

Winter 2004

Speech & Language Therapy *in Practice*

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Word finding
in children

**How I
advance total
communication**

Winning Ways
Introducing the keys

**Here's one I
made earlier...**
Personalised
place mats

My top resources
Dysphagia in adults
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And featuring
Grand designs - or just
changing rooms?

Signing the way?

BUILDING AWARENESS

Reader offer

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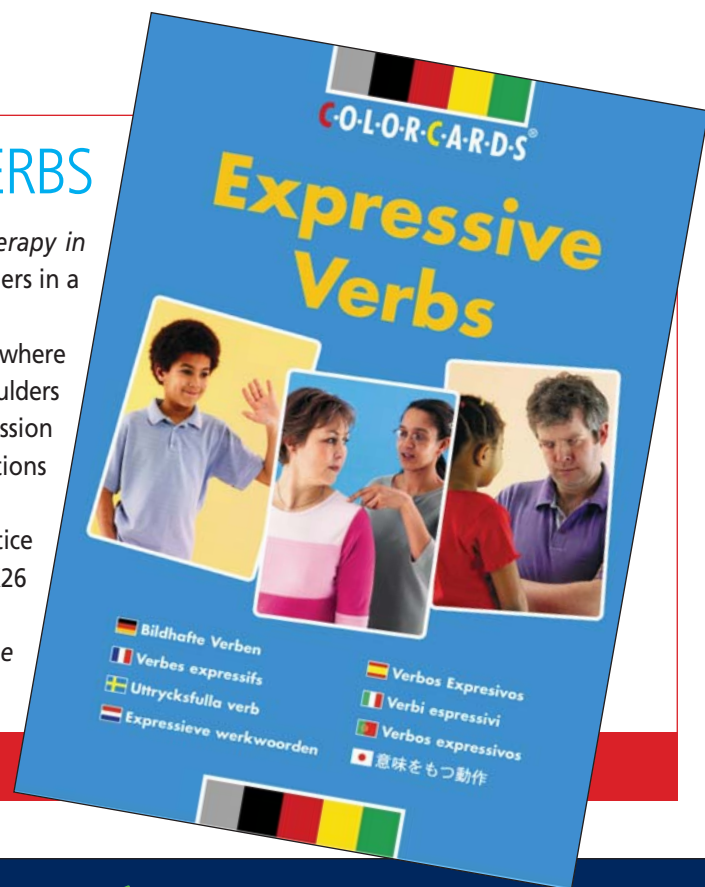
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Congratulations to Marie Swindells, the winner of our Autumn 04 reader offer for Keith's Interactive Storytelling book, courtesy of Speechmark Publishing Ltd.



Winter04speechmag

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Focus on... total communication.

In addition to the total communication theme running through Winter 2004, the editor has selected articles from earlier magazines to support you as you develop an inclusive communication strategy. If you don't have previous issues of the magazine, check out the abstracts on www.speechmag.com and take advantage of our article ordering service.

- (039) Murphy, J. (1998) *Talking Mats - speech and language research in practice*. Autumn: 11-14. (Reprinted in full at www.speechmag.com/archives/joanmurphy2.html.)
- (141) Tuson, W., Nicholson, C., Nieuwoudt, H., Charles, D. & Larkin, M. (2000) *My top resources*. Winter: back cover.
- (148) Matthews, A. (2001) *Big issues*, in *How I manage adults with mild-moderate learning disabilities*. Spring: 27-28.
- (153) Earle, S. (2001) *Sociology: a sure start*. Summer: 14-15.
- (202) Money, D. & Thurman, S. (2002) *Inclusive communication - coming soon near you?* Autumn: 4-6. **BONUS!** New at www.speechmag.com/reprintedarticles.html.
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- (231) McFarlane, H. (2003) *The heart of our service*. Summer: 4-7.
- (262) Scott, J. (2003) *Get out there and use it!* In *How I augment AAC*. Winter: 23-25. (Also unedited version of (263) Millar, S. (2003) *Communication - by the book* at www.speechmag.com/archives/sallymillar.html.)

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Cover picture by Paul Reid / Angus
Pictures. See p.4.
Jack (16 months) has been doing
baby signing since he was 10
months old. His mum is a teacher
for Tinytalk UK, which offers baby
signing and singing classes.
Further information at
www.tinytalk.co.uk.



INSIDE COVER

WINTER 04 SPEECHMAG, READER OFFER
Win ColorCards® Expressive Verbs

2 NEWS / COMMENT

4 COVER STORY SIGNING THE WAY?

"As a manager of a large paediatric service I have to be mindful of where we use precious staffing resource... I realise now that we have to see preventative work as a new client group. Our role extends beyond the pathological and we can have a real impact on the life chances of children who previously would have entered school with poor attention, vocabulary and comprehension."
Having developed her department's *Accelerating Babies' Communication Programme*, **Tania Allen** is clear that classes in baby signing should be part of our SureStart provision.

7 THE CLIENT VOICE

"... a person's voice is unique to them and is part of their self-identity and personality. In addition, a voice disorder that restricts a person from carrying out daily activities and participating in leisure and / or work pursuits will result in disability. Therefore, the emotional and functional disability associated with a voice disorder cannot be recorded using clinician-based tools."

Lynsey Bowie, Janice Dey & Rosemary Long use the Voice Handicap Index with a real caseload, and suggest its diagnostic and evaluation potential merits further investigation.

10 MIND MAP™ IT

"Mind mapping allows random thoughts to be well presented in a way that is easily communicated and familiar to me. It permits the trapping of thoughts - captured visually - and replaces the need for memory."
When IT specialist **Sheila Buchanan** developed symptoms including auditory memory difficulties, she discovered the power of computer based Mind Maps™ as an organisational tool and for emotional and practical support.

13 GRAND DESIGNS - OR JUST CHANGING ROOMS?

"[Connect] chief executive Sally Byng remembers very good advice from a disability access consultant architect about 'intellectual access' - how does the building work psychologically and navigationally, and how does it make you think and feel?"

A massive programme aims to replace old and crumbling clinics and hospitals with customised, multi-purpose spaces. **Avril Nicoll** asks how you can be ready for the opportunity to influence your working environment.

16 "HERE'S ONE I MADE EARLIER..."

Angela Crocker outlines a simple and effective way of summarising the information that can help adults with learning disabilities to positive, safe and successful mealtimes.

18 REVIEWS

Boxed cards, AAC, aphasia assessment.

19 KEYS TO WINNING WAYS SERIES (1) THE AWARENESS KEY

"Without awareness, change, growth and development are impossible. Without it, we cannot know our strengths and weaknesses. We cannot be sensitive to the needs of others and, as Anthony De Mello says in his wonderful book (2004), we stay asleep for most of our waking lives."
What is key to understanding yourself and others? Life coach **Jo Middlemiss** begins a series of short articles with a consideration of awareness.

20 SOUND SENSE

"Combining phonological and semantic tasks appeared to strengthen Ophelia's word-finding skills and provide her with some framework on which to hang further word learning. Her therapy gains also appear to have been generalised and maintained. Alice in comparison appeared to make no significant gains in this area."

Stephanie Delvin compares a semantic with a semantic + phonological approach to therapy for word-finding in children with a language disorder.

23 FURTHER READING

Acquired disorders, social language, ethics, lifespan changes, therapy satisfaction.

24 HOW I ADVANCE TOTAL COMMUNICATION

"Total communication promotes effective and inclusive communication for all individuals, whatever their abilities or disabilities... It is a simple idea - but one that is complex to implement."
Lesley Brown, Miranda Muir, Kate Grant, Linda Clark & Jenny Fletcher conduct a baseline audit of the implementation of a total communication strategy and standards and formulate an action plan. Then **Kim Hartley, Rosemary Gray & Anne Edmonstone** report on the progress of a long-term inclusive communication strategy for public services in Lothian.

BACK PAGE MY TOP RESOURCES

"...support and supervision when working in dysphagia is crucial. To maintain and develop my clinical practice, I find it useful to get second opinions, to obtain peer support when managing risk, and to debrief from emotionally difficult cases."

Hannah Crawford offers ten tips for adult learning disability dysphagia.

IN FUTURE
ISSUES...
VOICE
SENSORY
INTEGRATION
GOAL SETTING
LARYNGECTOMY
STORYBOARDS
EARLY YEARS
DYSPHAGIA



Students celebrate Beacon Award

Treloar College has become the first specialist college for young people with disabilities ever to receive a Learning and Skills Beacon Status Award from the Department for Education and Skills.

The Hampshire college takes students from all over the UK, and some from overseas. Most use wheelchairs and some also have communication or sensory impairment or associated learning difficulties. The award recognises best learning providers and encourages them to share good practice and undertake innovative activities that will benefit the whole post-16 sector.



And on that farm...

'Mum of the year' Melinda Messenger has been working with I CAN to promote its 2005 farm-themed Chatterbox Challenge.

The sponsored event, supported by Tesco Baby & Toddler Club and LeapFrog Toys (UK) Ltd, kicks off on 31st January. It aims to raise funds for the charity and, at the same time, raise awareness of the importance of speech and language development in a fun way.

For a ChatterPack, tel. 0870 4585475 or see www.chatterboxchallenge.org.uk.



www.toby-churchill.com

Toby Churchill communicates via his Lightwriter with a guest at the opening of his company's new factory in Over, Cambridge. The new building will bring together production, service and research and development, and provide a base for the company's launch into environmental control with adVOCate+. Toby Churchill Ltd was founded by Toby in 1973 after he became disabled and lost his speech as a result of encephalitis. Dissatisfied with the communication aids available at the time, he designed the first Lightwriter and began manufacturing them.



Helpline secured to 2008

The Chancellor of the Exchequer, Gordon Brown, has announced that the charity Contact a Family will receive additional funding from the Department of Education and Skills to extend its national freephone helpline and information services until 2008.

The UK charity offers advice, information and support to parents of disabled children. It will use the funding to promote the service more widely through GP surgeries, local community groups and children's hospitals.

The Chancellor is pictured with eleven year old Storme Toolis, who has cerebral palsy, at an 11 Downing Street reception held to mark 25 years of Contact a Family. Contact a Family freephone helpline, 0808 808 3555.

Something to say

A new advertising campaign, funded by a 'SAPPI: Ideas that Matter' award, aims to raise public awareness of stammering in Scotland by celebrating the life and work of famous people who stammered.

Well-known faces in the campaign include Sir Winston Churchill, Marilyn Monroe and Sir Isaac Newton. Along with a famous quote, the campaign message is, 'Please be patient, we all have something important to say.'

Jan Anderson, Scottish Development Manager of the British Stammering Association, was joined at the launch by L-R: John McAllion, BSA Patron, Oxfam Campaign Manager and former MSP; journalist and author Jack Webster; and the newly appointed Convenor for the British Stammering Association (Scotland) Frank Geoghegan-Quinn, all of whom have personal experience of stammering.

The British Stammering Association (Scotland) plans to train volunteers for a Helpline, offer monthly telephone support groups, hold two 'open day' events a year and research and develop a project to trial the use of telehealth in the treatment of stammering in Scotland.

www.stammering.org



Services for older people need to 'do better'

A Joseph Rowntree Foundation report is challenging service planners and providers working with older people to do better in future.

Based on a four-year research programme overseen by a steering group of older people, the report knocks stereotypes and the way they inform policy and practice assumptions. The research suggests that older people can often make the biggest difference to each other's quality of life, provided they receive better support than is currently available. It calls on planners to recognise that communities, community organisations and family and friends are the major players in supporting older people, and that older people should have the strongest voice in deciding what makes a good quality service and whether it is being delivered. The report also says that services need to be more holistic, responsive and adaptable to changing needs.

Stan Davison from Barnet Older People's Forum says, "In age, being healthy is about being able to enjoy yourself, keep mentally active, do things which interest you and meet friends. The real supports and services that are valued are those that help negotiate ordinary things in life: relationships, learning, transport, housing, contact and feeling comfortable and secure."

Older people sharing policy and practice, see www.jrf.org.uk, or £16.95 inc. p&p, tel. 01904 430033.

Views on professionalism wanted

What do you consider are the attributes of medical professionalism in the 21st century, and how can this be preserved, strengthened and promoted?

The Royal College of Physicians has set up a major working party, chaired by Baroness Julia Cumberlege, to look at the role of the professional in society, how professional people are educated and trained, and how they practise. Although it will concentrate on medical professionalism, it will include representatives from other professions. The college would like to receive written evidence from a wide range of organisations and individuals.

To submit evidence, contact Dr Susan Shepherd on tel. 020 7935 1174 ext. 517, e-mail MedicalP@rcplondon.ac.uk.

Signs of mouth cancer

Early detection is vital in combating the UK's fastest growing cancer, says an oral health charity. Around 4300 new cases of mouth cancer are diagnosed every year. While the main risk factors are smoking, drinking alcohol to excess and poor diet, the British Dental Health Foundation's 2004 mouth cancer awareness week also sought to draw attention to the importance of early detection for increasing the chances of survival from 50 to nearer 90 per cent.

The first sign of mouth cancer is often a mouth ulcer that doesn't heal within three weeks or a red or white patch in the mouth. Anyone affected should visit their doctor or dentist to get it examined.

Parkinson's awards

The Parkinson's Disease Society is asking clinicians to encourage clients with a talent for art, photography or poetry to enter the 2005 Mervyn Peake Awards.

Held in memory of the eponymous artist, illustrator, poet and author, the competition is directly supported by his family, and encourages people with Parkinson's to express themselves creatively.

Award information posters and leaflets, tel. 020 7932 1347 or

e-mail mervynpeake@parkinsons.org.uk.
www.parkinsons.org.uk

Please note

The e-mail contact address for Keith Park in Autumn 2004's A Midsummer Night's Conversation should have been info@storytracks.com. If you have had any difficulty getting in touch with Keith on the e-mail address given, please use this one instead.



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comment

Building awareness

Reality television shows about new buildings and renovations seem to have taken over our screens. Viewed from a distance, we either tut-tut at chaotic planning and organisation, poor communication and shoddy workmanship - or admire the vision, guts, determination and teamwork that have produced a building with soul.

What a shame that all the programmes focus on domestic properties, and how much we would learn from one devoted to a public or voluntary sector project! Our buildings feature (p.13) introduces you to the rewards, frustrations and problems experienced by therapists around the country, and suggests we may benefit from greater involvement of service users in the planning process.

We want so much from our buildings - accessibility, functionality, capacity, beauty, economy, longevity. We shouldn't be surprised that it takes a significant investment of time in research, planning, coordination and negotiation that is no different from the approach needed for any project we undertake. Our *How I...* (p.24) contributors have recognised this in their endeavours to spread the word - and signs and symbols - about total communication.

Sometimes simplicity is the key to success. The beauty of *Angela Crocker's* personalised place mats (p.16), for example, arises from the detailed specification presented in an economical and practical way. Sometimes what we do doesn't quite work on its own, and we need to add something else, as *Stephanie Delvin* (p.20) found with her word finding therapy.

Sometimes experience confirms our view of what is important, as when *Lynsey Bowie & colleagues* (p.7) evaluated the impact of voice therapy from the client's perspective. At other times experience changes our opinion of what is important. As a service manager with an eye on the purse strings, *Tania Allen* (p.4) has certainly moved in her views on work with whole populations, including the introduction of baby signing to SureStart projects.

When we don't have a clear idea of what we want, we need someone - or something - to help us make sense of our thoughts. *Sheila Buchanan* (p.10) uses computer-based Mind Maps™ for a whole range of purposes, including planning and remembering, to compensate for auditory memory problems, and *Hannah Crawford* (back page) finds peer support and supervision invaluable.

Life coach *Jo Middlemiss* (p.19) originally intended to do a series of four articles but is enjoying her contact with you so much that she has agreed to continue! Her new series of shorter articles considers the keys that will unlock understanding of ourselves and others. While our Winter 04 articles report on projects ranging from a conceptual challenge worthy of Grand Designs to the economy and attention to detail beloved of the House Doctor, they all, like Jo Middlemiss, focus on building awareness.

Avril Nicoll.



READ THIS

IF YOU ARE INTERESTED IN

- A WIDER INTERPRETATION OF OUR ROLE
- THE LINK BETWEEN POSITIVE INTERACTION AND BEHAVIOUR
- BUILDING ON AWARENESS STIMULATED BY THE MEDIA



Tania shows Theodore 'more'

At 22 months, Theodore's face lights up when he sees a car pull into the drive. Running to his mum he says, 'danda', bangs his fist up and down, points his finger and rotates it and moves his hand back and forward. 'Yes, it's Grandad,' says his mum, 'you're going to help him fix the fence with your hammer, screwdriver and saw.'

The previous year Theodore's mother had attended an *Accelerating Babies' Communication* programme designed to introduce baby signing and positive interaction techniques to parents of normally developing babies. Theodore now presents as a content, communicative child who uses around forty signs to supplement his developing expressive language.

As a speech and language therapist with a particular interest in using positive interaction techniques to develop delayed language, I was fascinated when one of the parents attending a parent programme I was running handed me 'Joseph Garcia's *SIGNwith your BABY™ Complete Kit*' that she had been sent by her brother in America. The pack advocated the introduction of American Sign Language to normally developing, hearing babies as young as 8 months. The idea of introducing signing to babies in the absence of any difficulties or risk of delay was new to me. We have all seen how the introduction of signs has a positive impact on our language delayed population, but what would be the point of signing with pre-verbal infants who were likely to begin to speak within the next 12 to 18 months anyway?

On watching the video the evidence to support such a move was compelling and I was hooked. Onto the screen came baby after baby signing 'more', 'milk', 'hurt' and much more. Here were babies showing that they had thoughts and needs that would previously have gone unexpressed, as their spoken language was simply not yet developed enough. Children able to express themselves at a much earlier age than would be possible with their spoken language meant that parents reported reduced levels of frustration. In addition an intimate bond could be seen between parent and infant as the signs were taught and understood.

Intrigued

Intrigued, I set about finding out more and discovered the original research into the use of baby signing took place in America in the late 1980s. Almost simultaneously research was taking place in two camps, Joseph Garcia in one and Linda Acredolo and Susan Goodwyn in the other.

Classes in signing for babies seem to be springing up everywhere. So are they just a fad for pushy parents, or do they sign the way to enhanced parent-child relationships? Should they be part of SureStart provision?

Having developed her department's *Accelerating Babies' Communication Programme*, Tania Allen is clear about the route we should take.

Having worked as an interpreter, Joseph Garcia had a wide network of friends in the deaf community and he had noted how the hearing offspring of signing deaf parents began to use signing long before their spoken language developed. In 1987, Garcia began to research the use of American Sign Language with hearing babies of hearing parents at Alaska Pacific University. His thesis research showed that babies who are exposed to signs regularly and consistently at six to seven months of age can begin expressive communication by their eighth or ninth month.

Drs. Linda Acredolo and Susan Goodwyn conducted a longitudinal study funded by the National Institutes of Child Health and Human Development. The study showed that signing babies understood more words, had larger vocabularies, and engaged in more sophisticated play than non-signing babies. Parents of the signing babies in the study noted decreased frustration, increased communication, and enriched parent-infant bonding. Signing babies also displayed an increased interest in books (Moore et al, 2001).

They revisited the families in the original study when the children were seven and eight years old. The children who signed as babies had a mean IQ of 114 compared to the non-signing control group's mean IQ of 102 (Acredolo & Goodwyn, 2000).

Garcia, Acredolo and Goodwyn then set about pioneering the use of signing with babies. Joseph Garcia developed the **SIGNwith your BABY™** program and Linda Acredolo and Susan Goodwyn produced a book called *Baby Signs*.

The overall message in both is similar, although there is one main difference: Joseph Garcia promotes the use of a standard sign language such as American Sign Language or British Sign Language, whereas Acredolo and Goodwyn advocate parents and infants making up their own signs.

Baby signing classes for hearing babies were then introduced in the United States and, due to the success of the programs in America, baby signing is becoming increasingly popular in the United Kingdom, with advocates for signing appearing on daytime television, news shows and in the press.

Following further research into the field, I contacted Joseph Garcia's team and registered as a **SIGNwith your BABY™** presenter. I initially began running baby signing courses as an independent venture. It seemed to make perfect sense. Teaching signs such as waving 'bye bye' and hand rhymes such as 'Insi Winsey Spider' is readily acceptable, so why not build up the ability to use hand gestures that appear at a developmentally earlier age than speech?

However, as a consequence of the recent press and television coverage, local interest in baby signing was developing. SureStart workers, parents and health visitors were asking if our speech and language therapy service ran baby signing courses. The time seemed ripe to develop a preventative programme that capitalised on parents' interest in something new but also 'snuck in' the positive

adult-child interaction techniques to a captive audience that would otherwise have been hard to reach. Subsequently I developed the **Accelerating Babies' Communication** programme to address the demand.

Positive interaction strategies

The programme runs weekly over four 1 hour sessions and involves showing parents of pre-verbal infants how to introduce British Sign Language, based on Joseph Garcia's **SIGNwith your BABY™** approach, and demonstrating positive interaction strategies from the **TIME to TALK** preverbal communication programme, a parent course that colleagues and I had run successfully for many years with parents of children with delayed / disordered language development (see sample session plan in figure 1).

Figure 1 - Example of presenter's agenda

Accelerating Babies' Communication programme

Session 1

1) Introductions

Presenter's Background etc

Show video clip of babies using signing.

Introduction to the **ABC** programme including the history of baby signing

15 minutes

2) Signing Babies

Handout Benefits of signing

Show video clip of babies using signs 'more, milk, eat'

Teach participants the above signs.

10 minutes

3) Communication Development

Handout My Child's Communication checklist

Steps to Speaking exercise

Handout Developmental Milestones for Language

Handout Is It Time To Talk?

20 minutes

4) Seven Signs

Introduce 4 more signs 'help, mummy, daddy, all gone'

Handout Signs Learnt Today

10 minutes

5) Signing Rhymes

Teach 'Dance To Your Daddy'

5 minutes

The infants participating in the programme can be as young as 6 months as parents learn the techniques and then introduce the signs at around 8 months.

The course objectives are that carers will:

- develop a special bond with their infants through excellent communication
- be appraised of the delights and benefits of signing with babies
- have an initial signing vocabulary of over 30 signs
- understand when and how to introduce new signs

- be aware of how communication develops and the influences on this
- be aware of positive interaction strategies that promote spoken language development.

Care was taken in the development of the programme to address different learning styles and present activities in a fun, interactive way. The course is also designed to be jargon-free with a commonsensical approach, so that it could be run by professionals other than speech and language therapists, such as nursery teachers or health visitors. We also envisage that a parent who has attended the course and is using baby signing could take on the role of presenter, under appropriate guidance.

Following on from the **ABC** programme, parents are able to continue to meet and practise their signing through the songs and rhymes taught on the course.

Despite the glowing recommendations from the researchers, there remain some sceptics who feel baby signing is just hothousing for babies of professional, middle class parents and that the impressive long-term results merely reflect the child's background rather than the direct results of the introducing sign language (although Acredolo's research would say not).

The benefits of signing that I have observed whilst running three **Accelerating Babies' Communication** programmes are:

1. **Signing allows an infant to communicate accurately their thoughts, needs and feelings before they can speak.**

Twelve month-old Baby Signer Emily came downstairs and signed 'bee' and then 'sleep' to tell her mum that there was a bee in the bedroom. Without signs she would have only been able to tug and point until her mum guessed what she was trying to say.

2. **Signing reduces frustration for babies. The second year of life can be one of great frustration for infants and their carers. One of the major causes of tantrums is the toddler's inability to communicate.**

When asked what he wanted to drink Josh was able to sign 'juice' as opposed to 'milk' rather than having a tantrum at being handed the wrong one

3. **Signing gives a window into the infant's mind and personality, as they can communicate outside of the here and now.**

At 15 months Jade was able to sign 'cow, tractor and fish' to 'tell Daddy what we saw today'. Theodore started signing 'dog' when he overheard his mum referring to 'Nancy' his Grandma's dog. His parents had no idea that he knew the dog's name. Baby signers have the means to refer to their feelings, things that are going to happen and things that have already happened at a much earlier age.

4. **Signing enhances parent-child bonding, facilitating a close relationship between parent and child.**

Better communication facilitates parent-child bonding, fewer tantrums facilitate parent-child bonding - plus the signing babies look very cute. Nine month-old Joseph can sign for 'milk' when he needs a nap rather than whinging and crying ▶

◀ because he's tired. When Adam had an ear infection he frequently signed for 'more water'. His mum was surprised at how much water he wanted saying that in the past he would have just cried and they would have assumed that he was in pain or tired rather than thinking he needed another drink.

5. Signing promotes excellent interaction.

Why? Because, when using signing, parents automatically adopt positive interaction strategies such as following the child's focus of interest, making eye contact, speaking slowly, and using simple key words (Goodwyn et al, 2000).

6. Signing facilitates an adult's ability to interpret early attempts at words and to assign meaning to them.

Thomas says 'ba' and signs bath, and says 'ba' and signs ball. Because he is using signs as well, his dad knows exactly what he wants.

7. Signing children tend to be more interested in books.

Using signing alongside looking at books allows an infant to become an active participant in the story telling and their interest in books soars. Parents don't feel that they have to read the whole story and instead are able to pick out key words to sign and say.

Totally inclusive

With the advent of SureStart nurseries and children's centres this seems to be a golden time for speech and language therapists to promote excellent adult-child interaction from the outset within education and daycare settings. Teaching signing to all the children in the nursery allows children to communicate with each other at a much earlier age than would normally be possible. It also allows for a totally inclusive communication environment for children for whom English is not their first language and for children with learning and communication difficulties.

Marilyn Daniels, a professor of speech communication at Penn State University, has found that hearing students in pre-kindergarten classes who receive instruction in both English and American Sign Language score significantly higher on the Peabody Picture Vocabulary Test (Dunn & Dunn, 1997) than hearing students in classes with no sign instruction. Her studies demonstrate that adding visual and kinaesthetic elements to verbal communication helps enhance a preschool child's vocabulary, spelling and reading skills (Daniels, 1994; 1996; 2001).

Parents attending the courses that I have run have taken on the use of baby signing to different degrees. Some parents and families are now avid signers whilst others just use the first few signs taught on the course. All participants have stated that they feel there have been positive changes in the way that they interact with their child as a result of attending the ABC programme. Mostly this relates to slowing down the pace of interaction and to understanding the level of communication that their baby is at.

A new client group

As a manager of a large paediatric service I have to be mindful of where we use precious staffing resource. I had seen the effect that the onset of hundreds of SureStart programmes across the country had on recruitment and I needed a fair bit of convincing that this was a worthwhile use of speech and language therapy time. It was really about a change in mind set, what was meant by 'core business'? Surely this was where we should be directing resource not, as was the case in practice, taking it away? I realise now that we have to see preventative work as a new client group. Our role extends beyond the pathological and we can have a real impact on the life chances of children who previously would have entered school with poor attention, vocabulary and comprehension. I'm constantly amazed at the demand for baby signing in our SureStarts. In Canterbury we had been running a drop-in Language and Play group for pre-verbal toddlers and attendance was extremely poor - more a case of drag-in than drop-in.

However as soon as we advertised the baby signing course we had 25 mums keen to come. We now use the Language and Play group as a follow-on group to keep parents' interest in communication high. Of course it doesn't have to be us doing all the work - but I've learnt we shouldn't underestimate the extent of our knowledge and presume too much of our colleagues. We can support others in this work and my next goal is to have a couple of the mums who have used baby signing take over the running of the ABC course.

On a personal level, the most exciting part of my involvement in baby signing is to see the positive effect it has had on my nephew. My own children at 13, 11, 9 and 6 years were too old to be my baby signing 'guinea pigs' but luckily Theodore, my one year old nephew, was just the right age and was happy to participate. It's a constant source of pleasure for all the family to see Theodore signing, using a mixture of British Sign Language and a variety of highly ingenious signs of his own. At two years old his expressive language is now rapidly developing but he continues to use his signs alongside, perhaps realising that this will help others to understand what he is saying. I presume

We had been running a drop-in Language and Play group for pre-verbal toddlers and attendance was extremely poor - more a case of drag-in than drop-in. However as soon as we advertised the baby signing course we had 25 mums keen to come.

that one day he will stop using the signs but feel we will all be rather sorry to see them go!

Tania Allen is head of paediatric speech and language therapy with East Kent Coastal Teaching Primary care Trust, Royal Sea Bathing Hospital, Canterbury Road, Westbrook, Thanet CT55BQ, tel. 01843 822085, e-mail Tania@signingforbabies.com. See www.signingforbabies.com for more information on courses.

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Resources

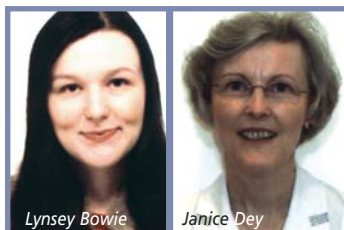
- **Accelerating Babies' Communication** (2004) by Tania Allen, £49.95 inc. p&p, from QEd Publications, Trent Park, Eastern Avenue, Lichfield WS13 6RR, tel. 0870 3806615, www.qed.uk.com.
- **Baby Signs** (2002) by Linda P. Acredolo & Susan Goodwyn, Higher Education, ISBN 0071387765.
- **SIGNwith your BABY™** Complete Learning Kit (UK edition, 1999) (book, training video, quick reference guide and BSL booklet combination) by Joseph Garcia, Northlight Communication, ISBN 0966836731.
- **The Peabody Picture Vocabulary Scale** (3rd ed, 1997) by Dunn & Dunn, Circle Pines, Minnesota: American Guidance Service.

REFLECTIONS

- DO I FULLY EXPLAIN THE BENEFITS OF SIGNING TO CLIENTS AND CARERS?
- DO I CONSIDER THE PROMOTION OF POSITIVE INTERACTION TECHNIQUES PART OF MY ROLE, EVEN WHEN THERE IS NO PATHOLOGY?
- DO I PICK AND CHOOSE THE EVIDENCE BASE FOR MY PRACTICE - OR AM I OPEN TO A VARIETY OF SOURCES?

The client voice

Ultimately, the best person to measure the impact of therapy is the client. *Lynsey Bowie, Janice Dey and Rosemary Long* use the Voice Handicap Index with a real caseload, and suggest its diagnostic and evaluation potential merits further investigation.



Lynsey Bowie

Janice Dey

READ THIS

IF YOU WANT TO

- ACCESS CASELOAD-BASED RESEARCH
- INCLUDE THE CLIENT'S VIEW WHEN EVALUATING THERAPY
- WIDEN THE APPLICATION OF OUTCOME MEASURES

Speech and language therapists use a number of perceptual and objective voice measurements both pre- and post-voice therapy treatment. This is in order to describe the vocal characteristics and severity of a voice disorder, and to establish whether the voice has improved with therapy. They can also be used to facilitate client education and set goals for therapy. The tools used range from acoustic and aerodynamic measurements to perceptual rating scales and audio recordings. Such measurements are essential to determine the effectiveness of the voice therapy intervention.

However, the literature has recently identified the importance of recording treatment effectiveness from the client's perspective:

"Neither acoustic objective measurements nor laryngeal examinations can assess the level of handicap or the quality of life impact a person has or that he or she perceives as a result of a voice disorder or as a result of treatment for the disorder" (Hogikyan et al, 2002, p.563).

It is important to remember that a person's voice is unique to them and is part of their self-identity and personality. In addition, a voice disorder that restricts a person from carrying out daily activities and participating in leisure and / or work pursuits will result in disability. Therefore, the emotional and functional disability associated with a voice disorder cannot be recorded using clinician-based tools.

Clients' perceptions

Our study investigated clients' perceptions of their functional, emotional and physical voice handicap pre- and post-voice therapy using the voice handicap index. We hypothesised that there would be a reduction in voice handicap scores post-voice therapy which would reflect an improvement in voice quality.

The Voice Handicap Index was developed by Jacobson et al in 1997 to address the psychosocial consequences and impact of voice disorders on daily functioning and quality of life. It is a psychometrically validated tool, which is used in the

clinical practice of speech and language therapy. The questionnaire consists of 30 statements reflecting experiences encountered by those with voice problems. Clients are asked to rate each experience on a 5-point scale from never to always. The statements are subdivided into functional, physical and emotional. The functional (F) sub-scale relates to the impact of the impaired voice on daily activities. The physical (P) sub-scale includes statements related to a person's perception of discomfort or unease in the throat and to voice characteristics. The emotional (E) sub-scale conveys information about how a person feels about their voice. A scale of 0-4 gives a possible total score for each sub-scale of 40. Higher scores in each sub-scale indicate higher levels of voice handicap. An 18-point change in pre-treatment to post-treatment total scores or an 8-point change in scores for each sub-scale is considered statistically significant.

The voice handicap index was developed and validated using people with a broad range of voice disorders and was therefore designed to assess all types of voice problems (Jacobson et al, 1997). To date, this self-completed questionnaire has been

used in several studies investigating the outcome of voice therapy (Jacobson et al, 1998; Rosen et al, 2000; Roy et al, 2001), adding to the reliability of this instrument's use in clinical practice. The voice handicap index is easy for clients to complete in a relatively short space of time, and the scoring system is straightforward to apply.

The clients were asked to complete the voice handicap index at their initial voice therapy assessment. Three speech and language therapists were involved in

carrying out the voice therapy. The second measurement of voice handicap was taken after each client had completed their individually tailored programme of therapy.

The first 30 clients with a medical diagnosis of dysphonia referred to the speech and language ►

We hypothesised that there would be a reduction in voice handicap scores post-voice therapy which would reflect an improvement in voice quality.

therapy department by an ENT consultant on or after 1st June 2000 and admitted for a programme of voice therapy were included in the study. We excluded all people with vocal impairments related to malignant disease, those who failed to complete their programme of voice therapy and those whose total score on the initial voice handicap index was less than 18 (as a minimum potential for change of 18 is required to assess for statistical significance). In total 2 people were excluded and 28 people (1 male and 27 female) were included in the study. Their mean age was 54 years, the youngest being 20 years and the oldest 79 years. While 12 were in employment, 13 were retired, 1 was a student and 2 were unemployed. The aetiologies of their voice disorders were:

- 4 vocal cord nodules
- 3 oedematous or red vocal cords
- 3 psychogenic
- 1 vocal cord palsy
- 2 bowed vocal cords
- 2 dysphonia plica ventricularis
- 8 related to vocal abuse / misuse
- 1 spasmodic dysphonia
- 4 related to psychological stress.

Of the clients included, 7 were smokers, 10 ex-smokers, 5 non-smokers and 6 were unknown. The mean number of voice therapy sessions was 6.5.

The voice handicap index scores pre- and post-voice therapy can be observed in tables 1 and 2 respectively. The tables display the mean sub-scale and total voice handicap index scores. As the tables indicate, the emotional, functional and physical sub-scale mean scores and the mean total voice handicap index scores all decrease post-voice therapy. Tables 1 and 2 also highlight voice handicap index maximum, minimum and mean scores with standard deviations for pre- and post-voice therapy treatment. These tables highlight the wide range in sub-scale scores before and after therapy, and the diversity of each client's scores from the mean. Note that, in both the pre- and post-voice therapy period, the physical mean sub-scale score is the highest at 21.6 and 11.5 respectively. Individual sub-scale and total voice handicap index scores are in table 3. An 18-point change in pre-treatment to post-treatment total scores is considered to be statistically significant (Jacobson et al, 1998). In table 3, pre-therapy scores are highlighted in black and post-therapy in blue. Twenty of the twenty-eight clients had statistically significant lower voice handicap index scores (highlighted in red in table 3) in the post-treatment period. The mean total voice handicap index score change from the pre- to post-treatment period was also statistically significant.

Statistically significant

Seventy-one percent of clients had statistically significant lower voice handicap index scores post-voice therapy treatment (see case example in figure 1). This demonstrates that they were aware of positive changes in their voices following therapy in relation

Figure 1 Case example

Client

Jean is a 33 year old single call centre worker.

Voice case history

- Onset of dysphonia associated with tonsillitis
- 1 year history of "losing voice"
- Increased use of voice socially and at work
- Smokes a few cigarettes in evenings
- Increased smoking at weekends
- Socialises in pubs and clubs
- Drinks spirits socially
- Used to sing in band; sings at home

ENT opinion

- Reddened vocal cords
- Small bilateral vocal cord nodules

Medical history

- Asthma (uses inhalers)
- Heartburn (on medication)

Voice assessment

- Mild dysphonia
- Breathily, hoarse voice quality
- Increased volume
- Hard glottal attack
- Reduced breath support
- Laryngeal constriction

Intervention

- Education regarding laryngeal structure and function, vocal nodule formation and causal factors
- Identification of misuse/abuse factors
- Programme of voice care/conservation
- Strategies to promote adequate breath support, appropriate glottal attack and volume

Discharge

- Jean reports that voice is mainly improved and it is no longer sore to talk
- Continues to smoke
- Agrees discharge

Voice Handicap Index scores

	PRE-THERAPY	POST-THERAPY
Total Score	31	9
Functional Subscale	8	2
Physical Subscale	21	7
Emotional Subscale	2	0

to the impact of vocal impairment on daily activities, the perception of throat discomfort and voice characteristics and how they felt about their voice. Although the use of the voice handicap index for client education and goal-setting was not part of the study, its focus on psychosocial consequences and impact of voice disorders on daily functioning and quality of life makes it a useful adjunct to objective measurements and perceptual rating scales.

Our study was completed in 2000 but we have continued to use the voice handicap index as an outcome measure to record the effectiveness of voice therapy from the client's perspective, and our positive experience has prompted us to share the results. We would recommend it as an easy-to-administer tool. In addition the voice handicap index could be used in future studies to examine and compare the functional, physical and emotional impairment linked to different vocal pathologies. The voice handicap index could also be used in further prospective research to compare the effectiveness of different voice therapy treatments.

At the time of writing, Lynsey Bowie, Janice Dey and Rosemary Long were all based at the Speech & Language Therapy department, Gartnavel General Hospital, 1053 Great Western Road, Glasgow, G12 0YN, tel 0141 211 3027, fax 0141 211 3031, e-mail Janice.Dey@NorthGlasgow.scot.nhs.uk. Lynsey is

now doing research at Glasgow Royal Infirmary, while Rosemary lives in Germany.

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REFLECTIONS

- DO I INVOLVE CLIENTS SUFFICIENTLY IN THEIR ASSESSMENT AND MANAGEMENT?
- DO I ATTEMPT TO MEASURE THE EFFECTIVENESS OF THERAPY FROM THE CLIENT'S PERSPECTIVE?
- DO I ASK CLIENTS THE RIGHT QUESTIONS TO UNDERSTAND THE IMPACT OF THEIR COMMUNICATION DIFFICULTY ON THEIR EVERYDAY LIFE?

Table 1 Pre-therapy voice handicap index (VHI) scores

	No.	Minimum	Maximum	Mean	Standard deviation
Pre-therapy functional VHI sub-scale scores	28	2.00	35.00	13.3929	8.77429
Pre-therapy physical VHI sub-scale scores	28	5.00	37.00	21.5714	7.4158
Pre-therapy emotional VHI sub-scale scores	28	0	37	13.7143	10.9269
Pre-therapy total VHI scores	28	18.00	109.00	48.6786	23.5640

Table 2 Post-therapy voice handicap index (VHI) scores

	No.	Minimum	Maximum	Mean	Standard deviation
Post-therapy functional VHI sub-scale scores	28	00	25.00	5.3571	6.3492
Post-therapy physical VHI sub-scale scores	28	00	31.00	11.4643	6.4778
Post-therapy emotional VHI sub-scale scores	28	00	27.00	5.7500	7.49135
Post-therapy total VHI scores	28	00	81.00	22.6071	18.7070

Table 3 Voice handicap index (VHI) scores pre- and post-voice therapy

Clients	Functional Score		Physical Score		Emotional Score		VHI Total Score		Difference between pre- and post-total scores
1	17	0	24	12	8	8	49	20	29*
2	14	0	17	9	6	3	37	12	25*
3	25	2	25	7	26	5	76	14	62*
4	5	7	5	10	8	8	18	25	-7
5	9	8	15	13	4	1	28	22	6
6	32	0	27	0	20	0	79	0	79*
7	6	0	31	5	4	0	41	5	36*
8	28	7	29	9	21	3	78	19	59*
9	8	2	21	7	2	0	31	9	22*
10	10	5	16	12	11	4	37	21	16
11	15	2	20	17	9	2	44	21	23*
12	8	4	18	17	18	5	44	26	18*
13	4	1	19	9	19	2	42	12	30*
14	21	13	27	17	27	22	75	52	23*
15	11	10	23	13	23	4	57	27	30*
16	8	0	16	12	16	3	40	15	25*
17	8	6	17	7	17	5	42	18	24*
18	14	4	21	13	21	2	56	19	37*
19	35	24	37	23	37	27	109	74	35*
20	22	6	37	13	37	7	96	26	70*
21	22	25	28	31	25	25	75	81	-6
22	4	6	9	8	15	15	28	29	-1
23	8	2	18	6	1	1	27	9	18*
24	14	4	19	7	0	0	33	11	22*
25	2	2	18	7	2	2	22	11	11
26	10	7	25	20	7	7	43	34	9
27	7	3	14	16	0	0	21	19	2
28	8	0	28	2	0	0	36	2	34*
MEAN	13.4	5.4	21.6	11.5	13.7	5.8	48.5	22.6	26.1

*statistically significant

resources

Talking tips

A new leaflet aimed at parents and carers outlines the benefits of talking to young children. The leaflet includes tips for parents to help babies and toddlers develop good language and communication skills.

Download from the National Literacy Trust's website at www.literacytrust.org.uk.

Auditory processing disorder

1. The Medical Research Council's Institute of Hearing Research has released a leaflet aimed at parents of children with auditory processing disorder. People with the condition are thought to have difficulty understanding the sounds that they hear, and sometimes to behave as if they cannot hear.

For a free copy, e-mail info@defeatingdeafness.org, tel. 020 7833 1733, or see the text of the leaflet at www.apduk.org.

2. Hearing systems specialists Phonak have developed EduLink, a multi-frequency FM device, which links a pupil and a teacher to improve the signal to noise ratio. This is intended as a personal classroom solution for children with auditory processing disorder. www.phonak.co.uk

Aphasia

Speakability has scripted a video, presented by Andrew Marr and people with aphasia, as an awareness raising tool.

Speaking up about aphasia is £12.50 from Speakability, 1 Royal Street, London SE1 7LL.

Qualifications

Edexcel, an academic and vocational award body, has launched a health and social care microsite containing news and information on issues and qualifications in the sector.

See <http://lhsc.edexcel.org.uk>.

Xerostomia

Oramoist spray and Oramoist lozenges are sugar and alcohol-free over-the-counter products for xerostomia (dry mouth) from Periproducts Ltd.

Brain injury

Headway now has a booklet to help 6-11 year old children cope with the trauma of having a parent with a brain injury. It includes information on the professionals who will help their parent and practical tips on how to deal with their own emotions.

'My dad's had a brain injury', £4.00 & p+p, contact Debbie Clarke, e-mail information@headway.org.uk or tel. 0115 924 0800.

Young people

Afasic has announced the publication of a Youth Information Pack for young people aged between 14-25 who have difficulty with speech and language. It contains cartoons and information on topics such as personal safety, driving, managing money and sex, along with contact details for national organisations. It is particularly relevant to young people in England.

Afasic Youth Info Pack, £7 inc. p&p, tel. 020 7490 9410, e-mail info@afasic.org.uk.

Looking after yourself

1. The Chartered Society of Physiotherapy has put together a leaflet to help people of all ages take care of their backs and avoid back pain.

For a free copy, send a stamped self-addressed envelope to 'Backs for Life', The Chartered Society of Physiotherapy, 14 Bedford Row, London WC1R 4ED. www.csp.org.uk

2. Repetitive strain injury has common symptoms of tingling fingers and hands, aching wrists or back pain. For support from other sufferers, log on to the RSI Online Forum at www.rsi.org.uk.

For more resources see p. 22

When *Sheila Buchanan* developed symptoms including auditory memory difficulties, she felt her ability to control her life was slipping away. However, as an IT specialist with a creative streak, she discovered the power of computer based Mind Maps™ as an organisational tool and for emotional and practical support. This is her story...

Over the last 30 years I have had major difficulties, attributed to the symptoms of multiple sclerosis (figure 1). In spite of this, I have been able to maintain some control of my life thanks to Mind Maps™ and my computer. I would like to think that the ideas represented here might stimulate possibilities for others, as I cannot emphasise enough the benefits that I have gained.

Figure 1 Background information on Sheila

Sheila (55) attends a Multiple Sclerosis Therapy centre in Glasgow. She lives alone, has a degree in biochemistry and has been employed as an information technology (IT) lecturer in a Further Education College, working until 2002. She has been diagnosed with multiple sclerosis, although this diagnosis is under review.

Sheila's initial symptoms appeared in 1972. Currently, sensory and balance difficulties, headaches, fatigue and cognitive-linguistic problems are her predominant symptoms. Auditory comprehension is restricted due to memory difficulties, although visual processing is less severely affected. Word finding difficulty is exacerbated by fatigue. While language processing has been considerably affected, her IT skills remain otherwise intact. Her hobbies include creative writing, and she regularly processes her emotions and coping strategies by writing poetry. Thanks to Speakeasier (a charity that provides communication aids for those with multiple sclerosis), Sheila acquired the equipment that she discusses in the article. She is able to combine her knowledge of mind mapping with her recorder and software to tape and analyse our speech and language therapy sessions, provide printouts to medical staff and process meetings with officialdom.

Lyn Steven, speech and language therapist

Mind Map™ IT

READ THIS

IF YOUR CLIENT

- IS STRONGER VISUALLY THAN AUDITORILY
- NEEDS ASSISTANCE TO ORGANISE THEIR THOUGHTS
- WANTS TO BE MORE IN CONTROL OF THEIR LIFE



Mind mapping is a graphical technique that mirrors the way the brain works. The subject of interest is represented in a central image and then the main themes radiate out from the central image on branches (figure 2). Each branch holds a key image, or key words, printed on the line. Details are added to the main branches and radiate out. If required, colours and images can be used to enhance the map.

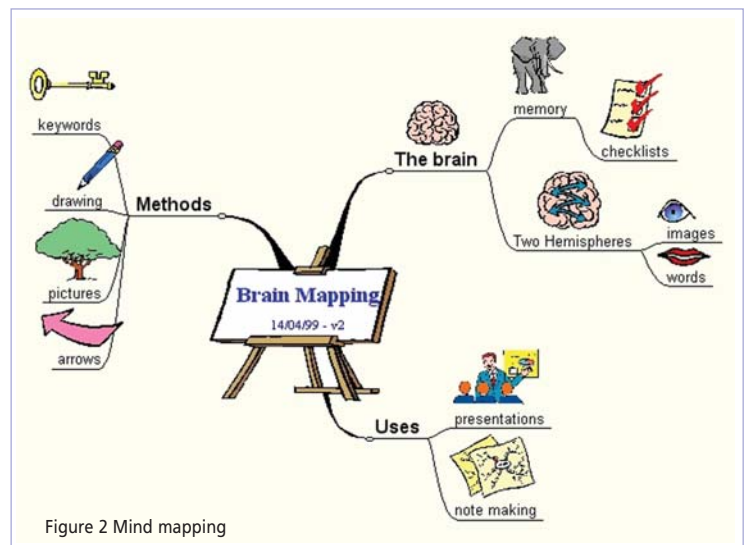


Figure 2 Mind mapping

The introduction of mind mapping techniques is of benefit to those with memory and speech difficulties as it is a visual tool. Using software such as MindManager® provides an easy link with Microsoft® Office and allows the user to display ideas graphically, and also to expand them by creating documents which can then be printed out or saved. It thereby reduces the need to rely on memory.

How do I Mind Map™?

Buzan & Buzan (2003) suggest you:

- Start at the centre of the page. Be creative. Creativity aids memory.
- Use just key words or, wherever possible, images.
- Make the centre a clear and strong visual image that depicts the general theme of the map. Think of the points or ideas within each of these.
- Put key words on lines. This reinforces the structure of notes.
- Use lower case as it is more visually distinctive - and better remembered - than upper case.
- Use colour to depict themes, associations and to make things stand out. Anything that stands out on the page will stand out in your mind.
- Use arrows, icons or other visual aids to show links between different elements.
- Don't get stuck in one area. If you dry up in one area, go to another branch.
- Put ideas down as they occur, wherever they fit. Don't judge or hold back.
- Break boundaries. If you run out of space, don't start a new sheet; paste more paper onto the map.

What are the advantages?

Memory is naturally associative, not linear. Mind Maps™ work the way the brain works and reflect the way your own brain organises ideas by recording key words and images and salient points. The main idea is at the centre and clearly defined. The relative importance of ideas is shown - more important concepts are near the centre. The connections between key ideas are obvious. Recall and review is faster and more efficient. Addition of new information is straightforward. The creative nature of the map makes it easier for the brain to think of new connections. Time is not wasted writing down unnecessary words or sentences. Mind Maps™ act as a permanent record; unlike memory, this record is always available (figure 3).

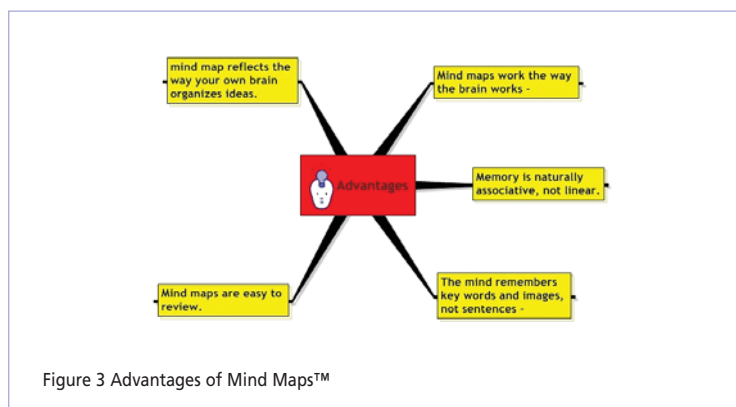


Figure 3 Advantages of Mind Maps™

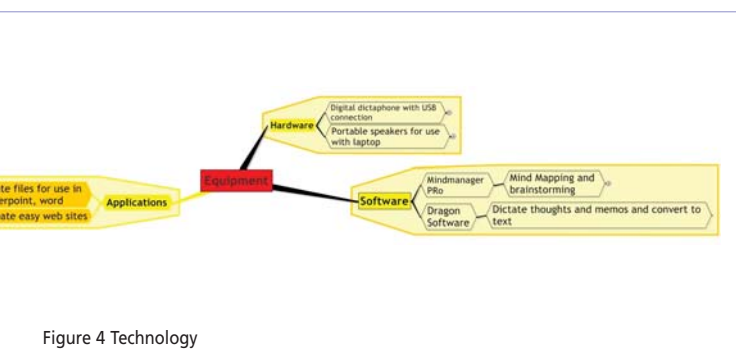


Figure 4 Technology

How do I use the technology?

The Mind Map™ in figure 4 shows the technology I use. The concept of mind mapping is valuable, but linking the paper-based technique to the technology is applicable to me and marries my IT skills to my cognitive needs. I use mind mapping for a variety of purposes:

a) Support

PowerPoint presentations are prepared easily in advance. I am able to do presentations in public, prepared directly from the mind map, which are professional and give confidence to me.

b) Note making

Whenever information is being taken in, Mind Maps™ help organise it into a form that is easily assimilated by the brain and easily recorded.

c) Planning and problem solving

I can consider all the possibilities in an ad hoc manner - the reality of not having good memory - but I am then able to record and reorganise into a logical plan.

d) Recording

Mind mapping allows random thoughts to be well presented in a way that is easily communicated and familiar to me. It permits the trapping of thoughts - captured visually - and replaces the need for memory. The map can be returned to often. The visual format is easier to recall and acts as a prompt to the memory.

Meetings can be recorded and / or summarised and stored. The map can then be updated as events take place.

What particular benefits have I had?

- I. Recall
- II. Accessibility of information visually
- III. Tangible resources created and recorded in pictures
- IV. Aids memory and organisation
- V. Easy, intuitive interface of software (figure 5)
- VI. Documentation and presentations
- VII. Removes the need for explanations in meetings by presenting a visual presentation of thoughts or fears (figure 6, p.12)
- VIII. Aids return to work (in some form). Evaluates the pros and cons of work / rehabilitation process
- IX. Meetings with medical staff are short - and therefore a map of history is invaluable
- X. Maintains diary of events or weekly tasks
- XI. Records symptoms and feelings to present as a summary each time I deal with officialdom
- XII. Maps save energy in having to recall and repeat things in interview situations
- XIII. Restores self-worth and allows me to value my skills
- XIV. Recording maps and thoughts on paper often has a calming influence and feeling of productivity, control and efficiency otherwise missing from my life.

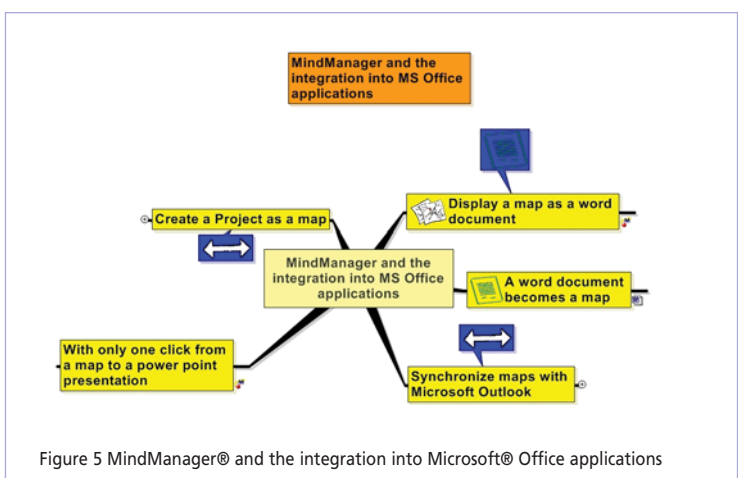


Figure 5 MindManager® and the integration into Microsoft® Office applications

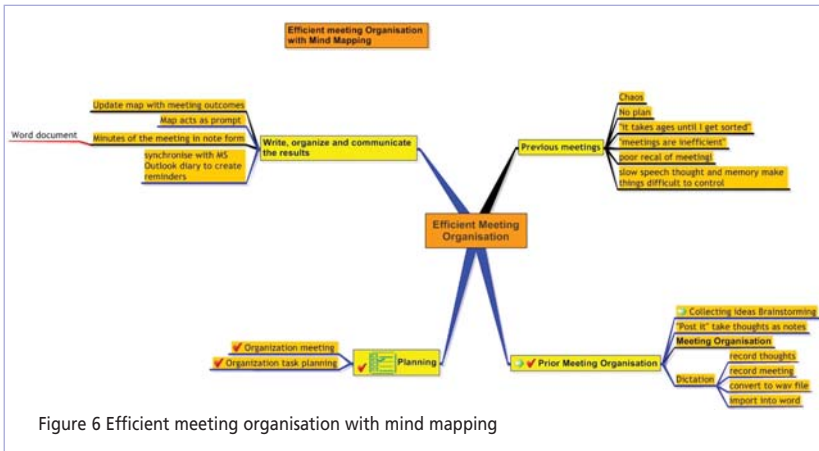


Figure 6 Efficient meeting organisation with mind mapping

My attempt to collate ideas for this paper was first created as a Mind Map™ (figure 7). Notes were added as required and ordered and then the map was exported into Microsoft® Word to easily produce a document using the original map text which could then be formatted into the final report format. This means that not only were the thoughts and text organised, but duplication of effort was prevented. Thoughts were stimulated and, despite not having looked at the content for a few weeks, I was able to produce the paper to draft very simply.

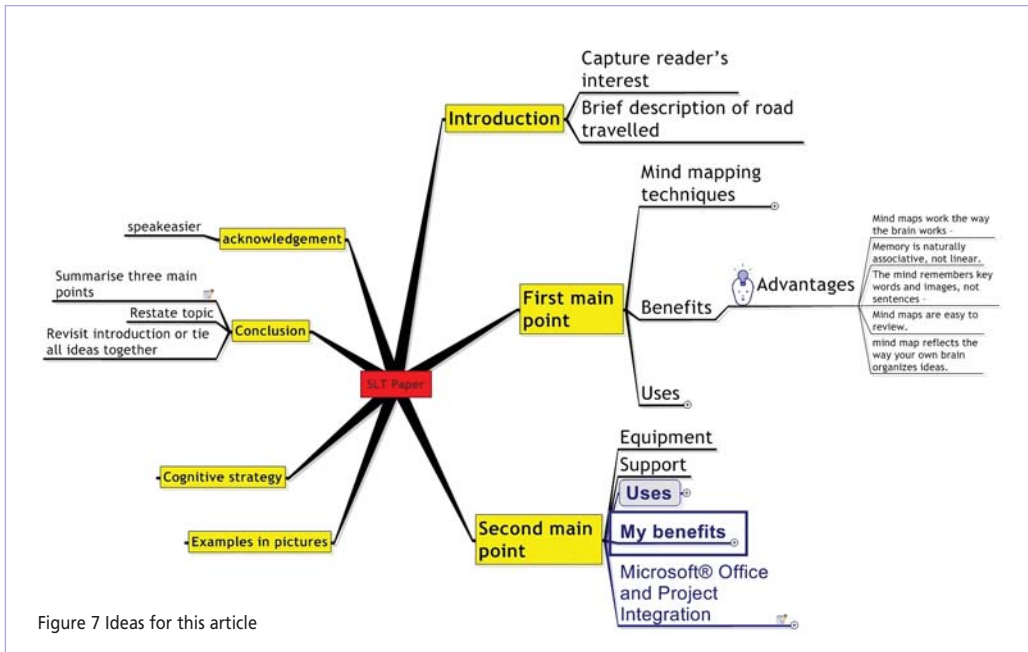


Figure 7 Ideas for this article

Mind mapping which is paper based (figure 8) can achieve some of the same results, but not so integrated and streamlined as by using technology.

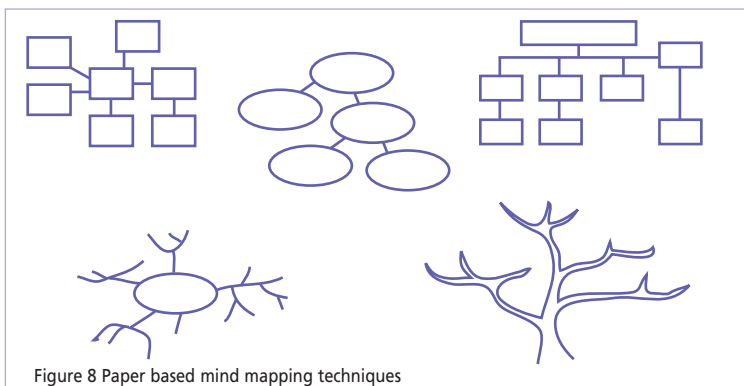


Figure 8 Paper based mind mapping techniques

When people write their deep thoughts and feelings about traumatic events, their heart rates slow, their bodies are better able to fight infection, and people feel a general sense of well-being (Bolton, 1999). Similarly, if an impairment which prevents easy communication can be minimised by useful strategies such as mind mapping, then a level of apparent control can be returned. This removes frustration, and the benefits are untold (figure 9).

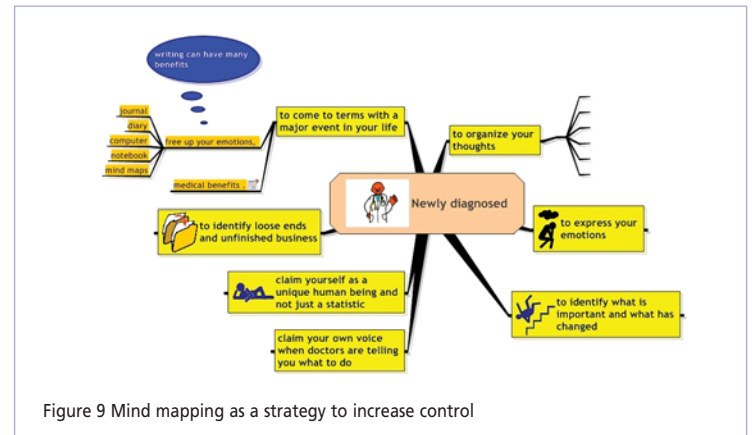


Figure 9 Mind mapping as a strategy to increase control

Sheila Buchanan (e-mail sheila_buchanan@hotmail.com) is a former information technology lecturer and a client of speech and language therapist Lyn Steven (e-mail lynstevan@hotmail.com).

Acknowledgement

Thanks to Speakeasier, Registered Charity number 1087208, P.O.Box 410, Cheltenham GL52 9GH.

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- Buzan, T. & Buzan, B. (2003) The Mind Map Book: Radiant Thinking - Major Evolution in Human Thought. BBC Consumer Publishing (Books).

Resources

* MindManager® X5 Pro is the latest version of the mind mapping software Sheila uses, and is available for a 21 day free trial on www.mindmanuals.com.

* ScanSoft's Dragon NaturallySpeaking® is software to turn speech into text (see www.scansoft.co.uk).

REFLECTIONS

- DO I ENCOURAGE CLIENTS TO RECORD THEIR THOUGHTS IN WHATEVER WAY THEY CAN?
- DO I LOOK INTO THE POTENTIAL OF COMMERCIALY AVAILABLE BUSINESS TOOLS FOR MY CLIENTS?
- DO I EXPLOIT THE POSSIBILITIES OF TECHNOLOGY AS WELL AS THOSE OF PAPER?



The café



Stopping and resting



Connect

Grand designs - or just changing rooms?

A massive programme aims to replace old and crumbling clinics and hospitals with customised, multi-purpose spaces. No regular viewer of Channel 4's *Grand Designs* could imagine that a conceptually challenging new build is easy. So, when the opportunity comes around to influence your working environment, how can you be ready? *Avril Nicoll* investigates.

The worst building I ever worked in was a dark, cold and isolated clinic where the chiropodist's substances sat precariously in an unlocked cupboard above the speech and language therapy toys. The best was a central clinic with a flexible, sunny suite of rooms that helped to create a real team atmosphere. The first face we saw was the receptionist's and she knew every client by name. Admittedly it was a nightmare for parking - but it had soul.

What has been your best working environment? Is it one that suited your clients as much as it suited you? Did it bring out the best in you as a therapist, encourage you to liaise with other professionals, make clients feel relaxed and welcome? If you were asked to design your 'ideal' therapy space, what would it be? Would you even know where to start?

One of the first objectives of the communication disability network, *Connect*, was to refurbish a London building that would make people with aphasia feel different about themselves. Chief executive Sally Byng remembers very good advice from a disability access consultant architect about 'intellectual access' - how does the building work psychologically and navigationally, and how does it make you think and feel? She also describes the graphic designer who did the bulk of the work on the planning as "visionary".

While many buildings are now wheelchair accessible, much less thought is generally given to communication. *Connect* asked people with aphasia what was really important to them in a building;

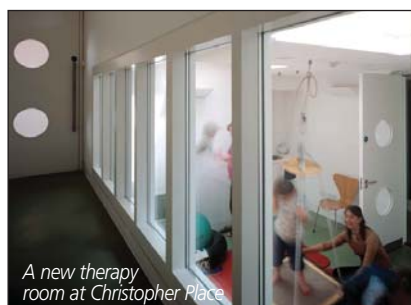
they said to be able to get to the toilet very quickly, have somewhere to hang their coats and get coffee easily, and to have a system around the things that aren't accessible. People with aphasia find the *Connect* building strikingly different to other environments. According to Sally, the key is that everything in it says, "you have been thought about - but it's up to you how you make use of it". Dotted around are sheets of steel as noticeboards with magnets, easy to use with one hand, and pens and paper on clipboards. 'Stopping and resting areas' mean users can think about where they want to go if they come out of the lift, without feeling rushed or flustered, and there are also refuge points for people in wheelchairs. Tables can go up and down in height and fit together to make different shapes. Door handles are neither too wide nor too slippery. The furniture was "a good investment", road tested by people with aphasia, and chosen to be comfortable, stylish and safe.

Looking around, I am surprised this was not an expensive conversion, but the quality comes from attention to detail. Navigation is aided by unambiguous colour coding of floors and soft furnishings - downstairs is a warm and welcoming orange, the first floor an energising green and the second a soothing and concentrating blue. The height of the doors and width of the corridors give a feeling of space. Light has been carefully considered, with uplighting rather than striplighting, and options for very bright or softer lights. Glass in partition walls lets light into communal areas, while domestic blinds add privacy, shield glare ▶

and let in more light than industrial ones. The building is air-conditioned and the windows are double-glazed. People with aphasia like the windows looking out onto real life, a contrast to a hospital environment.

A balance is struck between openness and privacy - for example, counselling rooms are set in an area where there is little through traffic, and are offset from the glass, while every room is lockable for security. The building creates the conditions for people to do things themselves, such as getting a drink when they want one, and the toilets are larger than British Standard to be truly wheelchair accessible.

This level of planning, attention to detail and focus on the end user is also behind director Angela Harding's satisfaction with the recent extension to Christopher Place in London. Despairing of the prefabs and basements children



A new therapy room at Christopher Place

with communication and associated difficulties are so often asked to attend, she was determined to create a "beautiful and joyful" physical environment with a focus on "excellence". With a much tighter site than Connect, the challenge for the architects was to turn a long, narrow building into one that said "hug", with light and no sharp edges.

The essence of the design is reduced sensory overload - posters and notices are absent from the walls, and the rooms are acoustically treated, gentle and calm, with soft, neutral colours and natural rather than plastic furniture and toys. Round tables give a sense of everyone together, and all individual therapy booths and classrooms have child and adult height round windows in the doors for accountability. The attention given to informal spaces as well as formal ones for families and staff creates a welcoming feel, and there are outdoor options too, including a rooftop sensory garden.

Angela believes that people do not give enough consideration to maintenance costs. Here, attention to the finish and quality of surfaces means they are easy to maintain and last longer. As with Connect, considerable storage space was planned but is "never enough".

Christopher Place benefited from a very committed and reliable building team, with everything completed on time and on budget. Elizabeth McBarnet can only wish her experience had been so smooth! When she and her husband converted an old pig farm in Northern Ireland into a family home, a two-roomed outbuilding provided the opportunity to put her clinic ideas into practice. The result may be a dream come true - but the process was more the stuff of nightmares.

Elizabeth's architect made errors including not recognising the implications of a roof problem, saying an uneven floor could be built up but not anticipating it would then be too high to fit in



Elizabeth McBarnet's converted clinic in Northern Ireland.

This photo: The two-way mirror is fitted. Right: the outbuildings before (top) and after (below) conversion. Below: the finished therapy room.

...aim first
for the
best picture
then
compromise.



the doorways, and putting a wall in the wrong place. She believes the percentage-based system used by architects rewards errors, and suggests negotiating a fixed fee. Although things improved when Elizabeth and her "very creative" husband took over as project managers, she recommends that, when you set a budget, you should think of a figure and at least double it, and also be aware of VAT and tax issues.

In spite of the tears and stress, Elizabeth's message is to be tenacious, and never take "it can't be done" for an answer. Finding a company to do the two-way mirror with very good sound-proofing and linking was not easy - but a new local company eventually came up with the goods.

The interior designer was also very helpful, saying, "Tell me the *function*, not how you want it to look." Describing the assessment, therapy and age range of the clients has led to her room having a warm feeling, chairs and tables, a squishy but durable sofa, nothing breakable and under-floor heating. A large, walk-in cupboard built behind a false wall ensures that nine years worth of toys for all ages and stages is stored out of sight of adult clients.

A strong vision

These non-NHS projects all benefited from a strong vision. In the NHS, where there are more

stakeholders and cultural differences between professionals, that can be a challenge.

In 1985 an NHS vision was finally realised as the Lambeth Community Care Centre was built (Higgs, 2003). Planned as an extension of home care, with patients to decide the style of their care, it was set up like a home, with the garden area considered just as important as inside. The architects were commended for giving time to getting the brief exactly right for design and function and helping the planning group progress the project.

However, children's service lead Maria Luscombe wonders if more work should be done by NHS professionals *before* architects are brought in. Involved from the early stages in a Harrow Local Improvement Finance Trust (LIFT) programme that includes a children's healthcare building, she has found more to the process than she expected.

She explains, "We started by asking what we could get out of the building, rather than what services we could put into it. We didn't know conceptually what we wanted. We actually needed a much clearer idea - before we brought in the architect - of the purpose of the building, who it was for, and how we could all work together and share space. Next time, I would talk it through much more beforehand with my therapy and other colleagues." Maria recognises it is difficult



GRAND DESIGNS: PRACTICAL POINTS

1. Concentrate on 'intellectual access'
2. Plan thoroughly and be very specific
3. Make clients and staff feel valued and independent
4. Think about the informal as well as the formal space
5. Balance privacy with accountability
6. Give attention to detail
7. Consider flexibility and adaptability
8. Note that storage is always a problem!
9. Weigh up initial costs and running costs
10. Remember that new builds are ultimately about improving client care.

to think ahead, but emphasises the need to be incredibly specific about detail such as the height of plugs on the wall, where handles will go, hidden sockets and panic buttons.

Allen Skinner, a quantity surveyor with the John Duguid Partnership, has undertaken many contracts with the NHS and its partners, and agrees that being specific is crucial. "You have to know what you want, and list these - the items, the way you want to face, light, sound and the finish." He suggests you aim first for the best picture then compromise. Be as detailed as you can be. What shape (long / short / thin / fat / square / curved)? What heating (radiators with low surface temperatures or underfloor)? Do you need a window? What colour scheme? Are you looking for clinical or homely? What furniture and equipment will you have in the room? Do you need a sink / washing facilities? Do you want to consider running costs? In his experience, specialist sectors can provide inspiration for specifications; for example buildings for Sense service users who are blind and deaf require floor coverings of different textures and a doorbell replaced by a puff of air.

When a new health centre was built in Greenwich, Helen Pearson and colleagues gave this kind of detailed information about their requirements. They planned the move well and kept clients fully informed. What they were not prepared for was arriving to find phones not working, no child-sized tables or chairs, no air conditioning - the list goes on. A year on, they have a "beautiful" building but are still trying to pin down the right people to fix the snagging.

Back in Harrow, Maria Luscombe also finds that, while being involved with a new build is interesting, it can be frustrating and repetitive. She says all professional groups need patience and a willingness to think of new ways of working, particularly regarding office space, filing, reception, administrative support and communication. Local knowledge of the broader needs of the area is invaluable. For example, Maria has raised the poor accessibility of the proposed location, and sug-

gested involving a community group who could use the space outside normal hours to benefit the population in an area of deprivation.

Southern Derbyshire service manager Mary Heritage has also been on planning groups for LIFT initiatives. Although involved with decisions on the overall feel, philosophy and purpose through to the detail of number of coat pegs and whether there should be a viewing window in the door, she is disappointed that she has not yet had the opportunity to influence the communicative environment of a building as a whole. She believes it would be "wonderful" for the profession to have the opportunity to be asked about making the places where people live and have conversations - such as nursing homes - communication accessible. However, as LIFT is really just a mechanism for funding new investment in primary care and community-based facilities, it is unlikely that an awareness of communication accessibility can be taken for granted. Maria Luscombe says that issues such as loop systems and interpreters have been raised by the client rather than the architects, and that the information the architects received from the Department of Health about the type of room required by therapists is very outdated.

Privacy and community

While primary care services are being renovated under the LIFT programme, crumbling hospital buildings are also being re-thought, particularly moving from Nightingale style dormitories to small bays and even en-suite single rooms. A research project (Wells-Thorpe, 2003) found that "being able to control the environment and decide what levels of privacy and community are wanted by individuals is extremely important to patients...indeed of greater significance to them than the general appearance or aesthetics of those surroundings."

A stroke rehabilitation unit move to a purpose-built facility has left Barbara Mutch (not her real name) with many questions about environment and what shapes it. Although from a speech and language therapy perspective she is "delighted", privacy has been achieved at the expense of a nursing overview, and what was a big happy team is now a group of smaller, disillusioned ones. She

believes that, had the architect spent time on-site to learn about the function of the space, or staff on the ground had been involved at an earlier stage, or visits been allowed while the building was being put up, the nurses would have felt more positive about the changes, and glitches could have been avoided. Patients who have made the transfer have noticed the different team dynamics. Barbara comments, "People forget that moving environments may also take quite an adjustment in a team. If you change it, or move people, you lose the cohesion. This is a problem if people become demotivated, especially if their motivation and character made the place what it was."

The Richard Stevens Stroke Unit has a similar move coming up, as part of a massive trust reconfiguration. Although confusion over several sets of plans means Belinda Walker is currently without a speech and language therapy room, there are moves afoot to lose a bed to create space for her, and she is philosophical. "Ultimately it is about improving patient care and trying to make their stay a better experience for them. We need to be cooperative not confrontational, and to be in there, making the best of things." Part of a strong team, Belinda is convinced the move will be a success, and sees it as a personal development opportunity. She feels that, although things are coming right in the end, staff need to be involved "every inch of the way" in the planning process.

Any integrated provision is a challenge both inter-professionally and architecturally. SureStart is the government's programme to bring together early education, childcare, health and family support, and Mary Heritage is fulsome in her praise of two Derby City SureStart projects which "show what public buildings can do". She also describes a local Healthy Living Centre eco- and community-build plan, which is really challenging current attitudes to how things should be done. The vision of the local people is central so, if they want to set aside a room for the use of several professionals to work together, that is what will happen - and professionals will be brought in at a later stage of consultation.

In new builds, the term 'service user' often refers to the professional(s) using the space, but perhaps it is time to be more adventurous and to consult

PLACE MATS

ANGELA CROCKER OUTLINES A SIMPLE AND EFFECTIVE WAY OF SUMMARISING THE INFORMATION THAT CAN HELP ADULTS WITH LEARNING DISABILITIES TO POSITIVE, SAFE AND SUCCESSFUL MEALTIMES.

How are they useful?

- When helping people with high support needs it ensures that the often-large amount of important information is easily accessible.
- They promote consistency and good communication.
- Having a photograph of a person's special equipment allows the equipment to be accessed quickly and accurately.
- New, unfamiliar caregivers can check the mat for important

information. This can be particularly useful when a person is eating out in the community, is on holiday, or when familiar caregivers are not available.

- They allow a person with communication difficulties to advocate for him or herself.
- They increase knowledge of essential safety issues. This is particularly important for people who have specific difficulties at lunchtime, for example someone who is at risk of choking or aspiration.
- The mat can act as an object of reference (Ockelford, 2002; Park, 2002) to tell someone it is lunchtime, or to encourage them to request lunch.
- The mat can provide a contrasting visual border for people with visual difficulties.
- Having the place setting outlined on the mat can help people with autism set up their own place independently.

Angela Crocker is a speech and language therapist with N&WBHSST, Everton Centre, 589-593 Crumlin Road, Belfast, BT14 7GB, tel. 028 90391172.

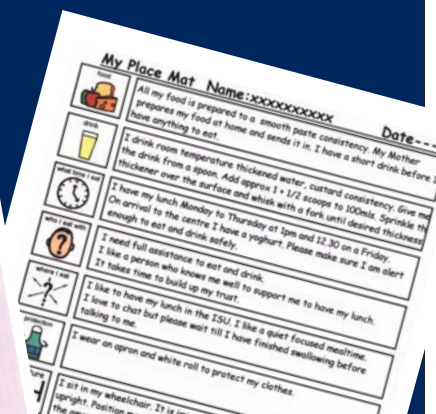
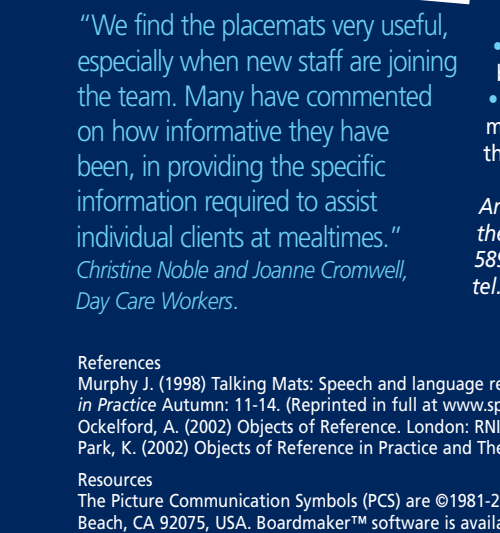
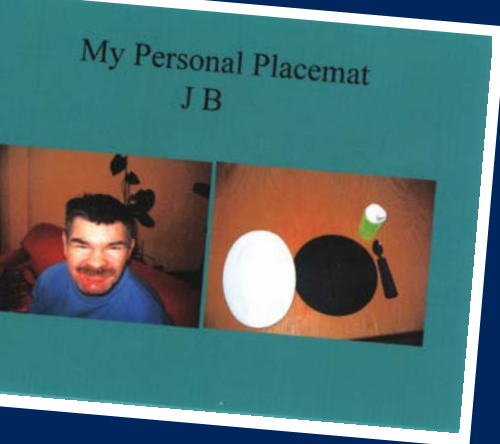
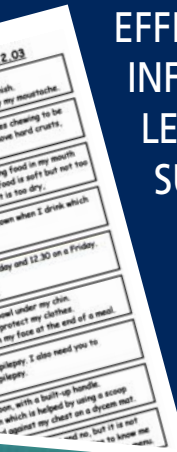
"We find the placemats very useful, especially when new staff are joining the team. Many have commented on how informative they have been, in providing the specific information required to assist individual clients at mealtimes."
Christine Noble and Joanne Cromwell,
Day Care Workers.

References

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Resources

The Picture Communication Symbols (PCS) are ©1981-2004 Mayer-Johnson Co., PO Box 1579, Solana Beach, CA 92075, USA. Boardmaker™ software is available in the UK from Don Johnson Special Needs, tel. 01925 241642.



'Earing aid

A Norwegian nursery school has hung an ear shaped noise meter on the wall to help adults and children think about noise levels, according to Defeating Deafness.

The charity says that the instrument is colour coded, with a green light indicating that the noise level is reasonable, yellow warning that it is approaching unsafe levels, and red showing that it is excessive.

Defeating Deafness wants to draw attention to the dangers of excessive noise for both children and adults in nurseries. It cites a Danish study that found the daily noise level in kindergartens was often in the 80-85 dB range - while a consistent noise level of 85 dB can cause hearing damage and, in many other workplaces with these noise levels, workers would be required to wear hearing protection.

Defeating Deafness has a factsheet, *Noise-Induced Hearing Loss: Children and Toys*, see www.defeatingdeafness.org.

Stroke: more work to do

The Stroke Association has laid out the work still to be done to achieve a first-class stroke service, following the Royal College of Physicians' 2004 Sentinel Stroke Audit. The organisation is calling for stroke to be identified as a medical emergency and for better treatment of transient ischaemic attacks. It would like to see a greater number and range of stroke specialists in multi-professional teams and is repeating its demand for an increase in specialist stroke units.

The association is also frustrated by the lack of specialist community-based rehabilitation facilities. Chief Executive John Barrick commented, "The Stroke Association receive calls daily from stroke patients who feel abandoned after they have left hospital. They need a comprehensive service that supports them at all stages of their condition. It is essential that there is a seamless transfer of care from hospitals to the community to ensure that stroke patients, their families and carers receive the support they need."

www.stroke.org.uk

Communication aid consultation

Comments are invited on a new discussion document focusing on assistive technology - including communication aids. The Royal College of Physicians and the Institute of Physics and Engineering in Medicine have produced 'Specialist Equipment Services for Disabled People: The Need for Change' to mark the beginning of an eighteen month consultation process which will end with a symposium and a final set of recommendations. It recognises that, for many disabled people, assistive technology is crucial to their ability to choose how they want to live and whether they can live independently. It covers access and assessment, delivery of services, clinical governance and competence, and allocation of resources for communication aids, computer access, environmental control systems and telecare.

Hard copies are £7 inc. UK p&p, tel. 020 7935 1174 ext. 358, or see

www.rcplondon.ac.uk/pubs/books/sesdp/index.asp.

reviews

If you like ColorCards®, see our reader offer on the inside front cover!

CARDS I

Talking Traffic

Mark & Katy Hill

LDA

ISBN 0742417530 £19.99 + VAT

Difficult to be enthusiastic

These 60 boxed, 2-sided cards are aimed at developing children's knowledge of how different question forms are used.

They are colourful and present a wide range of transport vehicles and related items. The booklet provides a variety of flexible activities to carry out with individuals or groups of children from 4 years.

We feel this pack would have a limited use, for older children, within the therapy context, dependent on the child's knowledge base, topic interest and age. The amount of detail on the relatively small cards could hinder children's interpretation of target themes. The visual clues on the vehicles are, at times, difficult to distinguish.

We found it difficult to be enthusiastic about this pack, beyond a basic picture resource. Enlarging the format would undoubtedly increase its practicability in group work. Karen Shuttleworth and Alison Taylor are speech and language therapists with Morecambe Bay Primary Care Trust.

CARDS II

ColorCards®: Familiar Verbs

48 cards and booklet

Speechmark Publishing Ltd

ISBN 0 86388 519 5 £25.95 + VAT

Extends the range

Do we need more verb cards? This set of 48 cards in a strong, easily opened box extends the range beyond Basic Verbs. The colour photos are clear and would be suitable for any client group. Even verbs that are difficult to photograph such as helping are shown clearly. The booklet gives a full listing and some limited suggestions for their use.

The pack will be useful for:

- developing vocabulary (filling, folding)
- extending the use of argument structure (looking for, listening to music)

- reading the pragmatics of situations (asking for directions, selling). A useful resource in any setting. Jane Barnard is a speech and language therapist working in a language unit in Essex.

CARDS III

ColorCards®: Indoor Sounds

40 cards, CD and instruction booklet

Speechmark Publishing Ltd

ISBN 0 86388 520 9 £35.50 + VAT

Versatile (if you have a CD player)

A set of 40 big photo cards depicting sounds divided into four fairly arbitrary categories, from 'people' (eg. whistling) to 'everyday sounds' (eg. washing machine). Clear and colourful, showing a mix of age, gender and ethnicity.

PROS:

- useful for attention / listening work and vocabulary development
- adaptable for other language work (perhaps by more experienced therapists)
- 3 out of 4 categories suitable for use with adult as well as paediatric caseload
- easy to use and move around CD tracks
- good for groups and individual clients

CONS:

- requires CD player (portable if not clinic-based)
- suggested games ideas rather limited

CONCLUSION

Versatile, so good value - if you have the equipment. Caroline Denby is a speech and language therapist with the NHS in Sheffield. She has a paediatric caseload in mainstream primary schools, and an adult one as a voice therapist with ENT outpatient referrals at the Royal Hallamshire Hospital.

CARDS IV

ColorCards®: Outdoor Sounds

40 cards, CD and instruction booklet

Speechmark Publishing Limited

ISBN 0 86388 521 7 £35.50 + VAT

Very clear sounds

These 40 large colour photocards are presented in a sturdy box together with a CD which gives

very clear sounds. The photographs are arranged in four groups: animal and bird sounds, out and about, having fun, and transport. The variety of pictures would be suitable to use with a range of age groups, although support would need to be given to help pre-school children identify some of the pictures. This resource would be beneficial to all therapists working with individuals and groups targeting attention and listening, auditory discrimination, speech sound work, vocabulary expansion and expressive language. I would recommend this set as a useful therapy tool.

Mary Corfield is a speech and language therapist working with the Maidstone Weald Primary Care Trust.

CARDS V

ColorCards®: Listening Skills - Sequencing Sounds

40 cards, CD and instruction booklet

Speechmark Publishing Ltd

ISBN 0 86388 522 5 £35.50 + VAT

Colourful and modern

This set contains two and three step sequences of familiar events with an accompanying CD. It is easy to use on a portable CD player or computer. I found this resource useful in the community clinic. It is worth buying as it has a wide range of uses, for example: work on attention and listening skills, sequencing skills, auditory and visual discrimination and general vocabulary development. It is suitable with individuals or small groups. The colourful and modern photo cards appeal to the children and they enjoy hearing the sounds. Louisa Pearce is a speech and language therapist with Bexley Care Trust.

AAC

Frenchay E-tran frame (with instruction card)

Speechmark Publishing Ltd

£85.00 + VAT

Affordable and useful

The Frenchay E-tran frame is a low-tech communication aid for individuals who have difficulty with speech. This version utilises eye pointing to select letters grouped around the clear frame. Users need to have basic spelling skills,

intentional eye movements and a consistent yes / no response. The frame is water resistant and portable, and can therefore be used anywhere. It could be an individual's main AAC system or may be used as an alternative to their high-tech system, for example when they are tired. Pictures or symbols could also be placed over the letters making it applicable to a wider range of clients. An affordable, useful AAC resource. Yvonne Mackenzie is a speech and language therapist with Greater Glasgow Health Board, South Glasgow Division.

APHASIA ASSESSMENT

The Butt Non-Verbal Reasoning Test

Pamela Butt & Romola Bucks

Speechmark Publishing Ltd

ISBN 0 86388 472 5 £64.95

Gives some clues

The BNVR is a short test (10 items and one sample) to assess whether the person with aphasia also has problem-solving difficulties. It gives a photograph of a problem (for example a broken cup and saucer) and four photos of objects. The client chooses which object would solve the problem, the solution being chosen from semantic, visual and unrelated distractors. We've used the test with clients who are aphasic on rehabilitation wards and felt it had a few limitations. We found we wanted more items; clients were sometimes just getting the idea when the test stopped. Although the authors present statistical evidence to demonstrate how the BNVR differs from another assessment, Pyramids and Palm Trees, we felt that it tested semantic association in a similar way. We would be more confident in feeding back to colleagues about a client's abilities and difficulties if there were more test items and clearer validity and reliability measures. However, it is quick and easy to administer and it gives us some clues as to a client's ability to link a problem with a solution. This is a useful addition to the range of assessment tools currently available. Rachel Hemingway is a specialist speech and language therapist at the Rehabilitation Unit, Royal Bolton Hospital.

The awareness key



A professor was invited to deliver a series of lectures in America. To reach the staff accommodation, he tried to take the lift to the third floor. He pressed the button marked '3'. The doors closed but nothing happened. He tried again,

still nothing. He pressed the button to open the doors. Still nothing. He punched buttons '1' and '2' - still no result. He felt panic beginning to rise. On the verge of pressing the emergency button, he made a final try with button '4'. Much to his relief, the lift set off and deposited him on level 4 after which he walked down to his destination. On reporting the "fault" he was asked, "But don't you have the key?" Sure enough, when he checked the keys he had been given, there was a small one marked 'Elevator'. It would give him access to those floors not normally open to the public. He had the key, but he did not know it.

I heard this story recently, and it struck me as a very strong and appropriate metaphor for how we often look at what is going on in our lives. We have the keys but do not know it, or the keys are easy to find but we don't know where to look.

We have previously discussed challenges, values and balance. Over the next few articles, I would like to develop the key metaphor, and consider what keys can unlock our understanding of ourselves and of others. The first is AWARENESS.

A study in Cumbria (Heelas et al, 2004) has uncovered the most dramatic rise in all things spiritual and alternative, including reiki, reflexology and hypnotherapy. This interest seems to cross the intellectual, class and ethnic differences in society. One of the arguments against this trend from the traditional religions is that it encourages selfishness and introspection. It is possible there is some truth in this thinking, but it shows a defensive lack of understanding about spiritual searching. It seems to me that it is far more about trying to understand oneself in order to be less selfish and introspective, but also to feel that solutions come from within rather than being imposed from the outside. If it is important to mention God - and I believe it is - then it is only important because God has to be within every cell of our body and therefore within every cell of the bodies of others. That is why the Indian greeting "Namaste" is so gentle, yet utterly appropriate: "The God within me greets the God within you."

Without awareness, change, growth and development are impossible. Without it, we cannot know our strengths and weaknesses. We cannot be

What is key to understanding yourself and others? Life coach Jo Middlemiss begins a series of short articles to encourage reflection and personal growth with a consideration of awareness - being present in every moment.



READ THIS

IF YOU WANT TO

- BE SENSITIVE TO THE NEEDS OF OTHERS
- CHANGE AND DEVELOP
- FIND YOUR OWN SOLUTIONS

sensitive to the needs of others and, as Anthony De Mello says in his wonderful book (2004), we stay asleep for most of our waking lives.

Priorities and perspective

How many of you have experienced the sudden shock of a car accident, burglary, death of a loved one or partner losing their job? This is a tiny list of the many things that make a dramatic impact on our lives. While you live through the aftermath you possibly describe yourself as numb. However I would venture that you are actually numb to the unimportant things of life. You are probably very much aware of the things that really matter. A sense of priority and perspective comes into everything. You just know that such things as

dirty windows, not having everything you want, work politics or whether or not you were invited to this or that event are suddenly not important any more. Your concentration zeros in on love and pride, consideration and gratitude. You swear that you will not lose this clarity and sense of purpose but, life being life, this precious sense often slips out of your grasp without you even noticing.

Deciding to be aware is the starting point of the journey. Keeping not only your eyes and ears open, but also your other senses - especially your sixth sense, that part of you that knows what is going on beyond the usual knowing. Think about:

- A new mother who always seems to know when her baby is crying despite the crying of many other babies.
- Stepping into your workplace and instantly sensing the atmosphere, friendly or otherwise.
- Asking yourself, with curiosity rather than criticism, what might have caused a strong reaction either in you or in others.
- The sudden instinct to make contact with someone.

This is a way of walking alongside yourself as you live your life, and just gently observing your way of being. Don't beat yourself or others up about perceived mistakes, just be an observer - 'the watcher of the thinker' (Tolle, 2004).

The awareness key does not take you out of circulation but encourages you to be fully present in every moment. You will find your awareness grows simply because of your intention to be aware. From the position of awareness, understanding flows and you learn to flow with life, rather than being rigidly fixed to one point.

Jo Middlemiss is a qualified Life Coach with a background in education and relationship counselling, tel. 01356 648329, www.dreamzwork.co.uk. Jo offers readers a confidential and complimentary half-hour telephone coaching session (for the cost only of your call).

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Tolle, E. (2004) The Power of Now: A Guide to Spiritual Enlightenment. New World Library.

Resources

- Chopra, D. (2004) The Book of Secrets: Who am I? Where did I come from? Why am I here? Rider. ■

READ THIS

IF YOU WANT TO

- CHECK IF SUCCESS WITH AN INDIVIDUAL IS TRANSFERABLE
- COMPARE DIFFERENT APPROACHES IN YOUR CLINICAL PRACTICE
- PLUG GAPS IN THE LITERATURE



Sound sense

“Take care of the sense, and the sounds will take care of themselves”, wrote Lewis Carroll - but *Stephanie Delvin* begs to differ. Her comparison of a semantic versus a semantic + phonological approach to therapy for word-finding in children with a language disorder suggests that taking care of the sense *and* the sounds is the key to progress.

Traditional approaches to vocabulary learning have been through improving semantic knowledge. This is often without any prior measurement of a child’s semantic knowledge due to the lack of formal assessment material of this kind, particularly for younger children. More recently the role of phonology in vocabulary learning and retrieval has gained ground. A number of studies have looked at either semantic or phonological approaches to therapy (Wing, 1990; Hyde-Wright et al, 1993; McGregor, 1994), with varying results. Some research into combined semantic and phonological therapy has been carried out in single case studies with positive results (Chiat & Hunt, 1993; Easton et al, 1997). However, no studies have compared semantic therapy alone with a combined semantic and phonological method.

I have worked on a combined therapy approach with a number of individual children with good results. But I decided to test the two methods against each other by running separate groups in the language units I work in - one a traditional semantic group and one combining semantic and phonological therapy. The results suggested that the semantic approach helped some children develop their receptive vocabulary but not their expressive word finding. However, they also showed that the combined approach

- significantly improved the ability to find the words targeted in therapy
- provided a framework around which the child could learn new vocabulary
- generalised to other vocabulary items within the same categories
- in some instances, was generalised and maintained outside of therapy sessions to other vocabulary.

For this article I have matched two girls from the groups for age and language profiles and compared the results to provide a clear illustration of the two outcomes.

Alice and Ophelia were both attending language units attached to mainstream first schools when therapy began. They were both in year 2 and presented with specific language impairment (figure 1). Both girls had significant word-finding problems that were of the most concern at this time, as other areas of their speech and language development were making steady progress and their word-finding difficulties were severely impacting on their expressive language.

Figure 1 Language profiles

Name	TROG (centile)	RAPT (Age Equivalent)	BPVS (centile)	TWF-2 (centile)
Alice	1st*	4;0-4;5 (Information) 4;0-4;5 (Grammar)	7th	1st
Ophelia	5th*	4;6-4;11 (Information) 4;0-4;5 (Grammar)	32nd	3rd

*Both girls scored poorly on the TROG but this was due to poor auditory attention and no specific difficulty in following grammatical structures was noted.

Both girls had weekly therapy sessions within a small group aimed at improving word-finding skills. In total each received 12 sessions of therapy.

Traditional approach

Alice was a member of the group who followed a traditional semantic approach to vocabulary learning using the Defining and Describing programme (Toomey, 1991), covering the categories of places, food, animals, clothes, buildings, tools and instruments. Within each category an average of 10 words was targeted for therapy. Each category was introduced in order and tasks included fine semantic categorisation, describing, and guessing games to include salient semantic features and definitions of use, location and so on. These tasks were differentiated to match the ability and age of the

children within the group. Before the next category was introduced, the current category was recapped through naming and sorting tasks. When the children had worked through all the categories, a general recap was given, with gross and fine semantic categorisation tasks and further describing and guessing games to promote naming.

Combined therapy

Ophelia followed a combined therapy approach focusing on semantic and phonological properties of the target words at the same time (figure 2). To test the efficacy of the therapy the children within this group were assessed using the Test of Word Finding - second edition (German, 2000) before therapy began. They were also tested on 60 words (figure 3) from six categories chosen from the Semantic Connections pictures (Speake & Lewis, 1995). The pictures were then divided into 30 treatment and 30 non-treatment words by looking at common error words and common correct words; a random mixture of these was selected.

Figure 2 Combined therapy

12 sessions of 30-40 minutes each

- 1) Categorise and name treatment items
- 2) Chose 5 words to look at in detail per session
- 3) Play dice games, card games, fill in a chart to answer the following questions about each word:
 - (a) What's it called?
 - (b) What category is it in?
 - (c) Describe it (try to use an adjective)
 - (d) Where do you find it?
 - (e) What do you do with it?
 - (f) What sound does it begin with?
 - (g) What does it rhyme with?
 - (h) How many syllables does it have?
 - (i) Name five other animals/vehicles etc.
 - (j) Name five more /s/ words (or five words which rhyme or have the same number of syllables)
- 4) After all 30 words have been treated, begin to combine, eg. name two animals that rhyme (cat, bat), name three fruits beginning with /p/ (plum, pineapple, pear).

When confident that the approach is working and the child is using the framework well, begin to use with more specific vocabulary (eg. school topic words).

Figure 3 Treatment and non-treatment words (60)

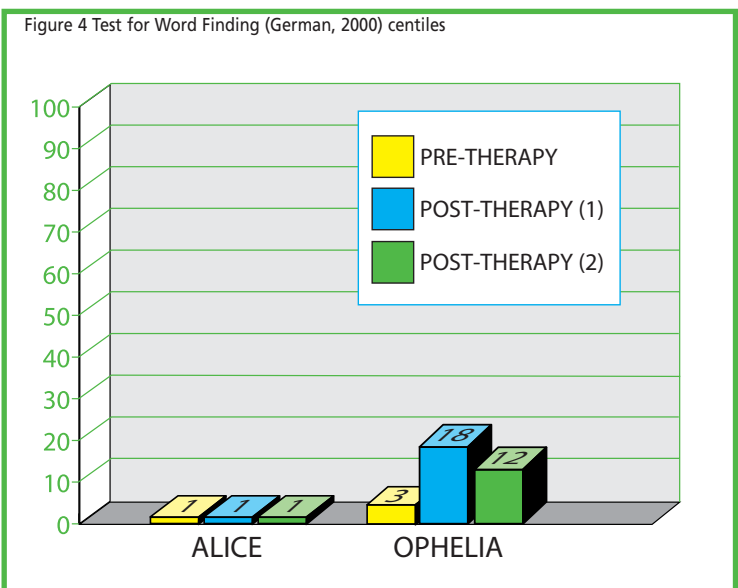
cot	snake	school	stool
motorbike	cardigan	chips	train
shed	sofa	monkey	windmill
sandwich	helicopter	scarf	strawberry
giraffe	stadium	desk	sheep
belt	pear	aeroplane	trousers
bookcase	zebra	farm	wardrobe
canoe	dress	grapes	coach
church	chair	lion	castle
apples	tractor	shorts	onions
dog	hotel	table	alligator
boots	cheese	bike	vest
armchair	horse	factory	
lorry	jacket	carrots	
house	shelves	rabbit	
lettuce	submarine	slippers	

At the beginning of each therapy session the children sorted and named the 30 treatment pictures. They then worked through the words, targeting about 5 for each session. The children were required to answer questions about semantic and phonological features (eg. Where do you find it? How many syllables

in the word? What does it rhyme with?) and to complete fluency naming tasks (eg. name 5 other words that start with /s/; name 5 other buildings). Card and dice games were used to vary the presentation of the questions, and charts were filled in to record the information about each word. Often additional work was needed on rhyme generation. For example, the children were encouraged to work through the alphabet adding each new consonant sound to the rime to see if they could make a new word. Gradually they were able to do this in their heads without sight of the alphabet and it became clear that they were using this strategy when generating rhymes.

Once all the words had been discussed we began to combine semantic and phonological information, increasing the complexity of the questions and promoting more neural networking of the stored information about each word. For example, the children were asked to fill in a table with semantic and initial sound information (name an animal which begins with /a/, /b/, /k/...) or to think of a type of food that only has one syllable, or animals which rhyme (cat, rat)).

At the end of the therapy the children were again tested on the 60 pictures. At two months post-therapy they were reassessed on the 60 pictures to gauge any maintenance and re-assessed with the Test of Word Finding (German, 2000) to see if there had been any generalisation and carryover (figure 4).



With the traditional semantic approach, Alice made no progress in her word-finding skills, scoring on the 1st centile both pre- and post-therapy. Observations during therapy sessions were that she continued to struggle to remember familiar vocabulary from week to week, with little or no change. It is worth noting that Alice continued to have both semantic and phonological therapy as part of her general programme, but without the specific targeting of the approach used with Ophelia. I went on maternity leave and, eighteen months after this therapy began, Alice's word-finding score remained on the 1st centile.

Ophelia was able to name significantly more treatment and non-treatment words than before therapy and this was maintained two months after the end of therapy (figure 5). Moreover, her score on the Test of Word Finding (German, 2000) went from the 3rd centile to the 18th centile post-therapy. Eighteen months after this therapy began the improvements in her word-finding score had been maintained at the 12th centile.

Figure 5 Ophelia's naming scores for 60 treatment / non-treatment words

Pre-therapy	Post-therapy (1)	Post-therapy (2)
48/60	55/60	52/60

- ◀ Combining phonological and semantic tasks appeared to strengthen Ophelia's word-finding skills and provide her with some framework on which to hang further word learning. Her therapy gains also appear to have been generalised and maintained. Alice in comparison appeared to make no significant gains in this area.

The results for Alice and Ophelia illustrate the trend in each of the groups. However, whilst all children following the combined approach made significant gains with the targeted vocabulary and generalised to words within those categories and maintained this, those whose comprehension difficulties still persisted did not show carryover to their word-finding scores as measured by formal assessment.

More investigation into the precise profiles of children to whom this is most beneficial is needed but I strongly believe that it is the links between sense and sounds that lead to greater word-finding skills.

On my return to work, Alice followed the combined therapy approach, and moved from a score of 35/60 pre-therapy to 53/60 at the end. She then left the language unit to return to her local school. Ophelia is continuing to use this approach to learn topic vocabulary relevant to her class work.

Stephanie Delvin is a speech and language therapist working with primary aged children with specific speech and language impairment in language units.

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Resources

See Diane German's website: www.wordfinding.com

REFLECTIONS

- DO I MAKE SIMPLE BEFORE AND AFTER MEASUREMENTS SO I CAN EVALUATE THERAPY?
- DO I ENSURE THAT GENERALISATION OF WHAT HAS BEEN LEARNT FORMS PART OF MY ASSESSMENT?
- DO I DESCRIBE MY THERAPY SO IT CAN BE REPLICATED AND TESTED BY OTHERS?

resources

Inclusion

1. Two publications from **Kids**, a national service delivery charity for disabled children and their families, support the inclusion of disabled children in play and childcare.

The All of Us pack contains an inclusion checklist for settings, which outlines good practice for childcare staff, and an inclusion framework for local authorities.

Available free from **Kids active**, e-mail pip@kidsactive.org.uk, tel. 020 7359 3073.

Pick & Mix is a selection of inclusive games and activities.

From **York Publishing Services Ltd**, tel. 01904 431 213, e-mail orders@yps-publishing.co.uk, £10.00 to voluntary organisations and £20.00 to statutory bodies.

www.kids-online.org.uk

2. The RNID has produced a 'one stop' resource for teachers who are trying to make their classroom as inclusive as possible, in partnership with the Open University, the University of Hertfordshire, The South East Regions SEN partnership, the British Association of Teachers of the Deaf and other specialist organisations. It aims to support learners with a range of disabilities and special education needs, and covers areas such as re-integration and social inclusion.

Inclusion strategies: supporting effective inclusion and attainment, tel. 0808 808 0123, price £17.50.



Special needs

AlphaSmart has introduced Neo, a computer companion for pupils with special needs. It has been designed to be lightweight, rugged and easy to use. It has a large screen, a full size keyboard and built-in features to reduce the risk of errors or loss of files.

£185.00 + VAT, see www.alphasmart.co.uk, tel. 020 8492 3690.

Consultation

The latest release from the CALL Centre is a pack of practical materials for anyone who wants to listen to and find out the views of children who have communication disabilities. It includes guidance on how to embed involvement, participation and consultation in everyday practice across services.

Listening to Children 2004, £17.00 inc. p&p, tel. 0131 651 6236,

e-mail call.centre@ed.ac.uk.

Clicker 4 success

Crick Software is celebrating the news that Clicker 4 has penetrated over 90 per cent of primary schools in the UK.

Ten years old and winner of many awards - including 'Best Special Needs product' at the Education Show and Special Needs Show London in 2003 - Clicker is used across the age ranges to support writing and multimedia authoring.

New address: **Crick Software Ltd**, Crick House, Boarden Close, Moulton Park, Northampton NN3 6LF, tel. 0845 121 1691, e-mail sales@cricksoft.com.



further reading

Therapy satisfaction

Keilmann A, Braun L, Napiontek U (2004) Emotional satisfaction of parents and speech-language therapists with outcome of training intervention in children with speech and language disorders. *Folia Phoniatri Logopaed* 56 (1): 51-61.

The outcome of speech-language therapy in children is highly dependent on the compliance of the treated children and their parents. 169 questionnaires of parents whose children had received speech-language therapy, usually once weekly, and 140 questionnaires of speech-language therapists were analyzed for satisfaction with the outcome of the intervention. The results showed that the majority of the parents were very satisfied with the outcome of the speech-language therapy, the professional knowledge of the speech-language therapists and the type of therapy. The speech-language therapists were in most cases pleased with the compliance of the parents. Speech-language therapists who have been working for many years tend to spend less time with parents, to consider insufficient progress as a challenge and to treat less frequently.

Acquired disorders

Catani M, Piccirilli M, Geloso M C, Cherubini A, Finali G, Pelliccioli G, Senin U, Mecocci P (2004) Rapidly progressive aphasic dementia with motor neuron disease: a distinctive clinical entity. *Dement Geriatr Cogn Disord* 17 (1-2): 21-8.

Within the group of frontotemporal dementias (FTD), the association of motor neuron disease (MND) with rapidly progressive aphasic dementia has been recognized as a distinct clinical syndrome. Although the clinical and neuropsychological features of this syndrome have been defined, the small number of post-mortem studies have had heterogeneous neuropathological findings. Cognitive, neuro-imaging and neuropathological studies were

performed on a 71-year-old male patient with rapidly progressive aphasic dementia and MND. The patient had selective non-fluent aphasia associated with hypoperfusion of the left frontotemporal cortex initially. Proton magnetic resonance spectroscopy revealed an asymmetric change of brain metabolites, with greater changes in the left temporal lobe. The bulbar manifestations of MND occurred over the following 6 months, and the patient died of bronchopneumonia. The neuropathological examination revealed loss of neurons in the hypoglossal nucleus and anterior horns of the cervical spinal cord with microvacuolation and dot-like ubiquitin-positive deposits in the frontoparietotemporal cortex, but no changes suggestive of Alzheimer's, Pick's or Lewy body disease. The findings support the conclusion that MND with rapidly progressive aphasic dementia is a distinctive clinical entity within the group of FTD-MND.

Social language

Pennebaker J W, Groom C J, Loew D, Dabbs J M (2004) Testosterone as a social inhibitor: two case studies of the effect of testosterone treatment on language. *J Abnorm Psychol* 113 (1): 172-5.

This study aimed to correlate testosterone levels with natural written language in 2 people undergoing testosterone therapy. Two participants, a man receiving treatment for loss of upper-body strength and a female-to-male transgendered individual, supplied records of injections over 1-2 years along with e-mails or journal entries as writing samples. Results showed that higher testosterone levels correlated with reduced use of words related to social connections. Language relating to anger, sexuality, and achievement was unrelated to testosterone levels. It appears that testosterone steers attention away from social connections but not necessarily toward concerns with aggression or sexual activity.

This regular feature aims to provide information about articles in other journals which may be of interest to readers.

The Editor has selected these summaries from a Speech & Language Database compiled by Biomedical Research Indexing. Every article in over thirty journals is abstracted for this database, supplemented by a monthly scan of Medline to pick out relevant articles from others.

To subscribe to the Index to Recent Literature on Speech & Language contact Christopher Norris, Downe, Baldersby, Thirsk, North Yorkshire YO7 4PP, tel. 01765 640283, fax 01765 640556.

Annual rates are CDs (for Windows 95): Institution £90 Individual £70 Printed version: Institution £72 Individual £50.

Cheques are payable to Biomedical Research Indexing.

Lifespan changes

Kray J, Eber J, Lindenberger U (2004) Age differences in executive functioning across the lifespan: the role of verbalization in task preparation. *Acta Psychol* 115 (2-3): 143-65.

Age-related changes in executive functioning across the lifespan were assessed in children (mean age=9.4 years), younger adults (mean age=21.5 years), and older adults (mean age=65.3 years). Executive functioning was investigated with a task-switching paradigm that permits the separation of two control components: to select and to switch between task sets. The specific aims

of this study were (a) to determine developmental functions in both control components across the lifespan; and (b) to examine whether age-related changes in these components are influenced by verbal prompts during task preparation. The results revealed an inverted u-shaped developmental function for the ability to select between task sets but not for the ability to switch between task sets. In contrast to younger adults and children, older adults generally benefited from verbalizations during task preparation. Children, but not older adults, showed a facilitation of task execution when verbal prompts were task-compatible. Conversely, older adults, but not children, showed stronger interference when verbal prompts are task-incompatible. Our findings suggest that inner speech is an important modulator of developmental changes in executive functioning across the lifespan.

Ethics

Sharp H M, Bryant K N (2003) Ethical issues in dysphagia: when patients refuse assessment or treatment. *Semin Speech Lang* 24 (4): 285-99.

The primary goal of intervention for patients with dysphagia is to restore oral feeding. When patients are unable to achieve adequate nutrition, hydration, or safety with oral feeding, then nonoral approaches are often recommended. Although patients' rights to accept or refuse clinical recommendations are widely recognized, when a patient refuses tube feeding or other recommendations, dysphagia specialists are left with a host of practical questions about their role in caring for the patient. We review the criteria for assessing patients' capacity to make informed choices, approaches to decision making when patients lack capacity, and the roles and responsibilities of clinicians when patients choose high-risk treatment options.

HOW I ADVANCE TOTAL COMMUNICATION

TOTAL COMMUNICATION PROMOTES EFFECTIVE AND INCLUSIVE COMMUNICATION FOR ALL INDIVIDUALS, WHATEVER THEIR ABILITIES OR DISABILITIES. THE APPROACH RECOGNISES THAT EACH INDIVIDUAL HAS THE RIGHT TO COMMUNICATE USING THE METHOD OF THEIR CHOICE. IT CHALLENGES THE BELIEF THAT INDIVIDUALS WITH COMMUNICATION DIFFICULTIES NEED 'FIXING'. INSTEAD, EMPHASIS IS PLACED ON CHANGING AND DEVELOPING THE COMMUNICATION ENVIRONMENT BY CARERS ADOPTING A FULL RANGE OF COMMUNICATION METHODS, SUCH AS SIMPLIFIED LANGUAGE, TOUCH, GESTURES, SIGNING, OBJECTS, PICTURES, SYMBOLS AND WRITING. SPEECH AND LANGUAGE THERAPISTS HAVE LONG RECOGNISED THAT COMMUNICATION IS FUNDAMENTAL TO QUALITY OF LIFE AND SOCIAL INCLUSION. THEY HAVE CONSEQUENTLY SPEARHEADED THE PROMOTION OF TOTAL COMMUNICATION ENVIRONMENTS FOR MANY YEARS, PARTICULARLY IN THE ADULT LEARNING DISABILITY FIELD.

IT IS A SIMPLE IDEA - BUT ONE THAT IS COMPLEX TO IMPLEMENT. OUR TWO ARTICLES SHOW HOW THE PROFESSION IS DETERMINED TO RISE TO THE CHALLENGE.

TOTAL COMMUNICATION (1): REACHING OUT

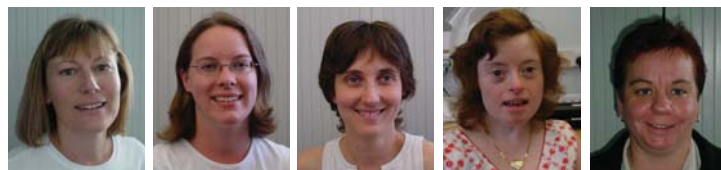
LESLEY BROWN IS A SENIOR SPECIALIST SPEECH AND LANGUAGE THERAPIST, E-MAIL LESLEY.BROWN@OXLEAS.NHS.UK, MIRANDA MUIR AND KATE GRANT ARE SPEECH AND LANGUAGE THERAPISTS, LINDA CLARK IS A SPEECH AND LANGUAGE THERAPY ASSISTANT AND JENNY FLETCHER A CO-WORKER WITH THE BEXLEY LEARNING DISABILITY SERVICE.

TOTAL COMMUNICATION (2): EXTENDING THE REACH

AT THE TIME OF WRITING RCSLT SCOTLAND OFFICER KIM HARTLEY (TEL. 0131 554 2265, E-MAIL KIM.HARTLEY@RCSLT.ORG) WAS A SPEECH AND LANGUAGE THERAPIST AND INCLUSIVE COMMUNICATION ADVISER FOR LOTHIAN PRIMARY CARE TRUST. ROSEMARY GRAY (TEL. 0131 536 8105, E-MAIL ROSEMARY.GRAY@LPCT.SCOT.NHS.UK) AND ANNE EDMONSTONE (TEL. 0131 537 6156, E-MAIL ANNE.EDMONSTONE@LPCT.SCOT.NHS.UK) ARE PROFESSIONAL ADVISERS FOR SPEECH AND LANGUAGE THERAPY FOR LOTHIAN PRIMARY CARE TRUST.

TOTAL COMMUNICATION (1): REACHING OUT

HAVING AGREED A TOTAL COMMUNICATION STRATEGY AND STANDARDS, LESLEY BROWN, MIRANDA MUIR, KATE GRANT, LINDA CLARK AND JENNY FLETCHER CONDUCTED A BASELINE IMPLEMENTATION AUDIT. THE RESULTS HAVE INFORMED AN ACTION PLAN TO REACH THE WHOLE LEARNING DISABILITY SERVICE.



Lesley Brown, Miranda Muir, Kate Grant, Linda Clark and Jenny Fletcher

Across the country a number of speech and language therapy services have been working to promote the adoption of total communication strategies. There is agreement that the key to success is to involve a wide range of stakeholders. It is particularly important to target senior managers, usually via the local Partnership Group. Some members of Learning Disability Partnership Groups are unaware of the communication needs of the client group.

This is often reflected in the extent to which service users are facilitated to participate in the group. Therapists in [Islington Primary Care Trust](#) have been working to agree a set of symbols, which will be used for Partnership Board minutes. Therapists from [Kingston Primary Care Trust](#) have developed an accessible power point presentation which explains what total communication is and what its benefits are. This has ensured that service users have been involved in discussions and has served as a useful example of how information can be presented in an accessible format. Therapists from [Salford Primary Care Trust](#) have succeeded in getting total communication included in the social services business plan. Within our [Bexley service](#), the NHS Trust has identified total communication as a 'must do' project monitored by its clinical governance committee.

At the time of writing, the Bexley Learning Disability Service Total Communication Strategy and Standards has been in place for a year (Brown, 2002). During this time Bexley therapists have organised two study days to share ideas and experiences with colleagues from elsewhere. Over the summer of 2003 we conducted an audit across the local service to review the implementation of the standards set out in the strategy.

Between late June and the end of August we carried out audit visits to 17 residential and resource centre locations within the borough of Bexley. Prior to each visit the service manager received a letter explaining the purpose of the interview and a copy of the audit form to be used (table 1). Managers were told that they would be expected to evidence any standard they said was in place.

Since the strategy and standards were agreed at the Bexley Partnership Group last Autumn, there has been a change in the local day and residential service provider. This has created a period of uncertainty and upheaval. No specific training around the strategy or standards has been provided over and above that usually delivered as part of the speech and language therapy service's day-to-day clinical work. In effect, we therefore see the audit findings as a baseline by which future progress can be measured following implementation of an action plan.

Overall, the majority of the managers interviewed were very positive about the Bexley Learning Disability Service Total Communication Strategy and Standards, and agree with the standards set out in the document. Indeed, several managers questioned why some aspects of the strategy were not already in place. Some locations have attempted to move towards some of the standards. Many, however, are yet to begin this process.

TABLE 1: BEXLEY TOTAL COMMUNICATION STANDARDS AUDIT			
LOCATION:		MANAGER:	
NUMBER OF SERVICE USERS:		AUDITOR:	
DATE:		PREVIOUS AUDIT:	
No.	Standard		Comments
Intro	Are you aware of the Bexley Total Communication Strategy and Standards?	Y/N	
4.1	Does every service user have a communication passport?	Y/N	If no, state how many do
4.2	Does every service user have a personally adapted copy of their activity timetable?	Y/N	If no, state how many do
4.3	Are any service users offered choices throughout their routine using: Written word Symbols Photos Objects of Reference	Y/N Y/N Y/N Y/N	
4.5	Have any staff had any training around communicating with people with learning disabilities?	Y/N	Give details - what, who from etc
4.7	Does every member of staff have a working knowledge of sign core vocabulary?	Y/N	If no, state how many do
4.8	Does location have: Sign of the week pack Displaying current sign?	Y/N Y/N	
4.9	Does location have: Photo staffing rota Displaying who is currently on shift Who is on the next shift	Y/N Y/N Y/N	
4.10	Does location have: a symbol timetable indicating activities for that day?	Y/N Y/N	
4.11	Does location have: Photo/symbol menu board Indicating choices for that day's menu?	Y/N Y/N	
4.12	Has location produced: Leaflets, policies, procedures etc In simplified language and symbols?	Y/N Y/N	If yes, please provide copies
Do you have any comments about any aspects of the Communication Strategy?			
Agreed actions:			
SIGNED (AUDITOR):		SIGNED (LOCATION MANAGER):	
Cc			

Our audit results had recurrent themes, which form six areas for us to tackle:

1. Communication must be seen as a basic need

The Learning Disability Service as a whole does need to consider communication. A common theme during the audit interviews, especially within services for people with challenging behaviour, was that staff do not feel they have time to develop communication when "basic needs have to be met". Communication should be seen a fundamental human need and right which must underpin all aspects of daily living. Only in this way can the service begin to address the four key principles of Valuing People - choice; social inclusion; independence and civil rights (DH, 2001).

During the audit period we also visited the local respite service for children with learning disabilities, as it is managed by the same organisation as the adult services. It is interesting to note that the manager had obtained a copy of the Bexley Learning Disability Service Total Communication Strategy and Standards, and had implemented the majority of the standards successfully. The staff were of the opinion that total communication was an essential part of their work. Indeed, they cited examples of how children's challenging behaviours had been reduced with improved communication. There is often a marked contrast in attitude and expectation of staff in children's and adult services. It is essential that therapist colleagues in paediatric and adult services work closely together to attempt to secure some continuity in terms of communication environment for service users in transition. The consensus of opinion during our study days was that there is a significant likelihood of service users' communication skills being under-utilised when they leave children's services.



2. All communication methods must be valued

Our audit confirmed a heavy reliance on spoken and written communication across the local service. Staff teams appear to find it particularly difficult to adopt methods such as signs and symbols when some of the service users they are supporting are verbal and others are non-verbal. As a result, on occasions, the views of verbal service users are taken to represent the group as a whole. Indeed, during some of the audit interviews, the impression was given that all the users of some services are verbal; only with prompting was acknowledgement given to the needs of non-verbal clients. It is essential that all methods of communication be valued, respected and promoted. It needs to be more widely recognised that non-verbal service users can make choices and express their views with the appropriate support and resources. Staff also need to be more aware that verbal service users benefit too from the use of non-verbal communication methods to support their understanding, memory and literacy.

Use of appropriate methods of communication should be a requirement, and be reflected in staff's job descriptions. We were concerned to discover that some service users are being supported by staff who do not have the appropriate communication skills and knowledge (such as signing). We were also made aware of instances of service users moving home or day service without their photo / symbol resources going with them.

3. Service managers must support and be supported

Difficulties with staff vacancies and frequent use of agency / bank staff were cited by a number of managers as a barrier to adherence to the strategy. There is no doubt that implementation and maintenance of the total communication strategy and standards

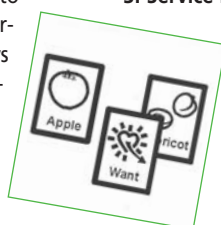


TABLE 3: TOTAL COMMUNICATION STRATEGY AND STANDARDS ACTION PLAN 2003-2004			
AIM	OBJECTIVES	BY WHO	BY WHEN
5.1 Identify how work created by strategy can best be achieved.	5.1.1 Meeting to be arranged to discuss speech and language therapy staffing and priorities and day & residential service provider role / responsibilities	Speech & language therapy manager NHS Trust Local authority Day & residential service provider	Dec 2003
5.2 Increase service managers' awareness of the strategy and support their implementation of the standards.	5.2.1 Each service manager will attend a day's workshop	Speech & language therapy manager Training dept	Feb 2004
	5.2.2 Each service manager will join and attend a Communication Strategy Network Group	Speech & language therapy Day & residential service provider	Following workshop
5.3 Develop and implement a rolling programme of staff training workshops focusing on specific communication methods	5.3.1 Meeting to be arranged for speech and language therapy and day residential services training to identify programme contents and schedule	Speech & language therapy manager	Dec 2003
	5.3.2 Programme to be advertised and implemented	Training dept	From Feb 2004
5.4 Improve quality and appropriateness of accessible information	5.4.1 Key staff from across the service to be identified for training	Day & residential service provider	Nov 2003
	5.4.2 All key staff will attend an accessible information workshop	Speech & language therapy service Training dept	June 2004
	5.4.3 All accessible information to be quality checked by speech and language therapy service	Speech & language therapy service	now

◀ would be more easily achieved through permanent and complete staff teams. However, the effects of staff turnover and vacancies could be in part ameliorated by a more robust and complete induction programme for all staff at all levels. Service managers play an essential role in modelling and monitoring good communication within their location. It is vital therefore that they feel appropriately trained and supported.

4. Training must be improved

During a number of audit interviews it became clear that, even when training had been provided, staff had not always applied and maintained the skills and knowledge gained (this is especially so with regard to signing). Consideration should be given to the methods of communication training used and to ways of monitoring outcome. We are recommending to the local service that a strong emphasis be placed on training in the coming year in order to achieve the critical mass of trained staff (at all levels) necessary to effect a change in the practice culture.

Most speech and language therapy services involved in developing total communication cite training as a key component. Some services are focusing on establishing induction training to influence attitude and expectations early on. At one of our study days we discussed the need for further training once staff have had some experience working with service users to develop practical skills. There is general agreement about the content of training, as outlined in table 2.

TABLE 2: TOTAL COMMUNICATION TRAINING

- ✓ What is communication?
- ✓ Why do we communicate?
- ✓ How do we communicate?
- ✓ Means - Reasons - Opportunities model (Money & Thurman, 2002)
- ✓ The foundations of meaningful communication
 - pre-intentional communicators
 - early intentional communicators
 - intentional communicators
- ✓ Symbolic development
- ✓ Development of meaningful language
- ✓ Key word levels
- ✓ Causes of communication breakdown
- ✓ Experiential exercises
- ✓ What is Total Communication
- ✓ Using objects of reference (Park, 1999)
- ✓ Using pictures and symbols
- ✓ Using signing
- ✓ Developing accessible information.

Discussion does need to take place as to who is best placed to carry out training. It is appropriate that the speech and language therapy service takes the lead with this work. However, given current staffing, a decision needs to be made about the balance between day-to-day, individual clinical work and additional training.

In some parts of the country, day and residential workers have been seconded to work with speech and language therapists as Communication Link

Workers or Coordinators. Julie Sutch, a speech and language therapist from Milton Keynes Primary Care Trust, has been able to second three staff, each for a day a week, from the local day centres and behavioural support team.

5. The strategy must extend to supported living

During the last year, supported living arrangements have been developed for a number of locations and service users in Bexley. There does seem to be some confusion as to whether the total communication strategy and standards apply in these instances. This should be the case. More consideration needs to be given to providing appropriate support for an individual's communication needs in order that they can take full advantage of the opportunities offered to them through supported living arrangements.

6. Accessible information must be coordinated

The audit indicated that work to produce accessible information does not appear to be coordinated. For instance, several locations have produced their own version of the complaints procedure. Often staff who have not been trained in producing accessible information or using relevant computer software are attempting to do this work. The results therefore vary considerably. As a result, some staff regard symbols in a negative light and struggle to see how they can be useful for service users.

The availability and accessibility of resources such as digital cameras, computers, colour printers and symbol software needs reviewing and developing. Appropriate training in the use of such resources is essential for the end products to be useful to service users.

The speech and language therapy service in City and Hackney has a multimedia service with designated workers. They have developed a database of photos and the workers provide support to staff in using multimedia resources.

Action plan

As a result of our audit, an action plan for the next year has been agreed by the Partnership Group (table 3). The Bexley Learning Disability Team has also included a specific objective around the communication skills of team members on its current business plan. We plan to carry out another audit next summer and hope to report our findings.

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- Park, K. (1999) Whose needs come first? *Speech & Language Therapy in Practice* Summer: 4-6.

TOTAL COMMUNICATION (2): EXTENDING THE REACH

KIM HARTLEY, ROSEMARY GRAY AND ANNE EDMONSTONE REPORT ON THE PROGRESS OF A LONG-TERM INCLUSIVE COMMUNICATION STRATEGY TO ESTABLISH A TOTAL COMMUNICATION APPROACH THROUGHOUT PUBLIC SERVICES IN LOTHIAN.



Kim Hartley, Rosemary Gray and Anne Edmonstone

A changing climate in terms of the culture of inclusion, service user consultation and involvement means that service providers are required to re-examine how they can effectively engage and involve consumers in service development and access.

Equality and accessibility of services, patient / public involvement and patient-centred services are all admirable service goals with a common essential foundation - effective communication between service users and providers. Without effective communication, providers are unable to take cognisance of the expressed views of users and, conversely, users are unable to respond effectively to information, advice and support offered by providers.

The legally enforced right to equality of access means providers can no longer narrowly restrict their communication methods to verbal and written language. They must extend their communication practices to reach out to the wide spectrum of users who have communication difficulties. This includes people with literacy difficulties, aphasia, dementia, learning disability, hearing and visual impairment and non-English speakers. A total communication approach enables providers to do just this.

In Lothian, Scotland, speech and language therapists have been working with partners across agencies to establish a total communication approach throughout Lothian public services. Locally, this development is called the **Inclusive Communication Strategy**.

The inclusive communication strategy is a long-term project, aiming to deliver services which

- are accessible to and responsive to all.
 - incorporate the attitudes, knowledge, skills and resources necessary to meet the needs of all with communication difficulties regardless of the cause of those difficulties, including congenital / acquired disability, sensory impairment, ethnic origin, literacy difficulties, educational attainment.
- An inclusive communication strategy will see cross sector development of
- a shared understanding of what communication accessible services means
 - knowledge of communication and communication difficulties among staff delivering services to the public
 - effective communication skills among the staff
 - consistent use of appropriate communication resources by the staff
 - awareness, understanding and appropriate use of interpreting and translation services by the staff
 - multi-agency structures, systems and pooled resources to facilitate development of knowledge, skills, standard resources and strategy evaluation.

Lothian lies in the south-east of Scotland and has a population of approximately 784,000. It consists of the city of Edinburgh, East Lothian, Midlothian and West Lothian, each with their own council. It covers a geographical area of 700 square miles, both urban and rural. Table 1 gives estimated prevalence figures of various populations with communication difficulties in Lothian, where they can be calculated.

Literacy difficulties	156,690
Hearing impairment	116,198
Minority ethnic groups, foreign language speakers and gypsy travellers	58,008
Pre-reading age children (< 7yrs)	44,893
Learning disability	19,233
Visual impairment	17,302
Autistic spectrum disorder	4,340
Acquired neurological conditions	2,953

Over the last few years a number of inclusive communication projects have been developed and implemented across the region by various agencies to meet the needs of people with communication difficulties. Some examples include:

- Bonnington Symbol System (Edinburgh City Council) has been designing and producing symbols based materials for adults with learning disability for over 10 years.
- Health Matters Project (Lothian Primary Care Trust and Jewel and Esk Valley College) provided a further education based course for adults with learning disabilities about effective use of primary care services. The course was delivered using a total communication approach (Christison et al, 2001).
- Better Health through Better Communication Project developed total communication environments in 85 per cent of primary care settings across two Local Health Care Co-operatives (Lothian Primary Care Trust)(examples on p.28).
- Bonnington Symbols Tri-pilot Project (City of Edinburgh Council) audited the impact of symbols in several public environments such as a library, gallery and park.
- 'The Same As You' (Scottish Executive, 2000) Service User Consultation (East and Midlothian Council) used total communication approaches to gather views from the users of adult learning disability services.
- Projects in East Lothian which facilitate transition from children's to adults' services, in relation to education and employment, have recognised the need for or incorporated inclusive communication.
- Family Advice and Information Resource (FAIR) provides information in user-friendly formats targeted at people with learning disabilities (third sector agency).
- Deaf Society, Deaf Enterprise and Deafblind Scotland provide awareness-raising information to staff in Lothian Primary Care Trust. Deaf Enterprise is undertaking a series of environmental audits to improve access to services.
- The need to involve speech and language therapists with an inclusive communication approach in the Appropriate Adult Scheme and other areas of the criminal justice system has been recognised.
- Minority Ethnic Health Inclusion Project (MEHIP) Sexual Health Information includes integration of symbols into health literature (Lothian Primary Care Division).
- Roodlands Hospital Outpatient Department (Lothian Primary Care Division) has incorporated symbols into signage and clinic information.
- The Loch Centre Project (East Lothian) has developed symbol signage with users and the general public and is rolling this out to other leisure, learning and cultural centres.
- Services for adults with learning disability in East Lothian regularly produce an accessible newsletter *Communication Links*, including photographs, symbols and simple text.

Comprehensive and consistent

Practitioners in the field recognised that there was a need for a coordinated strategy which would draw together these examples of good practice and enable wider, more comprehensive and consistent development of inclusive communication environments and also - hopefully - deliver efficiencies and economies of scale. ►

From: Better Health through Better Communication

◀ In consultation with communication service providers, a paper was produced - "Towards Inclusive Communication: An Inclusive Communication Strategy for Lothian" - to provide background information to support the initiative.

A steering committee was set up, chaired by the Health Inequalities Manager of the Primary Care Trust, with representation from speech and language therapy and the eight Lothian public sector agencies - one health board, three health trusts and four local authorities. Following much discussion, it was recognised that, to progress the strategy, it was vital to gain the support of senior managers. With this goal in mind, the steering committee organised an inclusive communication conference to:

- raise awareness of the inclusive communication strategy among service managers within the relevant agencies
- generate their enthusiasm and agreement that a coordinated approach was the way forward and
- seek their views regarding how best to move forward with the strategy.

Conference planning took many months. Originally scheduled for November 2002, it actually took place in March 2003. Funding was secured from the four local authorities, Lothian Primary Care Trust and West Lothian Trust.

To achieve the aims of the conference it was important to get high profile, influential and persuasive speakers. To this end, the conference was opened by Mary Mulligan, then Scottish Deputy Minister for Health and Community Care, and sessions were chaired by the Lothian Primary Care Trust Chief Executive Officer and the Chairman of Lothian Health Board.

Following the minister, there were five presentations from service users with communication difficulties: people with aphasia, hearing impairment, learning disability, literacy difficulties and English as a second language. Each described the barriers they had experienced when accessing services.

Speech and language therapists then put inclusive communication into a Lothian-wide context and the Scottish Accessible Information Forum described progress on the information standards they promote throughout Scottish local authorities (SAIF, 1999).

Finally there were presentations on some of the legislative and policy drivers behind inclusive communication strategy development, for example the Disability Discrimination Act, the Race Relations (Amendment) Act, the National Care Standards and the Joint Future Agenda (the integration of Health and Community Care Services in Scotland).

The afternoon sessions provided an opportunity for discussion around how to take an inclusive communication strategy forward, and poster displays of inclusive communication projects across Lothian were available throughout the proceedings.

The outcome of the conference was

- broad agreement that an inclusive communication strategy was a good idea
- the identification of the supporting structures and resources and barriers to success
- agreement that the next stage in the process was the development of a pan-Lothian policy to be implemented through local level strategies. This work is now ongoing.

Many challenges

The development of a strategy across a large geographical area involving eight statutory agencies, an enormous number of service users, relatives, carers and voluntary agencies presented many challenges. This was the first time that joint working on this scale, in terms of policy development, had been attempted in Lothian.

Medication Advice

To those filling in the chart - please read notes over page before completing the chart.
To those using the chart - always check the "patient name" is correct and that you are using the current, most up-to-date chart.

Patient's Name: _____ Prescriber: _____
Medication Name: _____ Date: _____
Dose: _____

	Breakfast	Lunchtime	Mid-afternoon	Teatime	Bedtime
Special Time					
M Monday					
T Tuesday					
W Wednesday					
Th Thursday					
F Friday					
S Saturday					
S Sunday					

To Practitioner - circle or draw the advice you want the patient to remember. Additional information can be drawn and/or written overleaf.

To Patient - remember to:

- Take medication
- Drink plenty fluids
- Eat healthy food
- Exercise
- Rest
- Make another appointment

I am referring you on to:

- Practice Nurse
- Hospital
- Health Visitor
- District Nurse
- Podiatrist
- Physiotherapist
- Speech & Language Therapist
- Occupational Therapist
- Dietician
- Optician
- Phlebologist
- Social Worker

The first challenge to the development of an inclusive communication strategy was to generate common understanding of the different consultation, communication and decision-making structures and systems within each organisation, so that the appropriate representation on the steering committee could be secured. More time spent on exploring and sharing such information in the initial discussion stages would have been helpful and avoided confusion and misunderstandings.

Another barrier to easy joint working was the cultural difference between health and social work in terms of language and attitudes expressed, for example the 'social' versus the 'medical' model.

There were also issues around different priorities, vested interests, balances of power and the perception of roles of the various agencies (for example the role of the clinical 'communication experts' such as speech and language therapists in contrast to the role of the 'organisational change agents' such as corporate communication directors). Our experience is that it takes time and perseverance to generate the shared vision and understanding of roles that is essential for successful joint working.

Another continuing debate, possibly particular to Lothian, focused on whether there is a need for a standardised symbol system and what that should be.

Discussion continues regarding meaningful service user involvement, with the recognition that this requires a variety of approaches.

The literature and professional grapevine have highlighted similar work progressing around the UK and elsewhere. We are keen to share our learning and learn from others and to this end the Royal College of Speech & Language Therapists has set up a Total Communication Network. If you are interested in being part of this network, please contact Kim Hartley, RCSLT Scotland Officer (e-mail kim.hartley@rclst.org).

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- Scottish Accessible Information Forum (1999) Standards for Disability Information and Advice Provision in Scotland. Scottish Consumer Council, Glasgow.
- Scottish Executive (2000) The same as you? (Available in full at www.scotland.gov.uk/ldsr/docs/tsay-00.asp).

Further information

- Better Health Through Better Communication - from Kim Hartley.
- Bonnington Symbol System - www.modeoperandi.co.uk/symbols/.
- Deaf Enterprise, see www.deafenterprise.co.uk.
- East Lothian and Midlothian inclusive communication projects, contact Rosemary Gray, Speech and Language Therapy Manager, Edenhall Hospital, Musselburgh, East Lothian.

events

CALL Centre

'On site' courses available include: Working together on Passports package, Brush up your Boardmaker, Clicker 4 in the Inclusive Classroom, Picture possibilities - digital photos and video.

Further information: Sandra O'Neill, tel. 0131 651 6075, e-mail sandra.oneill@education.ed.ac.uk.

I CAN

2 December 2004 Edinburgh
7 February 2005 Wales

Learning Together: Working Together - Teachers and speech and language therapists working together in the early years
19 January 2005 London

Involving Early Childhood Educators / Teachers as Language Facilitators - Advanced Workshop for Hanen Certified Speech-Language on Learning Language and Loving it - The Hanen Program® for Early Childhood Educators/Teachers

More information on these and other courses, tel. 020 7674 2790 or book online at www.ican.org.uk/professional_development.

NAPLIC (National Association of Professionals concerned with Language Impairment in Children)

Residential Conference
19-20 March 2005

University of Warwick

Speakers include Gina Conti-Ramsden, Nicola Botting, James Law, Shula Chiat, Penny Roy, Maggie Vance, Julie Dockrell and Dorothy Bishop.

Details: www.naplic.org.uk

VASTA (Voice and Speech Trainers Association of America)

First international conference - Breaking Boundaries: Crossing the Cultural Divide

9-13 August 2005

Glasgow

Details: www.vasta.org

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IN HER ROLE AS CLINICAL LEAD FOR DYSPHAGIA AND ADULT LEARNING DISABILITY FOR COUNTY DURHAM & DARLINGTON PRIORITY SERVICES NHS TRUST, HANNAH CRAWFORD (HANNAH.CRAWFORD@CDDPS.NORTHY.NHS.UK) PROVIDES SUPPORT AND SUPERVISION TO OTHER SPEECH AND LANGUAGE THERAPISTS, AND IS RESPONSIBLE FOR DEVELOPING DEPARTMENTAL GUIDELINES, POLICIES AND STRATEGIES FOR DYSPHAGIA. HANNAH HAS RECENTLY COMPLETED A CLINICAL MSc IN SWALLOWING AT NEWCASTLE UNIVERSITY AND IS A GUEST LECTURER IN ADULT LEARNING DISABILITY DYSPHAGIA ON THE QUALIFICATION COURSE AT NEWCASTLE UNIVERSITY. FROM 2004 SHE IS ALSO FACILITATING THE ADULT LEARNING DISABILITY MODULE OF THE ADVANCED DYSPHAGIA COURSE AT MANCHESTER METROPOLITAN UNIVERSITY.

1. SUPPORT AND SUPERVISION

As discussed in Communicating Quality 2, support and supervision when working in dysphagia is crucial. To maintain and develop my clinical practice, I find it useful to get second opinions, to obtain peer support when managing risk, and to debrief from emotionally difficult cases. In Co. Durham we have individual, clinical and professional dysphagia supervision every other month. We also have dysphagia peer supervision every other month, where all the speech and language therapists meet to discuss a range of areas, including cases, departmental developments, critical appraisal of research and multidisciplinary working. *RCSLT (1996) Communicating Quality 2: Professional Standards for Speech and Language Therapists. Royal College of Speech & Language Therapists: London.*

2. STETHOSCOPE

Although the evidence base for cervical auscultation is 'shaky', I still use my stethoscope quite a lot. I find it quite difficult to identify reliably all the swallow sounds discussed in the literature. However, what I do use it for is to listen to breathing - how is the breathing at rest? Does the breathing sound clear before a swallow? Does it sound clear after the swallow? Does it sound the same pre- and post-swallow? Are there any sounds suggesting residue after the swallow? Did the whole event sound quick and 'clean'? None of the evidence I gain is quantitative, but I find it useful as a screening method to rule in or out any further instrumental assessment such as videofluoroscopy. Some of the leading authors in cervical auscultation include Sandra Hamlet, Steven Leder, Julie Cichero, Alison Stroud and Pamela Zenner.

3. DEPARTMENTAL ASSESSMENT PACK

As is the case with many areas of adult learning disability work, there is a dearth of equipment and materials specifically designed for the dysphagia client group. In our department we have developed a detailed assessment pack that includes a case history, orofacial assessment, observation assessment, cervical auscultation recording chart, videofluoroscopy protocol and report writing guidelines. I now could not be without this and find it keeps me focused throughout the assessment process. It provides information that can be used by any of the speech and language therapists in the trust if necessary, and gives a clear framework for feeding back information and monitoring.

4. VIDEOFLUOROSCOPY

Despite a wealth of evidence for and against the use of videofluoroscopy, in the absence of any more reliable instrumental techniques it remains the 'gold standard'. I find videofluoroscopy an invaluable resource and am using it with increasing regularity. I often have reservations about whether it will be possible for a particular client, for example due to positioning, or concerns about the procedure - however, I have never had to abandon an assessment yet. This is often a testament to the client, carers and radiology department staff. In addition, the information has always been useful either to demonstrate and reinforce recommendations, or to alter them.

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5. MULTIDISCIPLINARY TEAM WORKING

I find the support of my multidisciplinary colleagues invaluable. Again Communicating Quality 2 stresses the need for the speech and language therapist to work within the multidisciplinary framework, and in Co. Durham I am lucky to have the support of many. In particular I work closely with occupational therapists, physiotherapists, community nurses, care co-ordinators, dieticians, carers and GPs. I find this multidisciplinary team framework especially helpful when considering managing risk, which is often necessary in adult learning disability dysphagia. To contribute to the effectiveness of a multidisciplinary team, you initially need to be prepared to clarify your role, especially as we are integrating with social care and working with new colleagues. I also find it useful to be assertive, open and honest, flexible, to listen and to have a good sense of humour.

6. THICKENERS

It would be just about impossible to practise as a dysphagia clinician without access to thickeners to trial with clients. I like to develop good links with thickener sales representatives. I can then sample other products that may be useful for my clients, such as pre-thickened drinks and ready-made foods. We are in consultation with one of the companies about the idea of a home delivery service, providing a range of products direct to clients' doors. This will reduce the inconvenience of having to organise repeat visits to the surgery and chemist, and may allow the client access to a wider range of products.

7. CAMCORDER

For a variety of reasons, I find camcorders very useful in my clinical practice, for example to take along to initial assessments and monitoring visits. Reviewing videotapes allows me to observe what is going on in the wider environment that I may have missed when focusing on the client. They also let me double check observations made at the time. Keeping video tapes then allows me to monitor the progress of the client, providing concrete methods of measuring outcomes. If consent is given, they also make a valuable teaching resource.

8. CONTINUING PROFESSIONAL DEVELOPMENT

The need for continuing professional development is a core requirement for continued clinical practice, as dictated by the Royal College of Speech & Language Therapists. In Co. Durham we have good access to and support for professional development activities, including reading, our departmental dysphagia peer supervision, local Special Interest Groups and external training. Although I am focusing on my MSc, I enjoy accessing the wide range of good quality training available in the North and North East.

- RCSLT, see www.rcslt.org
- North Eastern Speech & Language Therapists Association (NESTA), see www.nesta25.com.

9. COMPUTER

When I thought about things that I could not do without, or that I use every day, my PC was one of the major items. I use it for compiling information, developing resources, writing reports, writing and delivering presentations, e-mailing and statistical analysis, to name but a few. This leads on to the use of the....

10. INTERNET AND ELECTRONIC DATABASES

With the ever increasing need to ensure practice is evidence based, I find access to electronic databases, and the wealth of information available on the internet, crucial. I have received training during the course of my MSc so now I know how to do focused literature searches and arrive at the evidence I want, rather than obtaining 10,000 references to wade through! Medline (see for example <http://omni.ac.uk/medline/>) and Web of Science (<http://wos.mimas.ac.uk/>) are particularly useful search engines for our profession.