCS into three parts: arousal, awareness and communication.

For VS the clinical features are:

1. Arousal: Eye open spontaneously; a sleep-wake cycle is present. Arousal levels are usually low.
2. Awareness: There is no evidence of perception, communication ability or purposeful motor ability.
3. Communication: There is no evidence of a yes/no response, verbalisation or gesture.

The clinical features for MCS are:

1. Arousal. Eyes open spontaneously; a normal to abnormal sleep- wake cycle. Arousal level can range from normal to slow.
2. Awareness: There will be reproducible but inconsistent evidence of perception, communication ability or purposeful motor ability. There may be visual tracking.
3. Communication: Abilities may range from none, through unreliable, to inconsistent yes/no responses, verbalisation and gesture.

It is important that the diagnosis is correct because the level of care and the therapy intervention is influenced by the clinical diagnosis.

Methods

The researchers undertook a literature review to find out what is known and what has been done before in this area. The review related to the role of occupational therapy within these groups, the criteria for them and to see what tools were available for assessment and treatment. Most of the assessment tools they found and presented were made for adults, not for children.

The researchers used a survey design but the design was not clear. Their sampling strategy was based on the belief that many occupational therapists are members of specialist sections. They chose the specialist section for paediatric occupational therapists and those who work in the field of neurology. They designed a questionnaire that they piloted with ten occupational therapists; the article does not make clear if they work with these groups or not and if they changed anything after the piloting. It does not reveal if they did anything else to validate it. The questionnaire was in two parts, one for all occupational therapists and one part for

occupational therapists working with VS and MCS. The questionnaire was sent to 892 persons and the actual number of respondents was 271. Because of the sampling strategy, there was an overlap from occupational therapists member in both sections. They also got answers from occupational therapists not working within this area. They do not say what they did with the non respondents, if they got a reminder to answer or not.

The research questions in section A asked about the occupational therapists service, if they provided it for children with VS or MCS and if they currently had a child with VS or MCS in their caseload. Section B asked about assessment measures and the current treatment, that they used; if it was standardised or produce locally and how happy they were with the instruments. The last question was if they would consider using a new standardised procedure. There were no open questions in the questionnaire.

They used a data computer programme to analyse the data but they do not say what tests they used.

Results

Out of 271 respondents, 25 assessed and treated children in VS and MCS. The researchers found that most occupational therapists worked in a rehabilitation setting. Of the respondents, 5% offered a service for children in VS and 2% to MCS. Seven therapists had children on their caseload in VS and eleven had seen children in VS the last year. It was 15 therapists who had children on their caseload in MSC and 28 had seen children in MCS the last year. The number of therapists using a locally developed measure of assessment was 16 and twenty-one therapists used a locally developed treatment. Three therapists were happy and 18 were not happy with assessment procedures. Six therapists were happy were and ten were unhappy with the treatment. The rest was neither happy nor unhappy.

Conclusion

Because of the sampling strategy they may have missed occupational therapists working with children with VS or MCS. In the results, they present some therapists that work with VS and some that work with MCS but they do not reveal if the therapist works with both VS and MCS. As stated in the article, it is important to discover the clinical diagnosis because the level of care and the therapy intervention is influenced by this so the group that they propose in the conclusion should maybe be two, one that work with VS and one that work with MCS. Most of the occupational therapists were not happy and were interested in using a new assessment and intervention.