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The official magazine of the Royal College of Speech & Language Therapists



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COVER STORY:

Christopher Place offers integrated workshops for SLTs and OTs treating children with ASD

See page 9 for details

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A new look for *Bulletin*



Welcome to the new look *Bulletin* and *Bulletin Supplement* magazines. I hope you will enjoy the new design and the use of colour. Notice we have tried to keep the most distinctive features of our *Bulletin* while updating the format.

Remember to look at the extra pages of news and articles that will now appear in the *Supplement* section. The inclusion of extra editorial in the *Supplement* means College can inform you about the latest developments on important matters, such as Agenda for Change – where developments often occur too rapidly to be covered solely by a monthly publication.

Like any evolutionary process, the process of change is ongoing. Obviously, the introduction of colour and the new design is an instant transformation, but over the next few months, the editorial team will continue to make improvements to bring you a truly professional magazine.

The inclusion of advertising in *Bulletin* is in response to the Department of Health's (DH's) decision to develop a website to advertise NHS jobs. As public sector advertising revenue makes up a large part of College's annual income, the success of the DH's activities in this area could mean a reduced budget for the RCSLT.

The *Bulletin* team is building up a database of potential advertisers. So, if you have been impressed with any products or services you have used recently, and think that your colleagues would benefit from knowing about them, email: bulletin@rcslt.org and let them know. I also know they're keen to hear what you think about the changes they've made and will use these comments to further develop the magazine titles. If you would like to contact me, I would be grateful to hear your views. Email: caroline.fraser@rcslt.org

Caroline Fraser
Chair, RCSLT

LETTERS

Inclusion at its best

I read with interest the article on NASUWT's views about the SEN inclusion policy in June's *Bulletin* ('Inclusion policy a disaster says teachers' union', p6).

I am an SLT working in language units. At present our LEA is proposing to close one of the units in our county. This, it is said, is due to the increasing numbers of children with complex speech and language difficulties whose needs are being met in their local schools.

I am unaware of any evidence to point towards the effectiveness of treating these children in their local schools. To

my mind, language units are inclusion working at its best, as the children are fully integrated into the mainstream and yet have dedicated and specialist staff on site to help them with any specific difficulties.

I would be interested to hear if anyone has any evidence to support working with complex speech and language difficulties within their local schools and if any other language units in the country are facing similar problems.

Stephanie Delvin SLT
Cullercoats, Tyne & Wear
email: aces.delvin@virgin.net

Dysphagia research forum

For some time now there has been a nucleus of UK researchers who have made a significant contribution to the body of research evidence in dysphagia. In collaboration with some of these key researchers – David Smithard and Shaheen Hamdy, in particular – we are contacting SLTs to get their views/opinions and possible support for a UK dysphagia research society.

The purpose of this would be to present research activity and discuss developments in the field. The constitution of this organisation is, as yet, in its very early stages.

However, there is clear consensus that the drive of this meeting should be the science that underpins dysphagia. It would be multidisciplinary and receptive to all scientists and clinicians contributing to this research field.

If we get a good response, we plan to organise an initial meeting in late September to discuss the organisation

and a programme for our first meeting. It would be beneficial if you could indicate if you would like to be part of the initial steering committee, or if you feel there is someone else with research expertise that has not been contacted whom you would like to nominate.

We would also be really keen to hear from other people who have links/plans for a meeting such as this one, so we do not replicate work that has already been done.

Please feel free to forward this to anyone with an interest in dysphagia research. Email: m.power@fs1.ho.man.ac.uk; shaheen.hamdy@man.ac.uk or david.smithard@ekht.nhs.uk for more details.

Maxine Power
Research Practitioner/Lecturer,
Department of Stroke Medicine
Salford Royal Hospitals NHS Trust

AfC threat leaves SLTs feeling undervalued

RCSLT CEO Kamini Gadhok has delivered a firm message to the government about College members' concerns over the effects of Agenda for Change (AfC)

Speaking on BBC Radio 4's *You and Yours* programme on 9 June, Ms Gadhok said the profession did not feel valued and thought that government did not care about people with communication difficulties.

"The RCSLT has been working very hard with government on workforce planning and on encouraging SLTs who have had children to return to the profession. We've also worked with them on modernising services, to improve service development and delivery," Ms Gadhok said. "But we feel all this good work is now in jeopardy as a result of government introducing Agenda for Change."

Ms Gadhok told *You and Yours* that in one of the early implementer test sites four highly experienced and expert SLTs will lose £7,000 per year as result of AfC.

"And at a recent conference, a senior civil servant informed 200 SLTs that we would face a significant pay cut.

"Our main concern is that therapists will leave the profession and it will also be seen as a less attractive career choice for students. There is evidence that many who are now qualifying are considering leaving fairly soon.

"Even though the government is investing heavily in training, the new pay and conditions will not support the retention of staff."

Ms Gadhok added that SLTs were looking at alternatives to the NHS.

"The NHS has developed a really excellent service in some parts of the country. Some SLTs are internationally renowned for their work, and in fact work abroad to support others. It would be shame if we lost that expertise to the private sector," Ms Gadhok said.

During the programme the presenter read out

two of the many emails she had received.

Samantha Wallace said, "The profession will suffer enormous recruitment and retention difficulties if these pay cuts go ahead."

Dr Fiona Stewart added, "It will impact on the vulnerable who by their very nature struggle to have their views heard."

Meanwhile, RCSLT Scottish Officer Kim Hartley said SLTs in Scotland had grave concerns about the process of matching jobs to AfC profiles. "We are concerned that there will be a re-run of the inconsistencies thrown up by the equal value case and that job evaluation judgements may be influenced by historical (discriminatory) perceptions of a predominantly female profession," Ms Hartley said.

"We believe that poor

matching could lead to inequities within SLT teams, within multi disciplinary teams and within NHSS boards."

Ms Hartley said members of the SLT managers network and RCSLT had met with the Scottish Health Minister to communicate members' concerns around implementation and to secure the use of Amicus/RCSLT guidance by the job evaluation pilot sites.

Amicus and RCSLT have also agreed to set up networks to track implementation outcomes, share learning and promote and support consistency of implementation. Email: kim.hartley@rcslt.org for more information.

Coming soon
the results of the RCSLT
phone poll of members
on AfC

NEWS IN BRIEF

Palliative & supportive care SIG

The first meeting of the new Palliative and Supportive Care special interest group will take place on 22 July in Hammersmith, London. MacMillan SLT Justin Roe will be the main speaker and topics for discussion will include *SLT and Palliative Care: What have we got to offer?* For more details email: samantha.eckman@nwlh.nhs.uk or tel: 020 8869 2410.

Focusing on gender

Boys are twice as likely to have problems with speaking and listening than girls. That was the key message Australia's speech pathologists conveyed during Speech Pathology Week, 16-22 May. The aim of the week was to raise awareness about the many differences in the way males and females communicate. The week also focused on the composition of the profession – 97% of Australia's speech pathologists are women – and the ramifications this has on pay equity issues.

Addressing religious needs

The Foundation for People with Learning Disabilities has produced a good practice guide for services on meeting the religious needs of people with learning disabilities. *What about faith?* provides practical advice on how services can support adults in their religious expression, and explains why it is important to take the religious needs of people with learning disabilities seriously. Visit: www.learningdisabilities.org.uk

Older people's services review

The Healthcare Commission has published a new report setting out the approach it will take in a large-scale review of implementation of the National Service Framework (NSF) for Older People. The NSF sets standards of care of older people across health and social services, as well as other key stakeholders. Eight standards cover age discrimination; person-centred care; intermediate care; general hospital care; stroke; falls; mental health in older people and the promotion of health and active life in older age. Visit: www.healthcarecommission.org.uk

NEWS IN BRIEF

Assistive technology database

The NHS Purchasing and Supply Agency (PASA) has developed an electronic product information database to enable users, purchasers, prescribers and other health and local authority professionals make informed decisions about assistive products – including equipment for communication – available through the Agency's new national framework agreement. Visit: www.pasa.nhs.uk/eat

Communication centre opens

University College London (UCL) opened its new Centre for Human Communication on 4 June. The centre will promote cross-disciplinary research between national and international language, communication, psychology and neuroscience experts, who will collectively bring £4 million in research grants to the centre in its opening year. For more information on the new Centre visit: www.chc.ucl.ac.uk

2004 IALP Congress

Speech Pathology Australia and the University of Queensland will host the 26th World Congress of the International Association of Logopedics and Phoniatrics in Brisbane from 29 August to 2 September. Visit: www.conventionhouse.com/spcongressFRONT

Airline compensation win

A group of deaf passengers have received more than £5,000 and free travel in compensation after a pilot refused to fly them on safety grounds. The party of 11 were thrown off the Easyjet Amsterdam-bound flight at Liverpool's John Lennon airport in October 2003. A spokesperson said the pilot mistakenly believed the group "fitted the same category" as special needs passengers and needed to be accompanied by carers. **BBC News**

CLAPA celebrates 25 years

The Cleft Lip and Palate Association (CLAPA) is hosting an international conference, *Cleft care and the patient in the UK, Europe and beyond* in London on 14 September. The conference is a part of CLAPA's Silver Jubilee celebrations and is open to health professionals and parents supporting those affected by cleft lip and palate. For further details tel: 020 7833 4883 or email: info@clapa.com

SLTs hit the headlines

It's certainly been a busy media month for SLTs. In addition to RCSLT CEO Kamini Gadhok's appearance on BBC Radio 4 *You and Yours* programme on 9 June (see page 5), there have been numerous other opportunities to promote the profession.

The Countess of Wessex's visit to Northwick Park Hospital SLT department on 18 May to see the award winning work of SLTs Claire Wells and Graham Williamson now appears on the Royal website (visit: www.royalinsight.gov.uk/output/Page3179.asp).

Nottingham SLT Carolyn Desforges also featured in an article on allied health profession diversity ('A healthier mix ahead', *The Independent*, 27 May).

The top prize this month for SLT media exposure, however, goes to London SLT Jayne Comins.

Jayne featured on the RCSLT press release, 'Sing while we're winning at Euro 2004 – but look after your voice', designed to offer advice to football fans at home and in Portugal.

In a prolific 48-hour period, Jayne gave interviews on GMTV, Sky TV news, BBC London News Radio, BBC Radio Wales, BBC Radio



RCSLT urged football fans to protect their voices during Euro 2004

Shropshire, News Talk 106 and Dublin Q 106 (both in Ireland). Enquiries came from as far afield as Israel and South Africa, and Jayne was even asked to appear on *Fantasy Football*. As the demand for SLT comment intensified, RCSLT Deputy Chair Sue Roulstone also found herself on BBC News 24.

Jayne's comments on the dangers of voice abuse at football matches also featured in *The Guardian*, *The Daily Mirror*, *The Scotsman*, *The South African Star*, *The Irish Independent*, the British and American Press Associations, Reuters, Fox TV, and BBC Online.

Sign up to the RCSLT media alert list to receive the latest news on SLTs in the media and RCSLT media releases. Email: slt-media-alert-subscribe@yahoogroups.com

Wilstar closes its doors

The directors of Wilstar have announced the closure of the Wilstar programme created by Dr Sally Ward with Deirdre Birkett and launched in 1994.

The programme's purpose was to promote normal language development in infants showing signs of language delay, before the stage at which parents/carers become anxious, and before delayed language becomes disordered.

It offered a non-invasive, child-centred, natural interactive approach to language acquisition. According to its directors, the programme was a genuinely innovative approach to early identification and intervention.

Following the unexpected death of Dr Ward in 2002, it has not proved possible to provide the continuing training and research to support the programme. As a result, the directors and Dr Ward's family have reluctantly decided to withdraw it, and therefore the materials will no longer be available.

Deidre Birkett says, "This was a very difficult

decision to take. To use the existing materials without individual training is out of the question, due to the vulnerability of infant development at this stage. To develop the materials and training further, as had been envisaged, would need long term ongoing studies which we are unable to undertake, therefore we feel it is necessary to withdraw it completely."

Wilstar will not train any new users. Therapists who had applied for training since Dr Ward's death will be contacted on behalf of Wilstar.

Arrangements are being made for ongoing Wilstar projects, run according to the official protocol, and their trained users, to continue should they wish.

The directors hope the Wilstar approach will continue to influence the paediatric service within the SLT profession, and that a new generation of therapists will research and develop the philosophy and ideas that Wilstar represents.

For more information, email: julia-james1@talk21.com

Giving children the best possible start

Naomi Eisenstadt, the Director of the Department for Education and Skills' Sure Start Unit, describes the critical role that SLTs play

"The government's vision is to ensure all children receive the very best possible start in life and SLTs have a key role to play in this.

Sure Start, which brings together government policy on early education, childcare and family support is helping to improve children's early speech and language development. All of our projects in this area involve SLTs, including the Language Therapy Action Forum and national projects to support our key documents such as *Birth to Three Matters* and the *Curriculum Guidance for the Foundation Stage*. We have gained invaluable input from SLT colleagues both as advisors and as frontline workers.

Every three- and four-year old child is now entitled to a free part-time early education place. This will have a significant impact on children's early communication skills, and

will be particularly important for children at any disadvantage. To support this we are developing a project *Communicating Matters* that will provide training to embed effective practice in supporting children's early communication skills and we hope SLTs will have a key part in the roll out at local level in 2005.

The Sure Start Unit has developed a joined-up approach to children's services. The success of this approach has helped in the development of the white paper *Every Child Matters* in which multi agency working is seen as the way forward.

The bringing together of children's services into children's trusts and the roll out of children's centres will provide an ideal opportunity to integrate the work of SLTs alongside other professionals so that services



Naomi Eisenstadt

are organised around the needs of the child. There are already pathfinder trusts that are putting plans in place to address the speech and language therapy agenda.

I look forward to continued partnership with SLTs, who are critical to our continued success."

For more information visit:
www.surestart.gov.uk; www.dfes.gov.uk and
www.teachernet.gov.uk

Conference report: typical and a typical ageing

The effects of the ageing process were the focus of a joint conference organised by the SIG Elderly and SIG Psychiatry of Old Age (South), at Guys' Hospital on 22-23 April

Over 110 SLTs attended the impressive conference, where the excellent choice of speakers provided frameworks for newcomers and challenges for those more established in the field.

Deborah Klee, who heads the review of the National Service Framework (NSF) for Older People, outlined the processes they use and added a great deal of weight and sense to the NSF document.

Addenbrooke's Hospital's Clinical Director Dr Claire Nicholl provided a succinct update on the common pathologies of old age, which SLT Lizzy Marks added to considerably on the following day.

A psychologist and psychiatrist also covered subjects from executive function to

graduate schizophrenia, while Hammersmith Hospital chief dietitian Lucy Wright, and SLT Julia Binder covered issues relating to dysphagia in older people, and particularly those with dementia.

University of Surrey Professor Karen Bryan and SLT Sue Stevens gave detailed updates on the current understanding of language in older people and communication in dementia. Charing Cross Hospital SLT Dijana Wolfram also guided delegates through the concept of narrative based dysphasia therapy.

To end the day, Sheila Hale, author of *The Man Who Lost His Language* spoke of her experiences as a carer and the hurdles faced and met by her husband who had aphasia.

The Elderly and Old Age Psychiatry SIGs are at the forefront of research and touches thousands of lives across our country. Why not join us at our next meeting or conference?

Colin Barnes

SLT, Portsmouth City PCT
 email: cbarnes@ports.nhs.uk

RCSLT Policy Lead Clare Coles, who also attended the conference, adds that RCSLT is developing a position statement on SLT services for people with dementia, which will be the subject of debate at the joint SIG national forum on 11 October in London. For more information, tel: 0207 378 3013.

NEWS IN BRIEF

Money for NAS

Health Minister Stephen Ladyman has unveiled a £156,000 three-year funding boost for the National Autistic Society's *Social Skills: Young People with Asperger Syndrome* project. The money will provide a network of social groups for young adults. It will also enable them to lead independent lives by helping them learn how to form relationships, and run social skills courses to help young people acquire the skills needed to voice their opinions to decision makers. Visit: www.nas.org.uk

UCL library summer closure

Renovations at UCL's specialist SLT library mean it will close to visitors from 17 July to 1 August. However, library staff will be present to offer an enquiry, fetching and photocopy service during this time, so most of the Library's resources should still be accessible. Visit: <http://library.hcs.ud.ac.uk> or tel: 020 7679 4207 for the latest information.

Addendum

Mita Mistry ('Summertime learning', *Bulletin*, June 2004, pp8-9) would like to acknowledge the work of Carina McCormack who helped her write up the article and run the summer groups.

Revisit reveals Russian revolution

The latest phase of the multidisciplinary Anglo-Russian project took place in March when five SLTs from London visited their logoped counterparts in St Petersburg and Moscow

The five: RCSLT Deputy CEO Anne Whateley, City University lecturer and aphasiologist Jane Marshall, Lucy Rodriguez from the National Hospital for Neurology and Neurosurgery, and Liz Clarke and Juliet Concanon from Barts and The London NHS Trust, spent two weeks visiting hospitals and units in the two cities to observe the logopedists' work with clients and to participate in joint lectures on SLT treatments approaches in Russia and the UK.

For Anne and Liz, this was a return to St Petersburg after their visit in March 2001 (Whateley and Clark, 2002). The trip provided an opportunity to see what had changed in the last three years. The visit also offered the chance to view SLT work in Moscow for the first time.

For the other three, the trip was a chance to consolidate links with Tatiana Khotyakova and Olga Zychova, two logopedists from St Petersburg who visited London and Bristol in 2003 for a

month to study aphasia and dysphagia as part of the reciprocal agreement.

According to Anne, the trip provided a useful opportunity to see how the project has developed under the influence of the two Russian 'champions'.

Anne commented, "It was interesting to see how much more open the SLTs were in St Petersburg than during our first visit. This was partly because we'd been before. It is also a credit to the therapists who've been to the UK and the work they've been doing in terms of spreading the word. We also targeted our lectures to a more select audience of SLTs who are already working in multidisciplinary teams and who have been influenced by the project.

"It was fantastic to see how much more interactive the therapists were during Juliet and Liz's lecture on swallowing and how they had gained in knowledge from the course Tatiana and Olga had run as a result of their visits to the UK.

"It clearly shows that by choosing the right people to disseminate knowledge the process can work. Tatiana and Olga were obviously able to withstand a certain amount of cynicism when they brought back new ideas, which is not surprising given Russia's long spell of relative isolation."

Juliet Concanon added that what impressed her most from the trip was the way that Tatiana and Olga had implemented what they had learnt from their experiences in the UK.

"Using problem solving and developing a rationale behind clinical decisions is beginning to develop in Russia," Juliet said.

"This is a direct result of Tatiana's and Olga's experiences in the UK, and to the work of Anne and Liz in sowing the seeds of change in 2001."

Reference:

Whateley A, Clark L. To Russia with Love. *RCSLT Bulletin* 2002, January; 10-11.

Note:

The Anglo-Russian Project is funded by the Department for International Development

From left: Lucy Rodriguez, Liz Clarke, Olga Zychova, Juliet Concanon and Tatiana Khotyakova brave the Russian spring temperatures



Taking an integrated child-centred approach

Christopher Place, the London-based centre for children under five with speech, language or hearing difficulties, is running a series of workshops on integrating speech and language and occupational therapies in treating children with an autistic spectrum disorder. The first will be held on 14 September, with four or five more planned for the coming year.

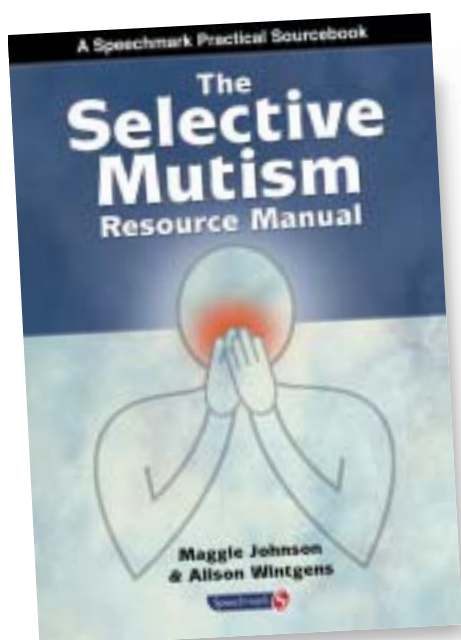
The workshops will take place in Christopher Place's new wing; a facility designed to provide training for therapists, teachers, parents and other people interested in early communication. The wing integrates professional training space with therapy rooms, allowing therapists to observe models of practice.

The centre has developed a range of integrated services, taking a child-centred approach, based on what a child needs and likes to do. An SLT, OT and consultant psychologist team assesses each child and designs an individual therapy programme, combining the appropriate balance of speech and language and sensory integration. This collaborative approach is aimed at addressing a wide range of therapy goals simultaneously and promoting innovative practice.



In the case of a child with autistic spectrum disorder, for example, an OT could work on helping the child to process optimally a variety of sensations, while the SLT works on promoting engagement and reciprocal interaction. Alternatively, the OT could work on the child's fine-motor skills by using paint or shaving foam, while the SLT develops their ability to make requests and choices.

The workshop costs £50, and can take up to 25 participants. For further information and to book a place, email: info@speech-lang.org.uk or tel: 020 7383 3834.



Norwegian consultant child and adolescent psychiatrist Dr Hanne Kristensen invited SLTs Maggie Johnson and Alison Wintgens to conduct a seminar on selective mutism (SM) after reviewing their book, *The Selective Mutism Resource Manual*, in the *European Journal of Child and Adolescent Psychiatry*. Dr Kristensen said she was keen that their "pioneering treatment methods" be used in Norway.

Pioneering SLTs address Norwegian seminar

The work of two UK SLTs on selective mutism has found a receptive audience in Norway, following a seminar to introduce their ideas

The two-day seminar, entitled *Selective Mutism: effective approaches to assessment and intervention*, attracted 65 health professionals from child and adolescent psychiatry and the school psychology counselling service, as well as teachers and parents of children with SM.

Opening the seminar, Dr Kristensen gave an update on knowledge about SM, and later presented a reflective piece about the place of silence in communication; looking at proverbs and quotations on silence and speech from around the world, and demonstrating why mutism may elicit strong feelings.

But the main presentation involved Alison Wintgens and Maggie Johnson explaining the methods set out in their book. Topics ranged from the stages of confident speaking, to

simple and complex assessments and the principles of intervention. Day two focused on planning and implementing intervention, coping with setbacks and monitoring and reinforcing progress, as well as discussing case presentations. Feedback from participants was very positive, and Dr Kristensen was convinced the seminar would "lead to therapeutic improvements for children with SM in Norway". For more information contact: Maggie Johnson, email: talktalk@compuserve.com or Alison Wintgens email: Alison.Wintgens@swlstg-tr.nhs.uk

Reference

Johnson M, Wintgens A. *The Selective Mutism Resource Manual*. Bicester: Speechmark, 2001.

FEES and feasibility

Sarah Wallace, Julie Jones and Amanda Carr explain how adopting endoscopic evaluation of the swallow function brought benefits to patients and raised the professional status of SLTs

Fibreoptic endoscopic evaluation of swallowing (FEES) is a relatively recent development that has enabled SLTs to offer an expert and efficient tool in the management of patients with dysphagia.

Professor Susan Langmore developed the procedure, which involves passing a fibreoptic nasendoscope transnasally to visualise the hypopharynx and larynx for assessing swallow function, in 1988 (Langmore *et al*, 1988). It broadly consists of an assessment of anatomical structures, secretion management, laryngopharyngeal sensation, trial swallows of food/liquids and trials of postures, strategies and manoeuvres.

Langmore's work suggested that FEES is an alternative objective instrumental assessment to videofluoroscopy (VFSS), and further studies have shown that it is as reliable as VFSS in detecting aspiration when used appropriately (Langmore *et al*, 1991). Similar videoendoscopic assessments have since been published (Bastian, 1993), but our department, in a large university teaching hospital, adopted Langmore's protocol as it is evidence based, and because one of our team had received FEES training from Professor Langmore and had accumulated a further two years FEES experience.

We began using FEES in 2002, and in one year, have received 765 inpatient and 145 outpatient dysphagia referrals. These patients underwent a total of 232 FEES and 265 VFSS assessments.

At the inception of the FEES service, our SLTs were already performing fibreoptic laryngoscopy at weekly joint voice clinics with the ENT department. Dysphagia patients identified in these clinics were undergoing 'milk nasendoscopy' tests; often found to be unsatisfactory by the SLTs, as they provided a screening tool only, not a full-functional swallowing assessment.

There were similar frustrations with our management of inpatients with dysphagia. Some patients, such as those who were

immobile, or in intensive care, needed instrumental assessment, but were unable to get to our weekly VFSS clinic. It seemed logical to develop a more formal protocol for the endoscopic evaluation of dysphagia patients independent of ENT, and so we adopted the FEES procedure.

As outlined by the RCSLT's *Invasive Procedures Guidelines* document (1999), SLTs intending to perform laryngeal endoscopy must have acquired a certain level of knowledge and skills in the proficiency in its use, selection of appropriate patients, and in the interpretation of results. Our first step was to organise training sessions for our experienced dysphagia-trained SLTs. The ENT service provided training in nasal anatomy and the performance of laryngeal examinations. Our FEES-trained SLT provided a one-day course including:

- FEES procedure and protocols;
- evidence base for FEES;
- patient selection for FEES vs VFSS;
- exclusion criteria, including contraindications; and
- practical experience of interpretation.


Our FEES procedure also now includes the use of the penetration aspiration scale (Rosenbek *et al*, 1996) and the secretion rating scale (Murray *et al*, 1996). We have developed a protocol for training new SLT staff that specifies the amount of supervised practice required and FEES competencies. This ensures the maintenance of the high standard of clinical skills required to perform FEES safely.

To gain official trust recognition, we submitted a proposal to the hospital board to support the introduction of FEES into our routine practice. We gained financial approval largely because FEES represents a cost-benefit over VFSS. Although the initial outlay on equipment can be expensive, ongoing costs are minimal. The department has recently acquired a digital FEES system that will allow us to expand our service. This

replaces the standard equipment set-up of fibreoptic nasendoscope, light source, camera unit, video recorder, monitor and trolley for transportation to the bedside. Gaining clinical privileges meant we could perform FEES on inpatients, and follow our VFSS model to provide a weekly FEES clinic for outpatients. On average we currently perform six FEES per week.

VFSS is not an option for our large tracheostomised/ventilated patient caseload. We receive referrals from the hospital's two intensive care, high dependency and burns units, and now heavily utilise FEES alongside blue dye tests in critical care. FEES improves the accuracy of our assessment, and allows us to make more specific safe-feeding recommendations. Compliance with SLT advice by patients and staff is better, owing to the impact the visual feedback provides. It has been met with trust and enthusiasm by the ICU medical staff, and has raised awareness of our role. One consequence of this has been a 500% increase in referrals of over the past two years, highlighting the need to consider the impact on staffing before embarking on a FEES service.

Another benefit of FEES is the ability to offer a conservative option to patients with severe dysphagia. Those with a compromised respiratory status who cannot tolerate even small amounts of aspiration, can undergo an assessment of secretion status without the risk of aspiration. This can inform swallowing prognosis and with repetition can reveal small signs of improvement when this occurs.

Many types of patients, including those recovering from stroke, head injury, head and neck cancer, through to progressive neurological disorders and children may benefit from FEES. Experience shows that FEES should not be attempted on very agitated patients, but even those with a history of pulling out their nasogastric tubes often tolerate FEES well. 

Overall, medical and nursing staff have quickly accepted FEES as a routine procedure, and it has raised our professional status. Interest still grows, and doctors and nurses are encouraged to observe our FEES examinations to facilitate awareness raising. Problems can arise when over-enthusiastic medics attempt to refer directly for FEES. Our protocol counters this, stating all patients must undergo a clinical bedside assessment prior to the procedure. First, because instrumental assessment may not be indicated and, secondly, FEES (which provides an anatomical perspective) may be less appropriate than VFSS. We are guided by Logemann's advice and Langmore's list of clinical indicators for selecting patients for FEES and VFSS (Langmore, 2001). See table one.

The service has benefited from a reduction in the number of VFSSs being performed, with a subsequent reduction in costs. Waiting times for VFSS have fallen to one or two weeks, and FEES can be performed the same or next day, if required.

Although some SLTs may regard FEES as invasive and potentially risky, there are few complications. Nose bleeds, vasovagal response, changes in heart rate or blood pressure, reaction to anaesthesia and laryngospasm are cited in the research (Langmore, 2001), but we have never experienced these and they are extremely rare if the SLT is competent and properly trained.

However, FEES is not suitable for all patients, and SLTs should be aware of the contraindications including: base of skull fracture; bleeding tendencies (check if the patient is on anticoagulant therapy); significant cognitive-behavioural problems; and nasopharyngeal carcinoma (seek advice from ENT). In cases of recent myocardial infarction seek medical advice;

Disadvantages of FEES include an inability to view the oral phase; the fact the procedure requires two SLTs (one to scope, one to feed); there can be SLT back discomfort when leaning over at the bedside and patient discomfort.

We now regard FEES as an essential part of our dysphagia assessment repertoire, and the benefits easily outweigh any difficulties. Other departments may have developed their own FEES service, and we would welcome any feedback and hearing from anyone interested in establishing a FEES interest group. ■



FEES enables SLTs to offer an expert and efficient dysphagia management tool

table one: clinical indicators for selecting patients for FEES and VFSS

indications for FEES	indications for VFSS
medically fragile, unable to mobilise or position for VFSS	oral stage requires viewing
suspect aspiration of secretions	need to image swallow coordination
concern re-radiation exposure	oesophageal stage involvement
severe dysphagia, absent swallow	possibility of cervical osteophytes
NG/PEG fed for a prolonged period	comprehensive view required
concern re-aspiration of barium	no known medical cause for dysphagia
dysphonia suggesting laryngeal involvement	investigate CP dysfunction
nasal reflux evident	complaint of food sticking
need to verify supraglottic swallow, glottic closure	need to verify hyolaryngeal elevation
suspect impaired laryngopharyngeal sensation	need to verify Mendelsohn manoeuvre
need to trial real foods	globus
tracheostomised/ventilated patients in ICU	
biofeedback tool for patient/carers	

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Acknowledgements: Thanks to the ENT Dept. at South Manchester University Hospital NHS Trust and to Sue Jones and the Wythenshawe Hospital SLT Team.

Issues of access

Thia Begg and Gillian Paton report on two studies from Glasgow; one examining accessibility to videofluoroscopy, the other looking at a potential aid to diagnosis where accessibility is not easily available

Videofluoroscopy (VF) assessment continues to be the 'gold standard' for identifying patients who aspirate or are at risk of aspirating. It is recognised as a reliable tool for dysphagia assessment (Scottish Intercollegiate Guidelines Network, 2002) and on which to base treatment. The validity of most other assessments and screening tools is often measured against VF and none comes close to the accuracy of VF in terms of sensitivity and specificity (Martino *et al*, 2000). Unfortunately, large regions of Scotland considered 'remote and rural' have recognised difficulties in accessing healthcare services, especially those that are considered specialist services (Thomson, 1995; Scottish Office 1998). The availability of VF facilities in these areas cannot, therefore, be assumed. We undertook two studies to examine aspects of VF service provision.

Accessing videofluoroscopy

In the first, researchers from the Nursing, Midwifery and Allied Health Professions Research Unit, Glasgow Caledonian University, examined the pattern of access to VF services (via SLT departments) for adults in acute stroke or intensive stroke rehabilitation settings in Scotland.

The researchers used a telephone questionnaire to interview 34 SLTs – identified by their managers as having specialist responsibility for dysphagia – in each of the acute and primary care trusts in Scotland. The SLTs identified the sites where they provided a dysphagia service to people post-stroke at either the acute or intensive rehabilitation stage. Additional sites, identified using a Scottish Health online database, were specifically followed up with each particular SLT.

The researchers identified 87 hospitals that had a remit for adult stroke patients at an acute and/or rehabilitation stage. Post-

stroke patients with dysphagia at any of these sites could therefore require access to VF. Patients at more than two-thirds (59) of the hospitals had to travel offsite to access VF facilities. The mean return distance travelled was 80 miles (with a range of four to 528 miles).

Many of the SLTs interviewed said they perceived offsite travel as a major barrier to VF access, stating that some patients with post stroke dysphagia are too frail or weak to embark on a long journey. Three SLTs who

Consideration should be given to the applicability of research findings in more remote and rural regions

worked in rural areas acknowledged that the distances their patients had to travel to access VF facilities prevented them from making regular requests.

Only four of the 87 sites identified reported unlimited access to VF. The majority (59) had restricted access primarily via an appointment system or specifically designated VF sessions (24). A number of sites also had a VF assessment waiting list. The study shows that although VF remains the recommended and favoured assessment choice for dysphagia assessments, access to VF in remote and rural regions of Scotland is not always feasible. We suggest that in generating evidence to inform clinical practice, consideration should be given to the applicability of research findings in more remote and rural regions.

Using lateral radiographs


The second study, at the Western Infirmary, Glasgow, arose when a normally excellent VF service was temporarily

disrupted due to radiology department staffing problems. During this time there were occasions when medical staff wanted patients recovering from stroke to begin oral medication and/or nutrition, but did not want them to risk even minimal aspiration.

The study aimed to investigate whether a lateral soft tissue radiograph (LR) provided an objective aid to the identification of aspiration or laryngeal penetration when the results of a bedside assessment had been equivocal.

Researchers assessed 23 inpatients – 10 women and 13 men – who were diagnosed as having acute stroke, confirmed by CT imaging, and who had suspected dysphagia following a bedside screening test. Their average age was 72 years (with a range of 43 to 88 years). All subjects had adequate comprehension of spoken language and were medically fit for transfer to the radiology department.

For the purpose of the study researchers defined aspiration as barium fluid entering the laryngeal vestibule, falling below the glottis and entering the trachea. Laryngeal penetration was defined as barium fluid entering the laryngeal vestibule but not entering the trachea.

Researchers used an LR followed by VF to assess each participant. The order of the investigation was consistent for all subjects. Each participant sat in an upright position in a conventional straight-backed hospital wheelchair or in a Vess swallowing chair in a general radiography room. A radiographer positioned each subject in the conventional posture for an LR. The SLT gave each participant a cup containing 165ml of barium water and asked the subject to take a drink of three mouthfuls, although this instruction precluded control of the volume swallowed. All participants achieved this. The radiographer took a film within five to 20 seconds of the final swallow and the 

participant then transferred to an adjacent room for a VF examination within 20 minutes of completion of the LR procedure.

The participant either transferred to an adapted hospital wheelchair or remained in the Vess swallowing chair. Participants again drank a minimum of three mouthfuls of barium water. A radiologist took a video film while the participants swallowed the drink and approximately 20 seconds post swallow.

The radiologist recorded the results of the LRs and the results of the VFs were documented by consensus between the radiologist and the SLT. The outcomes recorded on the basis of VF and LR were classified as aspiration; laryngeal penetration or neither (although 'neither' did not necessarily indicate a normal swallow).

Two months after the assessment procedures the anonymous LRs were presented in random order and re-interpreted by the radiologist in order to investigate intra-observer agreement.

Similarly, the anonymous VF films, with the sound turned off, were reviewed and re-interpreted by the radiologist and the SLT. A group of seven specialist staff representing medical, radiological and SLT teams also interpreted the LR films to evaluate the inter-reliability of this procedure. The raters received a brief preliminary training by the consultant radiologist. The films were simultaneously classified but no discussion or consultation was permitted during their interpretation.

The researchers calculated the sensitivity and specificity of LR examination for both aspiration and laryngeal penetration. Sensitivity refers to the proportion of individuals identified as aspirating by VF who were also identified as aspirating by LR. Specificity refers to the proportion of those identified by VF as not aspirating who were also identified as not aspirating by LR.

The results showed the sensitivity of the LR for aspiration was high (0.83) as was specificity (0.76). The sensitivity of the LR for laryngeal penetration was, however, not as encouraging (0.44) but specificity remained high (0.78). Agreement between ratings made by the specialist stroke team and the expert radiologist was acceptably high (86%), although this varied between 56 and 98%.

The results of the study support the fact



Sam Tanner

Some patients with post stroke dysphagia are too frail or weak to embark on a long journey

that videofluoroscopy is, to-date, the best tool available for the identification and diagnosis of pharyngeal level dysphagia. However, the study suggests that with further research and quality control of films, an LR could prove a useful adjunct to bedside evaluation in places where VF is not on site or easily accessed.

On the basis of our research we suggest that any further research in this area incorporates a baseline (pre-assessment) LR for comparison purposes. The study shows that although an LR does not demonstrate all dysphagic features, the variability of swallowing competence or transient laryngeal penetration it does nevertheless, have the following positive points, which may justify further exploration of it as a useful and objective adjunct to swallowing assessments:

- LR encourages sensitivity and specificity results;
- is a readily accessible examination;
- is easily organised;
- no radiologist is required at examination;
- uses low radiation levels;
- provides objective information on pharyngeal status;
- identifies pooling and residue;
- may allow further deductions to be made;
- minimal supplementary training is required. ■

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Notes:

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The Western Infirmary team was made up of Thia Begg, Andrew Bradford, Fredrick Adams, Christopher Weir and Kennedy Lees. Their study was funded by the Chest, Heart and Stroke Association

More meaningful and measurable therapy

Sylvia Ford, and colleagues report on the Kay's swallowing workstation and how it is proving an invaluable tool in the assessment of cancer patients

The North Wales Cancer Treatment Centre is the only place in the UK using a Kay swallowing workstation. The workstation can examine all aspects of a person's swallow: including the strength of the tongue, throat sounds, surface muscle strength (surface electromyography – sEMG), breathing and pressure changes in the throat. These elements can be examined individually, or in any combination, and also can be used alongside nasendoscopy or videofluoroscopy. Digital recording of studies allows easy playback.

We are currently using the workstation to carry out a number of research projects with head and neck cancer patients. One of the projects is looking at therapy for patients with swallowing difficulties. This involves seeing if biofeedback from the swallowing workstation helps patients to carry out exercises and, if so, whether their swallow improves. Biofeedback has been found to be useful in motivating patients in therapy (Denk and Kaider, 1997).

So far, I have completed therapy with five patients. They received six weeks of therapy with, and six weeks without, the workstation. The order of the therapies was randomly assigned as part of a randomised crossover trial. Full examinations were carried out before therapy began, and after the first and second blocks.

We looked at the video footage to determine the nature of the problem and therapy needed, and devised a therapy plan for each patient. A Frenchay Dysarthria Assessment (FDA) – examining reflex, respiration, lips, jaw, palate, laryngeal, tongue, intelligibility, rate, sensation, and associated factors – was also carried out so exercises could be prescribed for general weaknesses. Each patient performed daily oromotor exercises depending on the findings of the FDA.



Sylvia Ford with the Kay's swallowing workstation

Case studies

Mrs D

Mrs D had had surgery for a benign tumour in her neck three years previously, and since then had had swallowing problems. She attended the maxillo-facial outpatient department at Glan Clwyd Hospital, and although she was managing to eat and drink small amounts, she relied on a percutaneous endoscopic gastrostomy (PEG) for nutrition.

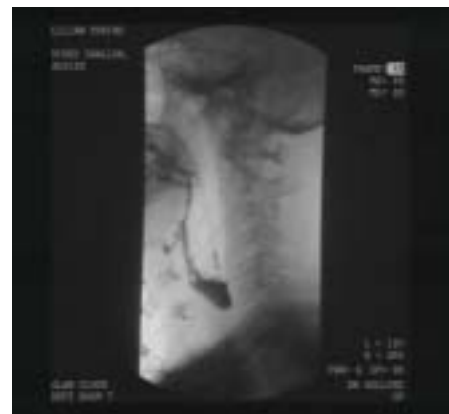
Investigation using the swallowing workstation found she had a slight spasm in her throat at the cricopharynx, which meant food and liquids tended to pool in the throat above this spasm. She also had reduced movement on the right side of her throat. There was penetration of the airway, but no aspiration – substances entered the upper airway, but did not go beyond the vocal cords. The throat above the spasm also appeared to be wide. She was assigned to have six weeks of therapy without the workstation, followed by a block with it. The FDA found Mrs D's speech was completely intelligible,

but very hyponasal. Mrs D carried out palate exercises daily as part of the therapy.

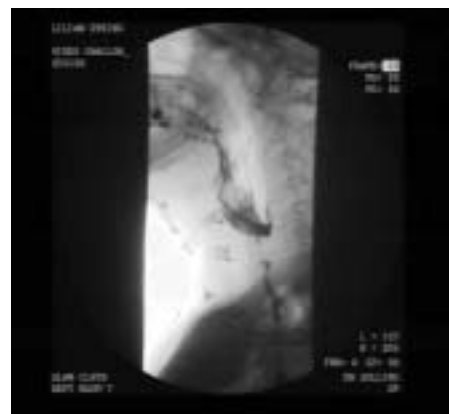
I decided Mrs D's therapy would focus on trying to tone up the whole throat to reduce the wideness and on practising swallow manoeuvres to help relax the cricopharynx. One of these is the 'Mendelsohn', which elevates the throat, protecting the airway for longer than normal (Kahrilas *et al*, 1991). See figure one.

figure one:

Usual swallow



Mendelsohn manoeuvre



Mrs D liked to see how well her swallow was doing. For example, a nasal cannula helped her to see her breathing patterns, and

tongue pressure pads helped her with her tongue movements. She also enjoyed having a better understanding of her swallow, and although this appeared to improve only slightly on the videofluoroscopy examination, at a functional level the effects were excellent.

We repeated the videofluoroscopy after six weeks of therapy without the workstation.

There was some improvement to the swallow. The best combination was the Mendelsohn, with her head tilted to the left side. This helped the liquid flow down more easily and reduced the amount of pooling. The improvement was maintained after six weeks of therapy with the swallow workstation.

Following completion of the block of therapy, Mrs D was able to take a near normal diet and normal fluids. The PEG was removed two weeks later, and one year on Mrs D was still managing with no difficulties.

Mr W

Mr W had surgery on the back of his tongue to remove a cancer. Part of his tongue was removed and replaced with a muscle flap from his forearm. After surgery he had radiotherapy for six weeks.

Mr W had a video swallow six months after the radiotherapy. He said he was unable to swallow, and was nil by mouth with PEG feeding. The video swallow showed he was silently aspirating on normal liquids. This can result in severe chest infections. He was better with thicker consistencies and when using a chin tuck, but these did not entirely prevent aspiration. He was randomised to have therapy with the workstation first. From the video, I decided to focus on improving swallow initiation and tongue strength.

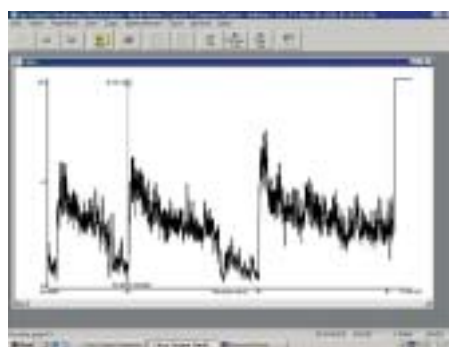
The FDA showed an extremely limited range and rate of tongue movement. Mr W's words were 70%, and his sentences 50%, intelligible. Clinical swallow assessment found his voice slightly gargly after teaspoons of water and better with sips. There was no coughing, but Mr W said he felt liquid sticking to both sides of his mouth. Mr W concentrated on tongue exercises and he enjoyed the competitive tasks. The swallow workstation records a visual display of the EMG waveform as swallows are carried out. The harder an individual swallows the higher up the peak the waveform reaches.

One of Mr W's exercises was the Shaker

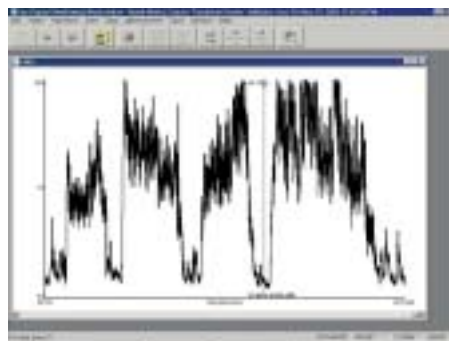
technique to improve the muscular strength in the neck needed to elevate the larynx during swallow (Shaker *et al*, 2002). In this the patient lies on his back with no pillow and lifts his head, but not his shoulders. A workstation sensor, attached to the patient's neck reads how hard the muscles are working. Mr W did this for 10 seconds and then for five sets of five bounces. The height of the graph shows how much strength is involved in the exercise. The improvements in one week are shown in figure two, and were maintained.

figure two:

week 1-Shaker technique



week 2 - Shaker technique




A repeat video after six weeks found that in 10 liquid swallows there was only one incidence of minimal aspiration. Mr W was able to carry out all the manoeuvres correctly individually and in combinations. Most effective and spontaneous was the effortful swallow (Lazarus *et al*, 1993).

The clinical assessment found a clear voice after swallows, and Mr W reported less sticking in his mouth. The FDA found his words to be 90%, and his sentences 80%, intelligible. This improvement was maintained at the final assessment after six weeks of therapy without the workstation.

Following therapy, Mr W could take liquids and soft diet. One year later, he continued with PEG feeding for nutrition. He managed

all fluids orally, but had difficulties with food because of limited tongue movements. Recent assessment found his intelligibility had decreased, and Mr W is to have therapy to improve his speech. His tongue movements were the limiting factor. The actual swallow was safe.

The maxillo-facial department is making Mr W a palatal device to help his palate contact the back of his tongue during the swallow to increase propulsion of the bolus into the throat. In this respect the workstation was useful in being able to inform the team about Mr W's further management.

The swallowing workstation is proving an invaluable tool in the assessment and rehabilitation of head and neck cancer patients. Research is continuing on whether therapy with the swallow workstation helps the swallow more than therapy alone. But there is no doubt that the feedback it provides makes dysphagia therapy more meaningful and measurable for the patient and the clinician. 

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Note: For more information on the Kay's swallowing workstation visit: <http://kayelemetrics.com/>

The Ron Smith Cancer appeal is funding the workstation at the North Wales Cancer Centre

Dysphagia in mental illness

Julie Regan, Rebecca Sowman and Irene Walsh report on a study that found a marked prevalence of dysphagia among individuals with mental illness

Dysphagia is now well recognised as being an impairment presenting in many disorders — notably among people with acute and progressive neurological disorders — and many SLTs treat the condition in their overall management of a patient’s illness.

However, the prevalence of dysphagia in other, less-researched clinical populations often remains undetermined. Individuals with mental health disorders (MHDs) are a case in point. Although SLTs increasingly provide therapy for this group (France, 2001), the management of dysphagia is relatively underdeveloped. One reason may be the uncertainty about its prevalence, which may be greater than generally realised. For example, in one study, Bazemore *et al* (1991) found videofluoroscopic evidence of aspiration in three quarters of 28 people with MHDs who had previously presented with overt signs of dysphagia according to staff at ward level.

Several factors are significant in the development of dysphagia. They include behavioural factors (for example, the rate of eating), organic sequelae of psychiatric disease, experiences of long-term institutionalisation, co-morbid medical disease and lifestyle factors (such as smoking and chronic alcohol intake) (Bazemore *et al*, 1991). These varying etiological factors may explain why Bazemore and colleagues recognise five sub-groups of dysphagia that can be identified within this population. They include those with:

- fast eating syndrome (hyperphagia);
- bradykinetic dysphagia (the most severe type but most successfully treated with a change in medication);
- dyskinetic dysphagia;
- paralytic dysphagia (related to oropharyngeal asymmetry); and
- medically-related dysphagia (for example, secondary to respiratory disease).

Another contributing factor may be the long-term side effects of medication on the central and peripheral nervous systems and their

impact on the swallow function — reported by Buchholz (1995). The effects of medication on the central nervous system, include brainstem suppression, lead to decreased levels of arousal. The effects on the peripheral nervous system include xerostomia (dry mouth), which further impairs the swallowing process. Antipsychotic medications can also cause peripheral neuropathy, neuroleptic malignant syndrome, tardive dyskinesia and extrapyramidal syndrome (Bazemore, *et al* 1991; Vogel *et al*, 2000).

Particular attention has been paid in the past to the extrapyramidal side effects induced by typical antipsychotics (Maxim and Timothy, 2001), and newer atypical antipsychotic medications have been introduced into the management of some MHDs. While these atypical antipsychotics are believed to cause fewer side effects, their impact on the swallow function has been recently documented (for example, in the case of Risperidone; see Stewart, 2003).

The literature suggests people with MHDs

may be more at risk of acquiring oropharyngeal dysphagia, and we are also aware of both the medical and social sequelae of a swallow disorder. Therefore, the identification of dysphagia in people with MHDs is crucial. The first task is to identify prevalence figures to be able to plan appropriate services.

We undertook a study to establish the prevalence of oropharyngeal dysphagia among attenders at mental health services in a Dublin suburb. We chose 60 individuals at random, drawn from an acute care facility (29 subjects) and from a number of community day services (31 subjects). The number of people, diagnoses and gender are outlined in table one.

Data collection took place over a two-week period. Two of us jointly assessed each client during one session within the familiar setting of the care facility they were attending at the time of the study. We used a swallow screening test (Farrell and O’Neill, 1998) to assess oropharyngeal swallow function and completed the checklists and evaluations

table one: subjects detailed by diagnosis and gender

diagnosis	number N=60	male 29	female 31
organic brain disease	1	1	0
schizophrenia	26	16	10
schizo-affective disorder	5	2	3
bipolar affective disorder	11	3	8
major depression with psychotic features	3	1	2
major depression without psychotic features	4	0	4
obsessive-compulsive disorder	2	2	0
other anxiety disorders	4	1	3
personality disorder	1	0	1
other psychosis	3	3	0

immediately after each session.

Of the 60 individuals screened, 32% (19/60) had overt dysphagic symptoms. The rate was slightly higher among those attending the acute care facility, at 35% (10/29), than for community service attendees, at 29% (9/31).

Taking the two most common diagnoses represented among participants in the study, 23% (6/26) of people with schizophrenia and 27% (3/11) of those with bipolar affective disorder had a swallowing impairment.

Among people with schizophrenia, 31% (4/13) attending the acute unit and 15% (2/13) attending community services had dysphagia. For those with bi-polar affective disorder, a third of the inpatient group (3/9) presented with dysphagia.

Our study found almost a third of the people screened had undiagnosed dysphagia. However, the figure is likely to be a gross underestimate of its prevalence in the population studied, given that the tool used relied exclusively on perceptual judgement of dysphagic symptoms. Objective instrumentation is required to identify accurately covert features of dysphagia, such as cervical auscultation and videofluoroscopy.

Causes of dysphagia

The increased incidence of dysphagia among acute unit attendees may be due to a number of reasons. One is the use of antipsychotic medication to treat schizophrenia, which can act as a dopamine blocker resulting in extrapyramidal features in the first few weeks of treatment (Vogel et al, 2000). The possible effects of changes in dosage of lithium-based drugs, used to treat acute exacerbations of mood disorders, may also be a contributory factor to the increased prevalence of



The long-term side effects of medication can impact on the swallow function

Getty images

dysphagia in this inpatient group.

It is difficult to make any diagnosis-specific generalisations, as the numbers of those with schizophrenia and bipolar affective disorder are too small. However, a number of individuals from the two groups reported swallowing difficulties prior to the screening assessment. For some people this problem was a cause of distress.

It is of particular concern that swallowing disorders among people in these two groups may go undetected, or be accepted, as part of their overall psychiatric problem. If this happens, they will not receive the treatment they need, and this could have serious repercussions for the individual on both a medical and a social level. ■

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NOTE:
The findings of this study were initially presented at an RCSLT Special Interest Group in Mental Health Study Day at University College London, in January 2004.

table 2: prevalence of dysphagia within two diagnostic groups across settings

diagnosis	total group	acute unit	community services
schizophrenia	23% (6/26)	31% (4/13)	15% (2/13)
bi-polar affective disorder	27% (3/11)	33% (3/9)	0% (0/2)

Book Reviews

Asperger's Syndromes in Adolescence

AUTHOR:

Liane Holliday Willey, (ed)

PUBLISHER:

Jessica Kingsley Publishers, 2003

PRICE:

£13.95

ISBN: 1-84310-742-2

This book documents the crucial but formative years of adolescence as experienced by individuals with Asperger's syndrome (AS).

Two areas that cause difficulties for young people with AS are friendship and sexuality. The book offers no hard and fast rules, but there is intelligent advice, plus website references for follow-up. Other sections discuss how the media pressurises children to mature earlier and how unintentional but conspicuous public behaviour can lead to unwanted attention, including that of the law.

The clear message throughout the book is to be proactive with the education and support of individuals with AS. Adults need to teach everything an adolescent might encounter, and to keep talking and discussing events and possible scenarios with them.

This book certainly provides a basis for discussion. Unfortunately, one or two chapters refer to the American education system, which is of limited use to UK readers. The book fills a gap in the literature on ASD. However, the diversity of the authors makes it hard to know whether the target readership is professionals, parents or individuals with AS. The initial chapters are theory based and could be a challenging read for non-professionals, whereas later chapters give more personal accounts and are easier to access for all readers.

This book would be a welcome addition to any department dealing with AS in adolescence, in particular the most useful chapter about sexuality.

CONTENTS:

READABILITY:

VALUE:

ANNA RHODES – Head of Speech and Language Therapy, St Dominic's School Surrey

Handbook of Neurological Rehabilitation (2nd ed)

AUTHOR:

Richard Greenwood, et al (eds)

PUBLISHER:

Psychological Press, 2003

PRICE:

£120

ISBN: 0-86377-757-0

This large book provides a comprehensive reference on disabling neurological disorders and the practice of rehabilitation. It has an expanded scope and list of contributors to reflect the range of healthcare professionals involved in neurorehabilitation.

Firstly, it provides a background covering epidemiology, principles of rehabilitation practice and mechanisms for recovery at the cellular level as well as learning and skill acquisition. The next section describes the assessment and treatment of functional deficits under the subheadings of mobility, other physical disability, cognitive function and personality and behaviour. There are also chapters on individual acquired neurological impairments and specific rehabilitation approaches.

The final section covers 15 specific disorders such as head injury rehabilitation, stroke rehabilitation, malignant cerebral gliomas and motor neurone disease. Each has an overview of associated issues individual to that condition, including diagnostic indicators, intervention options, multidisciplinary working and evidence-based practice.

Covering both individual functional deficits and specific disorder enables easy access to information but leads to some repetition. It is worth reading across related chapters as the depth of information and reports on the effectiveness of some treatments varies. For SLTs there are chapters covering communication aids, dysphagia, dysarthria and language impairment. However, cognitive-communication disorders are not mentioned. For managers there is valuable information on research into service organisation.

CONTENTS:

READABILITY:

VALUE:

GEORGINA WILLIS – Clinical Specialist SLT (Brain Injury), RCSLT Regional Advisor (Head Injury)

BOOK OF THE MONTH

Working with children's voice disorders

AUTHORS: Jenny Hunt, Alyson Slater **PRICE:** £34.95

PUBLISHER: Speechmark, 2003 **ISBN:** 0-86388-279-X



Two SLTs with extensive experience in the management of children with voice disorders have written this book, which aims to equip SLTs without specialist knowledge with the confidence and skills to provide an effective service to this group of children. In doing so they have made a significant contribution to the limited number of publications in this area.

The authors set children's voice disorders in the context of laryngeal changes associated with maturation processes and the many variables that can contribute to the vocal problem. They rightly suggest these aspects are often overlooked, resulting in a vocal problem being attributed solely to vocal misuse. Case histories illustrate the importance of exploring these underlying factors.

The primary focus of the text is intervention: case history, assessment and strategies for modification of vocal

behaviour. The authors suggest a comprehensive range of activities and exercises along with photocopiable evaluation and administration forms. A detailed vocal hygiene programme is considered to be central to the management of dysphonic children. Although the authors view group treatment to be the most effective approach, they also discuss other treatment options. The authors also address issues essential to good practice, such as the use of outcome measures to evaluate therapy.

Any student, generalist or specialist therapist working with dysphonic children, should read this book.

CONTENTS:

READABILITY:

VALUE:

VALERIE MORTON – Specialist SLT (Voice) Belfast City Hospital Trust, RCSLT Adviser, Voice

Any Questions?



Want some information? Why not ask your colleagues?

Email your brief query to bulletin@rcslt.org. RCSLT also holds a database of clinical advisers who may be able to help. Contact the information department, tel: **0207 378 3012**.



Does any other SLT department have experience of using auditory integration/therapeutic listening techniques with a range of clients?

Lorna Lloyd, Aniel Bodenstein, Kernesa Stephenson,
Tower Hamlets PCT

TEL: 0207 364 6473

EMAIL: Lorna.Lloyd@thpct.nhs.uk



Does anyone have alternatives to tinned sliced peaches or pears that could be easily supplied by an NHS kitchen as a 'soft solid' option for food assessment?

Sarah Macfarlane
Epsom General Hospital

TEL: 01372 735193

EMAIL: sarah.macfarlane@eeandms-pct.nhs.uk



We would be interested to hear from anyone who has produced information to ensure access to dental services is as user friendly as possible to individuals with learning disabilities.

Clive Evans
Learning Disability Service, Westbourne,
Scott Hospital, Beacon Park Road,
Plymouth, PL2 2PQ

EMAIL: clive.evans@pcs-tr.swest.nhs.uk



We are investigating suitable tools to measure baseline skills in rehabilitation as a multidisciplinary team and are keen to hear if anyone has used the Paediatric Evaluation of Disability Inventory or similar assessments with children who have had acquired brain injuries.

Amanda Ruff
TEL: 01737 365878

EMAIL: aruff@thechildrenstrust.org.uk



I would be interested to hear from other SLTs who liaise with services for children with hearing impairment. How compatible are the joint objectives on speech/language and communication, especially with regards to promoting functional communication through gestures and signs.

Jo Clarke, SLT
Cheshire West PCT, Moston Lodge,
Liverpool Road Chester CH2 1UI

TEL: 01244 364846

EMAIL: Jo.Clarke@cahc-tr.nwest.nhs.uk



I am trialling the conversation partners scheme that Connect teach on their *Training the Trainers* course. I work with inpatients and plan to use it in the community. Would like to share ideas and discuss working with volunteers.

Niki Freedman, SLT, Luton and Dunstable Hospital

TEL: 01582 497049

EMAIL: Niki.Freedman@ldh-tr.anglox.nhs.uk



Would like to hear from SLTs about the benefits of having a peer support network available within their team.

Patrice Mitchell

TEL: 02892 665181 ext 4805

EMAIL: Patrice_Mitchell@dltrust.n-i.nhs.uk



I am part of an initial project team carrying out research into a six-month post-stroke multidisciplinary service (SLT, PT, OT, podiatrist involvement). Does anyone have experience of setting up or working in such a service and know of any relevant research/issues/experiences?

Jo Hawke, SLT, Battenburg Avenue Clinic,
Battenburg Avenue, North End, Portsmouth, PO2 0TA

EMAIL: JLHawke@hotmail.com



We are reviewing our service and would be interested in hearing from other trusts about how they involve parents of children in their special schools.

Lisa Ford, Special schools team,
Western Sussex PCT

TEL: 01243 815260

EMAIL: Lisa.Ford@wsx-pct.nhs.uk



Has anyone had experience of working with adults with severe dysphagia (absent swallow) related to lithium toxicity/overdose?

Emily Highfield, SLT

TEL: 01243 831477

EMAIL: speech.therapy@rws-tr.nhs.uk



Can anyone help us with ideas on waiting list initiatives? We have huge numbers of children who have had an initial assessment but are sitting on a treatment waiting list for too long.

Philomena Cleary

TEL: 028 66384096

EMAIL: pcleary@slt.n-i.nhs.uk

Maintaining good practice with diverse community caseloads

A review of a multimethod study examines the challenges facing SLTs when using evidence-based approaches with heterogeneous paediatric populations

The diversity of community therapists' caseloads and the current state of evidence about therapy effectiveness means SLTs must take care when applying evidence from group studies to individual clients.

This is the view of Frenchay Hospital's Speech and Language Therapy Research Unit after a 12-month multimethod study of 21 SLTs in 16 community clinics in the Bristol area.

The study recruited 159 pre-school children – with auditory comprehension expressive language and phonological problems – from monolingual families.

The children were randomised to either receive one-to-one 'standard' therapy (n=71) or to be monitored (n=88) over 12-months.

The study did not constrain the timing, frequency and approach of therapy, but left each SLT to carry out what she/he considered appropriate to individual children within the local situation. Each SLT maintained detailed records of interventions as part of a monitoring process.

The parents in the 'watchful waiting' arm of the study were given full details of their child's difficulties and standardised information on how to facilitate their child's speech and language development. They could also request therapy at any point during the trial.

Questionnaires at the end of the trial investigated parents' perceptions of the therapy received and outcomes for their

child. A series of 16 interviews with parents from both trial groups covered their views on the initial referral, their children's difficulties, progress during the trial and their children's future.

The trial showed there was little evidence that the therapy offered in the community clinics had an effect when compared with the 12-month monitoring period.

According to the authors, the trial results in isolation provide little information for these negative outcomes.

However, comparison of the descriptive data and the parental feedback did provide useful data that had implications for good practice.

Out of the 159 trial children, 70% still met the trial's eligibility criteria at the end of the 12-month period. The authors suggest this high rate of children who still had problems suggests SLTs select children who do not respond spontaneously, at least in the pre-school period.

They make the comment that caseload selection is one of the, "distinctive and important roles of SLTs based in the 'frontline' of community clinics" and add that because these clinics are often the first posts offered to newly qualified SLTs, good practice should be to offer them support in their selection of children for therapy.

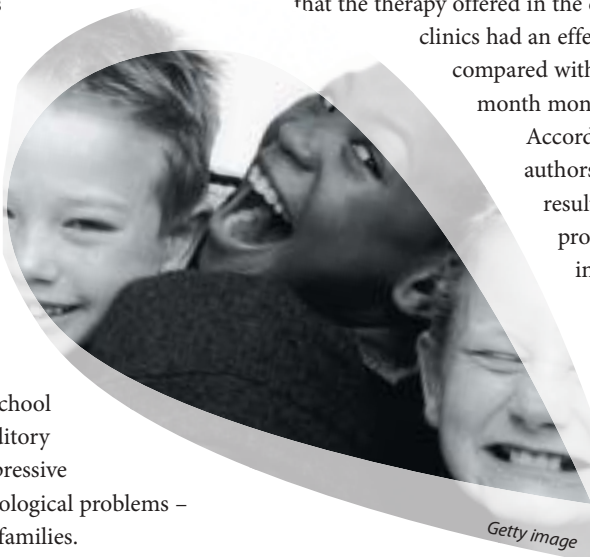
Scrutiny of the SLTs' records of intervention showed they used combinations of approaches that reflected general and language development theories, and adapted published programmes. The authors say that 'best evidence' may come from general theories of language development rather than interventions tested with particular client groups or from studies of interventions in different contexts.

The authors suggest best practice involves the use of a hypothesis-testing approach, where an SLT sets up a programme of intervention as a hypothesis that is evaluated by closely monitoring the outcomes of therapy.

The research also found that not all SLTs' targets areas had corresponding or clearly written goals. Some parents felt they were not included in the overall programme aims and expressed dissatisfaction with the activities given for their child.

To achieve successful co-working with parents, the authors say, SLTs must discuss programmes explicitly and in detail, and establish parents' existing knowledge and approach with their child. Discussion of the respective roles of parent and SLT might also increase parent satisfaction.

The authors' final comment is that it is important for SLTs to test and document their interventions using appropriate research tools, audit and reflective diaries, so that clinicians can share experiences and so that expertise becomes a shared, rather than a personal, development.



Getty image

REFERENCE

Roulstone S, Glogowska M, Peters T, Enderby P. Building good practice: lessons from a multimethod study of speech and language therapy. *International Journal of Therapy and Rehabilitation* 2004; 11:5, 199-205.

Have you read any recent research you would like to review in *Bulletin* as part of your continuing professional development? Contact Steven Harulow, tel: 0207 378 3004 or email: bulletin@rcslt.org



Kamini Gadhok is using her organisational skills with the NPfIT

RCSLT CEO Kamini Gadhok has joined the £6.2 billion National Programme for Information Technology (NPfIT) for England, on a part time basis for the next three months.

The move, a real coup for the allied health professions and speech and language therapy

Join the RCSLT policy team

in particular, comes after the resignation of the National Clinical Advisory Board's (NCAB's) Professor Peter Hutton and the dissolution of the board.

As a result, RCSLT is looking to second an SLT to work at College headquarters for two or three days a week for an initial period of three months.

This is an outstanding opportunity for the right person to add strategy and policy work to their CV; to gain a bird's eye view of the profession and to contribute to its development at a national level. The ideal candidate will already hold a senior clinician, team leader or management post and be looking for new challenges.

The secondment will provide an opportunity to be at the heart of the profession.

Communication with RCSLT members is a key part of the role.

Policy work will include working with the

RCSLT Management Board to support the activities on developing guidance on workforce planning for the profession.

Work with the other policy leads will also include drafting new RCSLT policy, developed as a result of a forum being planned for autumn 2004 on speech and language therapy for children.

Based at RCSLT headquarters in London, you will be joining a small, friendly organisation, which has a commitment to continuing professional development. Some travel may be necessary.

For an informal discussion about the post contact RCSLT Chair Caroline Fraser. Email: caroline.fraser@rslt.org, giving a phone number on which you can be reached after 6pm. An application pack is available from Paula Andrews, tel: 020 7378 3007 or email: paula.andrews@rslt.org. The closing date for return of completed applications is 2 August 2004.

SLTs and patient group directions

Speech and language therapists, dietitians, occupational therapists, orthotists and prosthetists have joined the list of allied health professionals (AHPs) able to supply and administer medicines under patient group directions (PGDs).

The AHP groups join midwives, nurses, pharmacists, optometrists, podiatrists/chiropractors, radiographers, orthoptists, physiotherapists and paramedics on the list. Patient group directions are written instructions for the supply and administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

According to the National Prescribing Centre (NPC), it is important that AHPs are aware of what they are able to do under this guidance and to explore the benefits this offers to patients.

"A PGD allows specified healthcare professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without them necessarily seeing a prescriber."¹ Therefore, patients can present directly to health care professionals using PGDs in their services without seeing a doctor.

The NPC say that in general, a PGD is not meant to be a long-term means of managing a patient's clinical condition.

"This is best achieved by a health care professional prescribing for an individual patient on a one-to-one basis."

The NPC also emphasises that it is the responsibility of the health care professional working within the PGD to assess that a patient fits the appropriate criteria.

Examples of SLTs using PGDs include the administration of a local anesthetic spray during endoscopy and the provision of thickening agents for a patient with dysphagia.

The NPC has produced a guide to good practice incorporating a competency framework for healthcare professionals using PGDs. Visit: www.npc.co.uk/publications/pgd/pgd.htm for details.

Reference

¹ National Prescribing Centre. *Patient Group Directions: A practical guide and framework of competencies for all professionals using patient group directions*. March 2004. Available online at: www.npc.co.uk/publications/pgd/pgd.htm

2004 RCSLT AGM reminder

This year's RCSLT annual general meeting will take place at the Penthouse Suite at Collingwood College, Durham, on 30 September. The afternoon session will feature top legal experts discussing medico-legal and education law.

Electronic networks offer mutual support

The NHS Alliance has joined forces with the NHS University's (NHSU's) contacts, help, advice and information network (CHAIN) to set-up an e-network for allied health professionals, primary care practitioners and other primary care and community professionals.

CHAIN is a 3,000-member multiprofessional and cross-organisational community based on the principles of mutual support, flexibility and informality.

Members include frontline healthcare professionals, teachers, managers, librarians, and other professionals. CHAIN provides members with networking opportunities, an online contact directory, events information and targeted information via email.

The network is open to all clinicians from the professions working in primary care and the community as well as to managers, researchers and others actively working with the professions. For more information visit: www.nhsu.nhs.uk/chain

The NHS Alliance Allied Health Profession and Primary Care Practitioners (AHP/PCP) Network has a steering group of people from the professions who are working in primary care and the community.

As well as working with the NHSU, the Network aims to raise the profile of the professions and represent the views of frontline clinicians on key policy issues.

The Network was a key contributor to *Engaging clinicians in the new NHS*, which was about the engagement of allied health professionals, dentists, optometrists, pharmacists and similar professionals with PCTs and strategic health authorities. For more information visit:



Getty Images

Join the online contacts, help, advice and information network

www.nhsalliance.org and click on 'Network'. The NHS Alliance has an e-network with professional executive committee (PEC) chairs for passing on relevant information and seeking a rapid response on key policy issues.

The AHP/PCP Network would like to set-up a similar group so the views of these professions can be included in the NHS Alliance's views and thinking.

If you are a PEC member or PCT advisor and are willing to be part of a rapid response group, email: kate.wortham@kwa-oxford.co.uk using your preferred email address, with your first name, surname and title; profession; PEC or adviser post held in PCT and the name of the PCT and SHA in which you hold this post.

If you have any queries about the CHAIN sub-group or NHS Alliance AHP/PCP rapid response group, contact Kate by email or tel: 01865 865 918.

Add your voice to the CQ3 debate

The project to develop *Communicating Quality 3* is now well under way and meetings are taking place across the four devolved UK countries to establish SLT views on how the next set of professional guidance should be structured and published.

It is seven years since the publication of *Communicating Quality 2 (CQ2)*, professional guidance and standards to support the provision of high quality speech and language therapy services. Since then, the working context and scope of practice have changed considerably.

RCSLT has also produced a number of documents that provide professional guidance for members, but which currently sit outside CQ2. It is now time to bring this information under one title and within a framework that makes it clear how all these

documents relate to each other.

The consultation meetings are proving to be very popular and successful, so please come along to add your voice:

Eastern (Cambridge)	Thursday 8th July
South Yorkshire (Sheffield)	Tuesday 20th July
North West (Stockport)	Friday 23rd July
Wales (Landinam)	Friday 6th August

To reserve your place, email your details to: bridget.ramsay@rcslt.org or fax: 020 7403 7254. If you're unable to come to a meeting but would like to contribute to this initial, or to the later stages by joining one of the e-working groups, send your details and comments directly to Kath Williamson email: kath.williamson@rcslt.org

Are you going up in the world?

If you've landed a new job recently, and you're an RCSLT member, you can use a new *Bulletin* column to tell the world.

Send the details, including where you've moved from and to, your new contact address (optional) and a photograph, to the *Bulletin* news desk.

Email: bulletin@rcslt.org or write to the Editor, *Bulletin*, RCSLT, 2 White Hart Yard, London, SE1 1NX.

West London Children with ASD SIG**DATE:**

13 July 2004, 3.30 – 5.30pm

Selective mutism, speaker Alison Wintgens**VENUE:**

Springhallow School, Compton Close, Cavendish Avenue, Ealing W13 0JG

CONTACT:

Gill Hilton, tel: 0208 998 2700

SIG Disorders of fluency (West Midlands) (C4)**DATE:**

13 July 2004, 1.30 – 4pm

*AGM and feedback from courses***VENUE:**

Room C217, Cox Building, University of Central England, Perry Barr, Birmingham

COST:

Members free/non-members £5/fee for year £5

CONTACT:

Barbara Moseley Harris, Telford and Wrekin PCT, Glebe Centre, Glebe Street, Wellington, Telford TF1 1JP

Autism SIG east (E35)**DATE:**

13 July 2004, 1.15 – 4pm

The HANDLE Approach, speaker Karen Landsman; *AGM***VENUE:**

Post Grad Lecture Theatre, QEII Hospital, Welwyn Garden City, Herts

COST:

Members free/SLT non-members £8/STLA and students £3

CONTACT:

Yvonne Wolsey, tel: 01438 748559

Oxford Voice and Laryngectomy SIG (E31)**DATE:**

7 July 2004, 9.15 – 4.15pm

Morning: *Voice clinics today – A review and discussion of different models*, speakers Jane Canteel, Jo Scriven, Carol Harris and consultant ENT surgeon Penny Lennox; *The cancer services and collaborative – SLT involvement update*, speaker Shirley James; *Competencies for working with voice and head and neck – RCSLT competencies project*, speaker Leonie Bird

Afternoon: *Amplifying voice to improve communication*, speaker Jackie Reeves; *Alexander technique*, speaker Alison Little

VENUE:

Nurses' Seminar Room, Radcliff Infirmary, Oxford

CONTACT:

Elaine Coker or Penny Taylor, tel: 01604 545737

SIG Elderly (South East Region) (L6)**DATE:**

15 July 2004, 2 – 5pm

Getting the best out of clients and colleagues; Dysphagia screening programme, speaker Lynne Clark; *Dysphasia treatment groups*, speaker Hillary Wren; *Action research nursing home project*, speaker Charlotte Ashburner

VENUE:

The Meeting Rooms, Neal's Yard, Covent Garden, London

COST:

Members £7/non-members £15/students £5

CONTACT:

Emma John, tel: 020 7928 9292 ext 3847, email: emma.john@gstt.nhs.uk

SIG palliative and supportive care (L26)**DATE:**

22 July 2004, 1 – 4.30pm

Inaugural meeting to discuss SIG content and canvas views on issues to cover. Main topic: *SLT and palliative care: what have we got to offer?* Speaker Justin Roe, Macmillan SLT; *Implementation of the NICE supportive and palliative care guidance*, speaker: Kim Ainsworth, AHP lead, NE London Cancer Network.

VENUE:

Board Room, LASER Macmillan Headquarters, 4th floor, Cambridge House, Cambridge Grove, Hammersmith, London W6 0LE

COST:

Free for inaugural meeting. Prebooking essential to secure a place and free lunch, Donations for tea and coffee

CONTACT:

Samantha Eckman, tel: 020 8869 2410, email: samantha.eckman@nwlh.nhs.uk

Northwest dysfluency SIG**DATE:**

27 September 2004 – 12.30 for 1.30 start

Adolescents and courses feedback

VENUE:

Manchester Metropolitan University

COST:

Free

CONTACT:

Win Ashmore, tel: 0161 627 8971 or Colette Fielding, tel: 0161 331 5156

Managers SIG**DATE:**

30 September 2004

CHAI and speech and language therapy: with reference to the national agenda and its challenges, speaker Jo Dent; *User involvement*, speaker Jenny Dodds, Associate Director of Nursing, University Hospital, Birmingham

VENUE:

University of Central England, Baker Building, Room 728

COST:

Members free/ non-members £10/students free

CONTACT:

Jane Stroud, tel: 0121 442 3400

Local groups**Central West Local Group****DATE:**

13 July 2004, 7 – 9pm

AGM and future of group

VENUE:

Child Development Centre, Stafford

COST:

£1

CONTACT:

Ian Kilby, tel: 01743 362443

SLUG Surrey local Group**DATE:**

6 July 2004, 8pm

SLTs, SLTAs, non-practising SLTs and students, join the social SLUGs for a meal

CONTACT:

Ann Adams tel: 01737 768511 ext 6090 (work) or 01737 843378 (home)

To advertise your RCSLT registered event for free send your notice by email *only* in the following format:

- Name of group and registration number
- Date and time of event
- Title of event and speakers
- Address of event
- Costs
- Contact details

Email to: bulletin@rcslt.org by the first Monday in the month before publication. For example, by Monday 5 July 2004 for the August *Bulletin*

To advertise in the *Bulletin Supplement* quick look dates section, (£24 for one insertion, £40 for two insertions) contact Katy Eggleton, tel: 020 7878 2344, email: katy@mcmslondon.co.uk

Please Note!

All bookings & enquiries regarding advertising in the *Bulletin* have now changed.

For any advertising information or to make a booking for the 1st of August *Bulletin* – deadline for booking & copy 10th July, midday, please contact Katy Eggleton at TG Scott Healthcare on Tel: 020 7878 2344 or email katy@mcmsslondon.co.uk

As of the 1st July issue advertising rates and procedures have changed slightly, below is a quick look rate card, but for more information please contact Katy on the details above.

Display

Full page	£1650
Half page	£1100
Quarter page	£800
Eighth page	£450

All rates are inclusive of colour and are subject to VAT

Column Widths

	Size in mm	
Full Page	248 x 185	Type area
	297 x 210	Trim size
	303 x 216	Bleed size
Half Page Vertical	248 x 90	
Half Page Horizontal	120 x 185	
Quarter Page	120 x 90	
Eighth Page	60 x 90	

Inserts are dependent on size and weight please call for an exact quote.