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The principles of Conductive Education (CE) have been implemented in the preschool and school services of the Spastics Association for more than two decades. More recently, it has been extended to the adult service for cerebral palsy and elderly service for stroke, Parkinson's disease and dementia. The major problem of patients with brain damage is the problem of learning.

Learning is process of active discovery that is geared to the biological equipment of a person. The cause of dysfunction of the brain damaged lies in the loss of underlying abilities making them unable to learn from interactions with the environment. The CE system for the adult and elderly clients is founded on three lines of development, namely: biological, social and cultural with the latter two built upon the first. It is believed that the parallel exploitation in the social and cultural paths under a supportive environment, in turn, contributes to the spontaneous development of the clients' biological capabilities.

The ultimate aim of habilitation for adults with cerebral palsy is upward mobility to an independent life, enabling them to integrate, as far as possible, into the community at each stage of the upward movement. On the other hand, the rehabilitative aim for the elderly with acquired disability is to improve their quality of life and allowing them to age with dignity. The traditioual medical approach puts a high priority on the enhancement of the clients' biological equipment, divided into different areas, each being tackled by different specialists. In addition to the fragmentation of clients, direct enhancement of biological capabilities in the medical approach may detach them from their social and cultural environments, By spending most of the time on receiving treatment by different specialists, the patients become more and more out of step with the society. Due to the absence of qualified conductors in our re-/habilitative system, the programmes built on the principles of CE are delivered by a transdisciplinary team that provides a holistic model of training in a structured environment so as to "lead out" the underlying abilities of the brain damaged for ensuring seif-directed learning. The Petö's Concept serves as a common philosophy that is shared by different disciplines of staff irrespective of their professional background. It provides a common perspective from which training goals are established. The training activities are no longer delivered with respect to the professional background of staff (e.g physiotherapy, occupational therapy, etc). Instead, they are incorporated into the clients' life. For adults with cerebral palsy, we emphasise the training activities for work, self-care and leisure domains while for the elderly, only the latter two domains are involves.

Consistency and continuity in the training activities throughout the whole of the clients' day is realised either by the rotation of professional staff between the day and residential centres or by

regular meetings with family members. The whole day management of clients constitutes the transverse subsystem of the CE system.

In the adult service for cerebral palsy, a longitudinal CE system has been established. It comprises vocational, residential and recreational routes. Each route is composed of centres with different levels of requirments on the level of independence of their client. The longitudinal subsystem provides 'ladders' for the adult clients to practice upward moblilty through any of the three routes.

Both the longitudinal and transverse subsystems are the hardware of the CE system. They are operated by a series of integrated curricula that link up the centres at different levels within the longitudinal subsystem and the day and residential centres within the transverse subsystem. Two major types of curricular activities have been distinguished: daily routine training (DRT) and group training (GT) programmes. They join with extracurricular activities constitute the activity programmes in the CE system.

Learning comprises three phases: acquisition, retention and transfer. The GT programmes aim at the acquisition of new skills and concepts through blocked practice while the DRT programmes aim at the retention and transfer of the learned skill and concepts through random practice. GT and DRT programmes are linked together by a daily schedule for ensuring that sufficient opportunities in the DRT have been given to the clients for practising the skill and concepts learnt in the GT. Extracurricular activities are programmes aiming for fun and enjoyment without specific training goals. The design of the extracurricular activities is based on an established 'theme' and community participation is encouraged.

Various teaching skill are used in the GT and DRT programmes in order to 'lead out' the underlying abilities of the clients. Both manual and cognitive facilitation techniques are employed. In most applications, manual techniques serve as an adjunct to cognitive techniques unless for clients with severe mental involvement. Basically, cognitive techniques are founded on the inter-relationship among movement, speed and intention. For patients with physical disability such as cerebral palsy, stroke and Parkinson's disease, speech is used to reinforce mental practice (intention) that is feedforward to the execution of an action (movement). For patients with mental disability such as mental retardation and dementia, movement, speech and sensory inputs are employed as cues for facilitating tbe retrieval of information from the long-term memory (intention). In both cases, rhythm is employed to facilitate motor and cognitive learning. The future development on the CE system in the adult and elderly services is directed at the development of objective outcome measure and the establishment of systematic programme planning procedures in accordance with the assessment results. In line with this trend, the association has developed a functional assessment based on the CE system and aiming at providing objective measure as well as programme planning. The assessment instrument is composed of standardized assessment procedures together with a standardised battery of assessment tools.

The scoring is founded on the client's level of independence in 13 personal self-care tasks and the quality of movement in accomplishing the tasks. The quality of movement is expressed in terms of basic motor patterns with the use of conductive furniture and aids. The assessment results also shed light on the programme planning in DRT and GT under the CE system. Validity and

reliability tests of the functional assessment are being conducted. Into the future, the standardization of the functional assessment are being conducted. Into the future, the standardization of the functional assessment will be undertaken with the establishment of norms for the different levels of centres within the longitudinal subsystem.

The outcome measure for the disabled elderly is founded on the measurement of their quality of life using the WHOQOL (1995). Baseline measurement has been established and the quality of life of the clients monitored once a month. The profile of the quality of life of the elderly persons on a year under the CE system serves as an indicator for evaluating its effectiveness for the elderly with disability.

Reference

WHO (1995).The World Health Organisation Quality of Life assessment (WHOQOL): Position paper from the World Health Organisation. Soc Sci Med, 41, 1403-1409.