

Speech and language therapy provision for people with dementia

Position Paper

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for review 2010



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Foreword

Speech and language therapists (SLTs) have an increasingly recognised and well-documented role in providing services for people with dementia, in spite of this being a relatively new area for the profession (see page 11 of this document). Service development has evolved in patches within the NHS.

Some centres now have well-established speech and language therapy services, which are integral within the multidisciplinary team (Heritage and Farrow, 1994). In these services, research activity takes place contributing to the development of the evidence base. In other areas new funding has been secured to develop small initiatives.

However, there remain many parts of the country where people with specific communication or swallowing needs are not able to access a specialist speech and language therapy service in relation to dementia (Ponte, 2001).

Given that the UK population is ageing and that the projected growth of people with dementia could be 1.5 million by 2050 (Alzheimer's Society, 2004), this situation is particularly concerning. Access to SLT services is currently a postcode lottery.

The Royal College of Speech and Language Therapists (RCSLT) believes that any older person with a communication disorder or dysphagia (eating, drinking and swallowing disorder), including those with a diagnosis of dementia, has a right to access a professional with expertise in these areas.

This is reflected in current UK government policies on needs-led services. The current situation of speech and language therapy service provision to people with dementia is not meeting these policies and is therefore unacceptable.

“any older person with a communication disorder or dysphagia ...including those with a diagnosis of dementia... has a right to access a professional with expertise in these areas”

1 Introduction

This position paper highlights the speech and language therapy provision that should be available to ensure equity of access for people with dementia, and the key role that SLTs should have within dementia teams.

These speech and language therapy services should be adequately planned and resourced, based on local demography and need.

The paper is intended to advise and generate discussion between commissioners and service providers regarding providing speech and language therapy services that meet the needs of people with dementia, their families, carers and other professionals in line with current national policies.

An expert panel of SLTs convened by the RCSLT has produced this document after extensive consultation with the SLT profession.

The RCSLT would like to thank all those who have contributed and particularly acknowledges the input of the expert panel.

The RCSLT is also grateful to the Alzheimer's Society for their support in allowing sections of their own policy to be incorporated within this document.

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2 Definition

There are over 100 different causes of dementia. The most common are Alzheimer's disease, vascular dementia and dementia with Lewy bodies.

Every person who experiences dementia does so in their own individual way, but there is usually a decline in memory, reasoning and communication skills and a gradual loss of the skills needed to carry out daily activities (Alzheimer's Society UK).

The ICD-10 criteria (World Health Organisation, 1992) definition of dementia includes:
“impairment of memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement” as features of dementia.

The *National Service Framework for Older People* (England) 2001 describes dementia as a “clinical syndrome characterised by widespread loss of function” and includes “language impairment...” as one of the features.

Although not curable in most cases, there have been many recent advances in treatments available to people with dementia, including various drug treatments as well as other therapeutic interventions.

3 Demographics

- Dementia currently affects over 750,000 people in the UK
- Dementia affects one person in 20 aged over 65 years and one person in five over 80 years of age

The number of people with dementia in the UK has been estimated as follows, using population figures for 2001:

England: 652,600
Scotland: 63,700
Northern Ireland: 17,100
Wales: 41,800

It is essential that more detailed local demographic information is also gathered to inform local needs.

The well-established prevalence rates for dementia in the UK are:

Age (years)	Prevalence
40-65	1 in 1000
65-70	1 in 50
70-80	1 in 20
80+	1 in 5

Communication disorder becomes apparent during the course of all types of dementia, varying according to disease type, duration and other factors including premorbid skills and environment (Bryan and Maxim, 1996). It may be an initial presenting feature of the disease.

Studies that look at the incidence of swallowing difficulty in dementia show a high rate of dysphagia: 68% of those in a Home for the Aged (Steele *et al* 1997). Horner (1984) found that bronchopneumonia was the leading cause of death in Alzheimer's disease; 28.6% in this study were found to be aspirating.

Swallowing problems are also a concern in other types of dementia eg, vascular dementia (Stach, 2000) and those conditions where neurological signs are present alongside cognitive impairment eg, Huntington's disease, progressive supranuclear palsy, Parkinson's disease and dementia with Lewy bodies (Logemann, 1998).

Younger people with dementia

While dementia is often perceived as affecting older people, in fact over 18,000 people aged under 65 years are affected in the UK. People with learning disabilities may experience a higher risk of dementia because of premature ageing.

For example, by their fifties, approximately half of people with Down's syndrome will be exhibiting some features associated with Alzheimer's disease (Down's Syndrome Association). Other studies such as Tyrell *et al* (2001) document the numbers of people with Down's syndrome that are affected by dementia.

Projected growth

- It is estimated that by 2010 there will be about 840,000 people with dementia in the UK. This is a rise of 12%.
- This is expected to rise to over 1.5 million people with dementia by 2050.

The RCSLT recently undertook work on behalf of the Older People's Care Group Workforce Team in England and estimated that the percentage of service time spent on this client group needs to increase significantly to meet the needs of the person with dementia and their family/carers (RCSLT, 2002).

4 National context

Current government policy

The *National Service Framework (NSF) for Older People* (England), *National Service Framework For Older People in Wales* (in preparation), *Adding Life to Years* (Scotland) and the Northern Ireland Dementia Policy all make recommendations for the care of people with dementia.

These recommendations refer to access to specialist services which include speech and language therapy. The following statements are taken directly from the NSF (England) and are reflected in the other policy documents:

- **Key interventions** – Mental health services for older people should be community-orientated and provide seamless packages of care and support for older people and their carers. The hallmark of good mental health services is that they are: comprehensive, multidisciplinary, accessible, responsive, individualised, accountable and systematic. (7.7)
- **Access to specialist care** – Specialist mental health services ... should provide a range of services from diagnosing and treating more complex problems, to providing community and inpatient services for those with a clinical need (7.17)

4 National context continued

- **Referral to the specialist mental health service** should be considered for those with suspected dementia:
 - > if the older person has complex or multiple problems, for example, where an older person needs specialist methods of communication due to their sensory impairments (7.42).
- Service model – **A comprehensive mental health service for older people** will involve providing a specialist mental health service for older people. The **specialist mental health service for older people should have agreed working and referral arrangements with speech and language therapists.** (7.44/7.48).
- Specialist mental health services should provide **training and advice** for other professionals and staff whose responsibilities include providing care and treatment for older people with mental health problems (7.54).
- Specialist mental health services for older people should provide **advice and outreach** to those providing:
 - > primary care
 - > residential care and nursing homes, and sheltered housing
 - > domiciliary care
 - > day care
 - > hospital care, where there are known to be particularly high levels of mental health problems in older people (7.56).
- Carers of older people with mental health problems may need **information, advice and practical help** to support them in caring for the older person (7.8).

The draft *National Service Framework for Older People* (Wales) states that:

- The maintenance of good mental health, effective treatment of mental health problems and support for older people and their families depends upon ... **effective, person-centred health and social care**, delivered by integrated, seamless and comprehensive services.

- **Community focused specialist mental health services** for older people form a network, usually with a community mental health team, which will be multidisciplinary and usually multi-agency. Core team members will include consultant psychiatrists specialising in old age psychiatry, community mental health nurses, clinical psychologists, occupational therapists, social workers, physiotherapists and **speech and language therapists.**

The progress report *Better Health in Old Age* (DH England, 2004) states that:

"Further investment in specialist old age mental health services is required to provide care for those with the greatest needs as well as providing advice and support to mainstream services."

The *NHS Plan* (DH England, 2000) stresses the importance of patient-centred care and the involvement of the public in planning local services. Special effort needs to be made if people with dementia are to participate in these initiatives and derive the benefits of empowerment that are being advanced for older people in general.

Other relevant reports

The *Forget Me Not Report* (2000) published by the Audit Commission emphasises the need for services such as speech and language therapy to be available in primary care and residential settings. The need for commissioners of healthcare to be aware of the value of speech and language therapy is also emphasised.

The influential Health Advisory Service report, *Not because we are old* (2000), which examined the treatment of older people in UK general hospitals concluded that: "where they were present, therapists are highly valued and seen as making an important contribution.

"In addition to their own specialist skills, they had an important role in training and supporting others. These specialist staff also played a very important role in shaping the overall 'philosophy' of the ward team and in emphasizing goals of maximizing independence".

It is well documented that carers of people with dementia experience high levels of stress and burden that impact on their own mental health and adversely affects relationships.

The Audit Commission report, *Support for Carers of Older People: Independence and Well-being* (2004), highlights the need to provide support to carers of older people and outlines the importance of including them in care planning.

5 Philosophy of care

The current policy agenda is clear in that services should be “designed around the needs and choices of patients, service users and citizens”.

It is emphasised that service users should have greater choice in the care they are able to access and that “diversity of service provision will be required to increase choice for service users”. (*Better Health in Old Age*, DH England 2004).

The NSF (England) states that: “Older People and their carers should receive person centred care and services which respect them as individuals and which are arranged around their needs” (NSF Standard 2). This should also be reflected in services for people with dementia and their families and carers.

This philosophy was encompassed within the work of Kitwood (1997) and has been developed and expanded by a number of researchers and practitioners.

The notion of personhood with its emphasis on preserved ability and well being encourages the belief that all people with dementia, at all stages, have something to communicate.

There has also been renewed interest in cognitive rehabilitation for people with dementia (Clare and Woods, 2001) enabling people to achieve an optimal level of physical, psychological and social functioning.

Stokes (2000) has argued that challenging behaviour is often an attempt by the person to make sense of the environment or communicate an unfulfilled need.

Through careful communication with the person, the caregiver can take steps to understand the hidden meaning concealed by the confusion and therefore take steps to reduce the incidence of challenging behaviour.

It can therefore be seen that optimising the communication skills of both the person with dementia and of the caregivers is a central theme to providing person-centred care.

Assessment and treatment should be individualised, should draw from the broad range of approaches available and should take account of the increasingly well-documented evidence regarding patterns of language breakdown in different forms of dementia (Snowden 2000).

It is therefore essential that all people with dementia and their carers are able to access specialist services such as speech and language therapy if this agenda and philosophy is to be met locally.

6 The role of the speech and language therapist

SLTs have clinical expertise in the areas of communication disorder and dysphagia (eating, drinking and swallowing disorder) and are therefore essential in the care and management of this population by the contribution of specialist knowledge and skills within the specialist mental health team.

All people with dementia should have access to these specialist services.

- SLTs aim to maximise functional gain from residual skills based on specialist assessment.
- SLTs have specific skills in analysing, diagnosing and managing communication disorder and dysphagia and are trained to use a variety of techniques to do this.
- The role of the SLT encompasses working with clients, their carers and the multidisciplinary team from the early to late stages of the disease providing services that aim to enable people to retain a sense of independence/self worth and remain at home for as long as possible.
- The SLT aims to reduce the impact of the communication disorder and/or dysphagia on the person and their carers by providing advice, training and support to them and the multidisciplinary team, for example to enable people to participate in decision making.

People with dementia do not receive all of their health and social care within one setting. SLTs working in other sectors such as acute medical, rehabilitation and learning disability, should have an understanding of the needs of people with dementia in order to adapt their intervention accordingly.

SLTs working in different settings should be able to access professional support from a specialist SLT in managing people with dementia.

Services should not be withheld from people on the grounds of the diagnosis of dementia, but rather should be determined on the clinical need of the person.

7 The benefits of providing a speech and language therapy service

The SLT can support people with dementia; caregivers and the wider health and social care team in a variety of ways.

- **Specific analysis of language disorder to inform differential diagnosis**

There is now recognition that different causes of dementia lead to different patterns of cognitive decline (Neary, 1999; Snowden, 1999).

Neuropsychological assessment has an important contribution to make to differential diagnosis of dementia. Assessment across a range of cognitive domains including language is required to decipher these different patterns of impairment.

Detailed language assessment is particularly important in examining frontotemporal dementia and the progressive aphasias (Snowden and Griffiths, 2000).

SLTs are qualified to carry out such assessments and therefore have a crucial role to play when language symptoms are prominent eg, frontotemporal dementia, progressive aphasia, language presentations of Alzheimer’s disease and corticobasal degeneration.

Examination of speech disturbance and dysarthria by the SLT may be important in those conditions affecting motor and subcortical areas eg cognitive difficulties associated with Parkinson’s disease, dementia with Lewy bodies, vascular dementia, Huntington’s disease.

SLTs have a key role in the recognition of different types of dementia (Snowden and Griffiths, 2000) and make a vital contribution to early diagnosis (Garrard and Hodges, 1999). They are also able to monitor the course of the dementia including changes to language skills and communication as a result of drug treatment.

- **Specialist assessment of dysphagia**

When dysphagia occurs as a feature of dementia, difficulties presented at mealtimes are often complex and will include feeding, positioning, behavioural and psychological problems (Steele *et al* 1997). It is known that the correct specialist advice and management increases independence, helps to maintain eating skills and can reduce the risk of undernutrition (Alzheimer’s Society, 2000). Management of eating and drinking should always encompass the person’s cultural needs.

- **Provision of specific programmes to maximise function**

There is a growing body of evidence to justify that intervention with people who have dementia improves communication (Powell, 2000). Communication in semantic dementia can be maintained and enhanced by specific interventions (Snowdon and Griffiths, 2000). Communication disorder in Korsakoff’s dementia associated with memory difficulties has been shown to respond to a validation approach to communication management (Bryan and Maxim, 1998).

- **Ensure carers expectations of communication are realistic**

It is within the remit of the SLT to identify strengths and needs of an individual, to clarify what can be expected in terms of communication and to assist others in managing communication disorder (Stevens and Ripich, 1999).

Unrealistic expectations can lead to communication breakdown and stress for both parties. The SLT is able to provide intervention at specific stages of the progression of the disease thereby assisting carers to develop more realistic expectations and appropriate coping mechanisms (Barnes, 2003).

- **Reduce stress and burden on caregivers by providing specific management strategies**

Haley *et al* (1994) found that carers of people with dementia rated behavioural and communication problems as more stressful than daily living and self-care impairments. It is therefore important to provide carers with strategies to manage such difficulties as burden has been shown to improve with intervention (Barnes, 2003).

Intervention for dysphagia focuses on care practice, environmental modification, adaptation of equipment and texture modification of food and drinks. These modifications reduce the impact of the dysphagia and improve nutritional intake (Biernacki and Barratt, 2001).

Mealtime difficulties such as food refusals, difficulty eating certain foods textures and coughing/choking when eating can be challenging and stressful for caregivers.

- **Maintenance of an ongoing interpersonal relationship between the individual and carers**

Profile based assessments allow the communicative relationship between the person with dementia and their carers to be analysed in terms of the use of communication strategies and their success (Perkins *et al*, 1997) and targeted advice given to improve/maintain these.

7 The benefits of providing a speech and language therapy service *continued*

- **Maintenance of function in later stages of the disease**

Work by Le Dorze *et al* (2000) suggests that viewing caregivers as communicative partners who can take on a greater share of the communicative burden as deterioration progresses is a positive way to encourage communication by direct intervention.

SLTs can advise on adapting existing provision to enable the inclusion of people with advanced dementia in activities and to help staff achieve effective communication with them (Powell, 2000).

- **Enable carers and other professionals to provide the optimum environment for communication and eating and drinking**

The environment of people with dementia is a crucial determinant of their well being. SLTs can advise on how to enhance the communication environment by passive enrichment and improvement of active interaction between people and their physical and social surroundings (Lubinski, 1995).

Manipulating the environment may significantly increase the patients' ability to take an adequate diet. SLTs can provide detailed assessment of the eating environment and make appropriate recommendations to ensure maximum independence. (Osborn and Marshall, 1992).

- **Contribution to multiprofessional problem solving and care planning**

Inability to communicate effectively may be the cause of many challenging behaviours (Stokes 2000; Bryan and Maxim, 2003).

Heritage and Farrow (1994) found that the work of the SLT was most effective when the SLT was a permanent and specialist member of the multi-professional team.

As well as specific benefits for clients, the whole team benefitted from heightened awareness of communication disorder and advice and training on how to manage it.

Difficulty in eating and drinking may need a specialist view to differentiate challenging behaviour from dysphagia. SLTs train the multidisciplinary team in the assessment and management of clinical risk associated with dysphagia and in the provision of nutrition that maximises independence and reduces clinical sequelae (VOICES, 1998).

- **Assessment of capacity to consent to treatment and care**

SLTs are uniquely qualified to assess an individual's capacity to communicate and understand information and to advise on the most effective means of presenting information and choices to the individual, maximising their opportunity to exert free choice.

- **Act as advocate for people with communication disorder**

All people with dementia have the right to maintain optimal use of their residual communication.

Supporting and enabling communication is an ethical obligation for healthcare professionals (Barnett, 2000; Allan, 2001).

SLTs have the specialist skills to facilitate optimal communication, maximising the individual's choice and degree of control.

- **Train others to manage communication and dysphagia**

As the person with dementia deteriorates, caregivers spend less time communicating and more time supervising them (Marin, 2000).

Nurses working in the traditional model of dementia care may feel intimidated and frustrated by their attempts to communicate with clients (Packer, 1999).

The SLT has skills to enhance the performance of others and to optimise communication throughout the duration of the illness (Maxim *et al*, 2001).

- **Specialist input to inform decision making around non-oral feeding**

Decision making regarding non-oral feeding involves complex medical and ethical discussions. The SLT has a vital role in contributing information to the team (including the person and carers) regarding the safety and efficiency of oral intake and the prognostic indicators for change (Kindell, 2005).

- **Specialist input to clinical networks for policy development, risk management, ethical decision-making, research and audit**

The SLT has unique skills and expertise that complement and complete the knowledge base of the multiprofessional team within specialist mental health services for older people (Griffiths and Baldwin 1989).

8 The risks of not providing a speech and language therapy service

Risks to individuals

- **Decrease in quality of life and sense of well being for both the person and their carers**

The loss of meaningful interaction and conversation places increased pressure on the caring relationship (O'Connor *et al*, 1990; Nolan *et al*, 2002). Gilleard *et al* (1984) found that carers of people with dementia exhibiting communication and behavioural difficulties were twice as likely to report symptoms of their own psychiatric distress.

Dysphagia has well documented effects on physical health but also has adverse effects on self-esteem, socialisation and enjoyment of life including anxiety and panic during mealtimes (Ekberg, 2002).

- **Reduced access to and benefit from necessary interventions from other professionals**

People with dementia have complex needs and it is therefore vital that services are coordinated and seamless.

The problems they face include delays in diagnosis, poor integration of the different agencies providing care and lack of understanding about dementia and dementia services among key professional groups (Audit Commission, 2000 and 2002; Briggs and Askham, 1999).

As communication is so fundamental, SLTs should be core multidisciplinary team members readily accessing and being accessed by other professionals, sharing goals of intervention and preparing joint goals.

Evidence suggests that SLTs have a role in assisting other professionals to achieve effective communication with patients who have dementia (Orange and Ryan, 2000).

- **Social exclusion**

Within the population with dementia, there is a group of people with specific communication difficulties (ie where language is the domain most affected) who are particularly vulnerable to social exclusion and warrant specific service provision.

Hagberg (1997) suggests that intervention should aim to enhance coping skills and self-efficacy, combat threats to self-esteem and help the person with dementia to make the best possible use of their individual resources.

- **Increased level of dependence at an earlier stage**

Communication skills are vital for independence. Communication and memory therapy for people with early dementia can maximise and maintain communication skills and independence for longer (Clare and Woods 2001; Powell 2000; Bourgeois 1991).

In the early stages some areas of cognition may be relatively spared and some individuals may be able to learn and retain strategies taught to them to increase communicative effectiveness and therefore reduce dependence (Azuma and Bayles 1997; Acton *et al*, 1999).

Training for carers within the residential setting has been shown to be effective (Jordan *et al*, 2000) and the role of SLTs as trainers has been outlined (Maxim *et al*, 2001).

The onset of feeding dependence correlates with the onset of dysphagia in dementia. It is therefore essential that staff and relatives caring for the person with dysphagia are aware of ways in which they can assist and prompt without reducing the person's ability to self-feed (Siebens, 1986).

- **Avoidable death due to malnutrition, choking and aspiration pneumonia**

Dysphagia, if not managed, results in malnutrition (Hudson, 2000) and dehydration, and is a causal factor in repeated chest infections and choking risk. However, weight loss in dementia is not inevitable (Wang, 1998).

Oropharyngeal aspiration is an important etiological factor leading to pneumonia in older people. Pneumonia is a major cause of morbidity and mortality in older people and is the leading cause of death among residents of nursing homes (Marik and Kaplan, 2003).

El Sohl *et al* (2004) examined the indicators of recurrent hospitalisation for pneumonia in the elderly and found swallowing dysfunction to be top of their list of hazardous variables, followed by smoking, use of tranquilisers.

These studies highlight the importance of swallowing assessment to manage aspiration and the consequences on morbidity, mortality and hospitalisation.

- **Delay in diagnosis and/or incorrect diagnosis**

As outlined under benefits above, SLTs have a crucial role in differential diagnosis particularly where language disorder is prominent. Without contribution of this specialist knowledge and skills as part of the team, people may be misdiagnosed and appropriate treatment delayed.

8 The risks of not providing a speech and language therapy service *continued*

- **People excluded from decision making and service planning**

The SLT is often the person best qualified to advise on the most effective means of presenting information and choices to the person with dementia who has significant communication disorder, in a way that maximises their opportunity to exert free choice. This is a particularly important role for SLTs in relation to current legislation such as the *Adults with Incapacity Act (Scotland)* and the draft Mental Capacity Bill (England).

Risks to organisations

Organisations are at risk of receiving formal complaints, high profile adverse publicity and becoming involved in costly litigation if they fail to meet the policy agenda, or as a consequence of incidents involving individuals or groups of patients as highlighted below.

- **Organisations will not be able to meet government policy agenda**

Lack of provision of SLT to people with dementia contravenes several aspects of current policy agenda from those subsections of national policies already referenced (equal access; person centred care; choice, seamless care, support for carers etc.) to the *Human Rights Act 1998*.

The following articles of the *Act* may be particularly relevant:

- 2 – The right to life, which shall not be taken away arbitrarily.
- 3 – The prohibition of torture, inhuman or degrading treatment or punishment.
- 5 – The right to liberty and security of person.
- 10 – The right to receive and impart information and ideas...regardless of frontiers.
- 14 – The right not to be discriminated against.

- **Unnecessary admission and readmission to hospital and residential/nursing care**

A study by Brodaty and Peters (1991) showed that training carers reduced unnecessary admission and was cost effective in avoiding respite and residential care costs. Direct SLT intervention with carers providing training, advice and support on communication disorder and memory difficulties enables them to continue in the caring role for longer (Barnes, 2003).

People with dysphagia are often admitted to hospital when they reach the stage of severe malnutrition or aspiration – timely intervention can prevent this. SLTs can give advice re: reduction of clinical risks, maximising independence and improving well being in people with dementia related to their mealtimes.

Optimal management of dysphagia should reduce clinical risks and decrease the need for crisis management and hospital admissions.

- **Challenging behaviour not managed effectively**

Goudie and Stokes (1989) first proposed that much challenging behaviour can be understood within the framework of poorly communicated need.

Failure to evaluate and maximise potential for communication may contribute to unmet needs, frustration and behavioural change.

Staff who are trained to recognise how people in their care communicate distress, anxiety or pain through their behaviour (verbal and non-verbal) are better equipped to identify the triggers of challenging behaviour in an individual, and address the potential for a person with dementia to harm themselves or others.

- **Needs of vulnerable adults not met**

Those with communication disabilities are particularly vulnerable to abuse or neglect and are least able to report it.

Organisations have a duty of care to ensure that staff are alert for signs of abuse/neglect. Effective and sensitive communication skills are required for this purpose. Kitwood (1990) describes the malignant social psychology in which people with dementia are disempowered and denied a voice.

Optimal management of communication including training carers and care staff may help to protect and meet the needs of this vulnerable group.

- **Perpetuation of the current postcode lottery re: access to SLT services**

A survey of old age psychiatry services (Challis *et al*, 2002) indicated that many services are not fully multidisciplinary and that service variability continues to exist with many services not yet fully compliant with the standards in the *NSF for Older People (England)* (2001).

An Alzheimer's Society report on eating and drinking in dementia (2000) found that while a third of respondents were concerned about swallowing difficulties, few (8% carers and 40% care professionals) had obtained SLT advice.

In addition, the survey by Ponte (2001) showed that 40% of NHS providers did not offer specialist SLT assessment and advice for communication problems in dementia.

Therefore, there is current evidence of inequity of both access to, and provision of, speech and language therapy, communication and swallowing services (Ponte, 2001).

- **Perpetuation of inappropriate/harmful practice**

Without comprehensive assessment and advice people may inadvertently be inappropriately managed. For example, those with communication problems may be at risk of isolation and social exclusion and if this is not managed, depression. Those with dysphagia are at risk of malnutrition and aspiration (Orange and Ryan, 2000).

9 Key recommendations

- There should be equity of access to speech and language therapy services across the UK rather than the current situation of a postcode lottery. Commissioners and service providers should therefore examine the SLT services they currently provide.
- Speech and language therapy services should provide equal access to intervention for communication and swallowing disorders.
- Speech and language therapy services should be adequately resourced to provide quality care for people with dementia.
- Speech and language therapy services for people with dementia should be provided within an integrated multidisciplinary context to ensure the philosophy and goals of intervention are shared and consistent.
- "Cost per case" arrangements or service level agreements with minimal levels of provision for SLT are unlikely to provide a service of the quality and expertise that people with dementia require.
- Communication and swallowing are the responsibility of the whole team – the role of the SLT is to empower and educate others as well as providing direct specialist input as appropriate.
- Early speech and language therapy intervention is crucial so that people with dementia and their carers have their needs met in a timely way.

10 Further information

This document complements several other RCSLT publications, which are outlined below:

Reference Framework Underpinning Competence to Practice (2003) – The framework provides a guide to the range of knowledge and skills a therapist needs in order to work at a basic and competent level with a given client group.

Clinical Guidelines (2003) – The guidelines contain recommendations that are explicit statements providing specific clinical guidance on the assessment and management of each clinical area. Each recommendation is supported by evidence from the literature or is based upon the consensus of clinical experts.

Communicating Quality 2 (1996) – currently under revision – Standards and guidelines that represent the benchmarks of SLT practice and provide criteria against which compliance can be judged.

RCSLT Position paper speech and language therapy provision for adults with learning disabilities (2003) – This document provides a detailed account of the principles and processes surrounding good practice. It also discusses the wider policy and service delivery issues that SLTs need to engage with if they are to work effectively in this field.

RCSLT Workforce Project – work in progress (due for publication 2006) – this project aims to define service models and skill mix required for SLT services to different client groups.

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