RCSLT hosts CPLOL congress in September

HRH the Countess of Wessex to be new patron

June 2003
Issue 614

bulletin

ROYAL COLLEGE OF
SPEECH & LANGUAGE
THERAPISTS

bulletin

ISSN 0953–6086

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The *Bulletin* is the monthly magazine of the Royal College of Speech and Language Therapists.

Editorial

It never ceases to amaze me how diverse the activity of the profession is, and yet how similar many of the issues are. This is neatly illustrated by articles appearing this month. The solutions identified by Melanie Adams and Katrina Clarkson in overcoming communication barriers between SLTs from different national cultures are mirrored in the work of Alex Stirling. She talks about successfully adapting her ways of teaching and communicating for members of the wider healthcare team, each with their own professional culture.

There is so much to learn from each other, even when working in completely different clinical fields, and in September, when RCSLT hosts the CPLOL congress in Edinburgh, we will have the chance to learn from colleagues across Europe as well as the UK. I hope many of you will grasp this exciting opportunity.

As you know, after eight years at the helm of *Bulletin*, Jenny Sheridan has left for pastures new, and we are in the process of recruiting her successor. Her commitment to *Bulletin* and loyalty to College will be sorely missed, as will her sense of fun. We wish her all the best for the future and are looking forward to her contributions to the letters page!

Anne Whateley

NEWS

Uncertain future for new foundation hospitals

Foundation hospitals could lead to inequalities in service provision for patients, RCSLT chief executive Kamini Gadhok has warned.

The government's latest plans for reorganisation of the NHS, the Health and Social Care (Community Health and Standards) Bill, which passed its second reading in the House of Commons last month, will give three-star hospitals greater administrative and budgetary freedom, including the power to raise money on the open market and set separate pay and conditions for staff.

"I understand the rationale for having dynamic hospitals," Ms Gadhok said, "but the competition for staff could have detrimental effects on other hospitals. It is quite understandable that staff will want to work in the best places, but we don't want to see inequality of access to speech and language therapy services because of the growing development of one hospital at the expense of another."

Ms Gadhok said that, at the moment, no one had any idea how speech and language therapy would be affected. "I would be very interested in hearing from speech and language therapists in hospitals considering foundation status."

The Health and Social Care Bill has been opposed by many of the Labour and Lib-Dem MPs, health academics, trade unions and members of the public, who fear that foundation status is a move away from the principles of the NHS, and could lead to a two-tier service for patients. The Conservatives have opposed it for not being radical enough.

The bill was not expected to pass its second reading, but a revolt of some 130 Labour MPs did not materialise, and the government secured a majority of 74 votes. The bill will now be considered in detail by a committee of MPs, and opponents are expected to seek to amend it extensively.

The bill has been changed since its publication in response to a barrage of criticism, and it is unclear exactly how foundation trusts will work. But health secretary Alan Milburn has described the trusts as: "not-for-profit organisations, wholly part of the NHS, subjected to NHS standards and inspections, but no longer directed from Whitehall." Governing boards composed of local people and staff will help manage them.

So far, 32 three-star hospitals have applied for foundations status. The aim is for all hospitals to be trusts by 2008. A £200m development fund has been established to help failing hospitals become trusts.

Tracheostomy team wins major award

At a ceremony in January, judges awarded the tracheostomy team at Addenbrooke's Hospital, Cambridge, a £5 000 performance award for "demonstrating bright ideas and innovation, over and above normal working practice".

They also welcomed the multidisciplinary team working ethic.

Team member specialist SLT Pippa Hales said: "We have introduced changes to the tracheostomy team service that significantly benefited patients in terms of improved safety, active rehabilitation and timely discharge. The trust also benefited from reduced critical incidents and readmission rates and from cost-effective use of in-patient beds."

Photographed at the presentation are (from left to right): chair of the trust Mary Archer, tracheostomy nurse practitioner Claudia Russell, SLT Pippa Hales, senior physiotherapist Louise Elliot, and the finance director Roger Swain.

Government recognises British Sign Language as official language


PICTURE: RNID

In March the government officially recognised British Sign Language (BSL) as a minority language. This milestone in the campaign for equality for deaf people means that extra funding will now be available for improving communication between hearing and deaf people and to improve access to public services. The Department for Work and Pensions (DWP) has allocated £1 million for various initiatives to support BSL. Andrew Smith, Secretary of State for DWP, said: "It is important for the rest of society to understand that BSL is a language and what this means."

It is estimated that currently about 50, 000 people use sign language in the UK as their preferred option.

Leadership from Leading Lights

A new leadership development programme giving long-term support for allied health professionals has just been announced.

Leading Lights is an intensive leadership development programme designed for the NHS by the Work Foundation's Campaign for Leadership. For further information about the project, please contact Josie Payne at the Campaign for Leadership, Peter Runge House, 3 Carlton House Terrace, London SW1Y 5DG. Tel: 020 7004 7100; fax: 020 7004 7111; email: jpayne@thecampaignforleadership.com Use 'Leading Lights' in the subject field.

AHPs 'must improve research'

A quantum leap is required to improve the quality of research in nursing and the allied health professions, according to the *British Medical Journal*. Nurses and members of the AHPs represent two-thirds of staff responsible for direct care of patients, yet little is known of the clinical or cost effectiveness of the sectors. Everyone is poorly served by the 'undernourished research base', it says in an editorial, and calls for investment to upgrade research capacity to an 'internationally acceptable level' for all health professions. RCSLT's policy lead for research, Anne Whateley, said, "I am delighted that AHP research, and the need for more resources, has been flagged up by the *BMJ*."

SLTs missing research opportunities

The Stroke Association offers research funding of up to £60,000 a year, yet very few SLTs take advantage of the scheme.

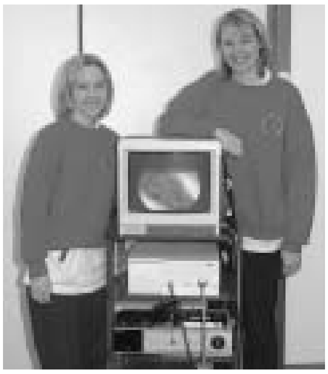
RCSLT member Sue Stevens, who sits on the association's committee considering award applications, says that she is disappointed at the relatively small number of applications coming from SLTs.

"I appreciate that time and support for preparing applications are limited," she said, "but the Stroke Association is providing opportunities for therapists working with communication and swallowing problems to pursue research. This can be done on an individual basis or as part of a multidisciplinary team."

Applications for funding of up to £60,000 a year for a maximum of three years are awarded twice a year in July and November. A therapy research bursary award of £20,000 a year over two or three years, which can be used towards an MPhil or PhD, has a closing dating of March.

For more information contact the Stroke Association research office, Stroke House, 240 City Road, London EC1V 2PR; tel: 020 7566 0348; email:research@stroke.org.uk

SLT project wins award for innovative work in stroke care



Carolee McLaughlin (left) and Roslyn Wilson with the FEES equipment

Carolee McLaughlin and Roslyn Wilson, specialist SLTs at Belfast City Hospital were recently awarded the Boehringer Ingelheim and NIMAST 'Innovations in Stroke Care Award' for their project called 'The use of fibreoptic endoscopic evaluation of swallowing (FEES) to objectively assess and treat dysphagia in patients with acute stroke in Belfast City Hospital'. Since introducing the service in March 2002 a larger proportion of stroke patients with dysphagia have been able to have objective instrumental assessment of their swallowing: this has eliminated the previous long waits for videofluoroscopy, which has significantly improved patient care. In particular, the team noted that the immediate biofeedback feature of FEES has been most useful in enabling patients and their carers to fully understand the assessment findings and reasoning behind the recommendations, improving compliance.

The team plans to use the £1 000 prize money to buy the more specialised scope required to further develop the FEES service which will allow objective sensory testing to be carried out as part of the swallowing assessment. For further information contact Roslyn Wilson on 028 9032 9241 extension 2039.

Charity launches I CAN TALK!

The charity I CAN has launched an education pack to help develop young children's speech and language skills. Ten thousand I CAN TALK! packs are being distributed to early years settings across the UK. They include a video suggesting practical ways to develop children's language ability, which has been endorsed by RCSLT. More details from I CAN: 0870 010 4066.

National Service Framework for Children

Two documents have recently been released: *Emerging Findings* and *Standard for Hospital Services.* RCSLT welcomes these documents for the NSF for Children, as they address concerns that children services have been a major gap in the government's priorities and local services.

RCSLT's education committee will critically analyse the documents to identify the impact for the profession to identify opportunities for SLT to support service development and delivery. This will be reported in the next issue of the *Bulletin.*

RCSLT has contributed to the development of the NSF, and a major challenge for SLT services will be the implementation of this policy.

We would encourage SLT managers and clinicians - particularly therapists in hospital services - to get involved with this work by working with local policy leads and informing RCSLT of concerns and progress made.

Comments/feedback to Yvette Johnson tel: 020 7378 3020; email: yvette.johnson@rcslt.org

New guidelines urge early intervention for children with ASD

A report published in March by the National Initiative for Autism: Screening and Assessment (NIASA) gives comprehensive guidelines for professionals and families dealing with children with autism spectrum disorders (ASD).

The National Autistic Plan for Children (NAP-C) plan offers a template to multi-agency teams so that everyone involved knows what is agreed as current best clinical practice, irrespective of location. It has been developed by a multidisciplinary core group of professionals from health, education, social services and parent and voluntary groups.

Speech and language therapists Tessa Gittens and Maureen Aarons, RCSLT advisers and members of the NIASA working party, said: "As members of the core group we were impressed by the professionalism and commitment to the project by everybody involved. The aim was to develop a gold standard for assessment and early intervention which at present is recognised as being piecemeal and poorly coordinated with only pockets of good practice."

Good practice recommendations include the following:

- a positive response to parental concerns at all times
- local ASD awareness training for community based staff working with children
- increased recognition of alerting signals to identify children needing further investigation
- a multi-agency assessment for all children suspected of having ASD
- appointing a key worker at the beginning of the assessment process
- a baseline assessment of skills and difficulties for the child and family
- a written report to be discussed with parents and the key worker and within six weeks of the end of the multi-agency assessment, lead to a family care plan which should identify general and ASD specific interventions for the child and family.

The report recommends that within 18 months of its publication, local areas establish a local ASD co-ordinating group to review existing training needs and the necessary resources. The plan suggests that every pre-school child with ASD should have access to specialist input specifically geared to the individual child's needs.

"We understand this to be Portage, Hanen or Early Bird type of approach, or well supported input into a well managed mainstream playgroup or nursery. There is no suggestion that one-to-one speech and language therapy input is recommended for children with autism spectrum disorders," say Ms Aarons and Ms Gittens.
www.nas.org.uk/profess/niasa.html

Surrey police launch website

Surrey police have relaunched their website to give greater access to people with disabilities. The site includes a 'browse aloud' feature that allows people with reading difficulties to listen to information. The website was developed in co-operation with representatives of a cross section of disability groups. It uses a simplified design and each section is colour coded so visitors can identify where they are, and the site can be navigated easily.

Joy Rosenberg and **David Moore** describe how Phonomena, an auditory training tool, can help children with auditory processing problems

Winning game

A significant number of children – the figures vary widely between different studies – have language impairments that appear to be based on, or are correlated to, a difficulty in processing sounds. These children are not those with clinical hearing loss, but those who have difficulty in tasks that include distinguishing high and low pitched tones and separating sounds that occur close together in time. While some would wish to diagnose these children as having a primary auditory processing disorder (APD), they are more commonly viewed as having a language or attention-based learning impairment, such as SLI, dyslexia and ADHD.

Latest research (Ramus, 2001) suggests that the proportion of children in those traditional groupings who have APD is probably in the range 20-50%. Many other children who have APD but lack secondary symptoms (for example, significantly impaired speech or reading) that would earn them a designation of special education need, battle on in mainstream education and compensate to a greater or lesser degree for their APD.

New research suggests that APD and other aspects of language-based learning disorders may be effectively treated by auditory training, a technique that has grown out of experimental psychology and academic neuroscience. There is currently great excitement in neuroscience about the ability of the brain to reorganise itself, even into adulthood and old age. How, and to what extent, auditory training and other forms of sensory and motor training produce such a reorganisation is now the subject of intensive research in university labs here and abroad. But from a more practical perspective (and from psychology) we know that when you train on a task you get better at it. If that training is optimised for an individual and presented in a highly motivating way to maximise the time spent on the training, the results can be impressive.

At MindWeavers, an Oxford University spin-out company, we have been developing professional tools for use in the treatment of language difficulties based on these principles. The tools use auditory training, particularly phoneme training.

With the help of speech and language therapists, we recently conducted a nationwide field trial of Phonomena, a phoneme discrimination game with the look and feel of an arcade-style computer game. Phonomena presents a sample phoneme followed by two trial phonemes, one of which matches the sample. The trial phonemes are arranged along one of 11 standard phonological contrasts, for example /i/ - /e/, /r/ - /l/. If the listener succeeds in matching the trial and the sample, the task becomes more difficult on the next presentation; if not, the task becomes easier. The aims of this trial were to:

- confirm expectations for improvement in phoneme discrimination with practice (training)
- examine whether the training 'generalised' (ie whether training on phonemes transferred to the more useful skill of discriminating words)
- gather feedback for the further development of Phonomena and other training-based products.

Twenty-five SLTs completed the trial, which was geared for children aged 6 to 12 (though several were older) with a speech/language impairment or diagnosis. The only requirements were normal or near-normal hearing and the ability to use a computer mouse and keyboard (space bar and arrows only). We asked the SLTs to attempt three 30-minute sessions a week for eight weeks, but we appreciated that this was not always possible due to highly variable schedules. Before and after this auditory training, children were tested with the Word Discrimination Test (WDT), also developed by MindWeavers.

To benchmark Phonomena training, we needed a measure of hearing and listening skills that relied minimally on cognitive ability. The WDT consists of 40 pairs of words, seven the same and 33 different by only one phoneme. Words were chosen to be short, high frequency and to encompass the range of phonological categories of English. The words are spoken by an adult female, digitised, embedded in background noise (the level of which was calibrated to optimise the difficulty of the task), and presented through headphones via a laptop PC. For each pair of words, the listener tells the tester whether the words are the same or different. Before the SLT trial, we administered the WDT to 185 children, aged 5;6 to 9;6 years, in mainstream education. The object of this exercise was to standardise the WDT. The number of different pairs correctly identified (out of 33) in each six-month age group is shown in table one. These data were well fit by a linear regression (r = 0.91). We were therefore able to convert WDT scores to age-equivalent scores.

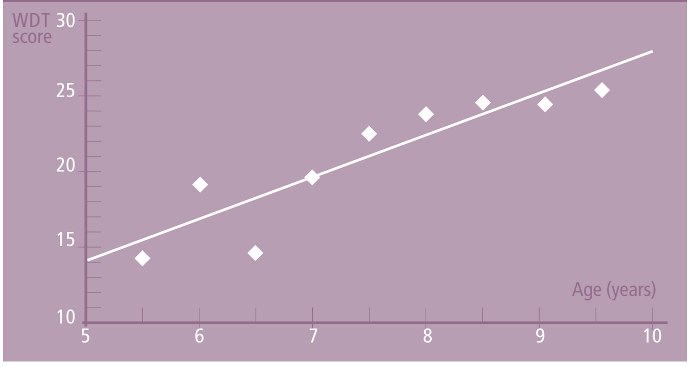


Table one: word discrimination scores increased with age for children in mainstream education. Data points show mean WDT scores for each age group of children and the fitted line is a least-squares linear regression

The SLTs who completed the trial returned pre- and post-training WDT data and performance scores on the Phonomena game itself for 84 children of varying speech and language abilities. All except three were native English speakers. Before training, their mean age-equivalent WDT score (table one) was 7;4 years (chronological age = 10.8 years). Following an average of 4.5 weeks of training, almost all children showed impressive improvements in their Phonomena performance. Their mean age-equivalent WDT score (table one) improved significantly from 19.73 before training to 24.07 after training ($t_{84} = 7.36$, $p<0.0001$). Mean age-equivalent scores for word discrimination, measured by the WDT, also increased by 1.6 years for all trial participants (sem = 0.5), and by 1.7 years for participants under 12 years.

Training

So children training on Phonomena improved both their phoneme and word discrimination abilities. By comparison, a control group took the WDT test and then repeated it with no training on Phonomena between tests. The average age-equivalent score improvement of the group was minimal (less than half a year) and commensurate with the average amount of time (3.5 months) that had passed between pre and post tests. Improvements following training were therefore due to the training rather than to familiarity with the WDT.

We received very positive feedback from SLTs. One, for example, detailed the progress of two children, both of whom showed improvements in their listening skills:

"Child A showed obvious improvement in general listening skills over the trial period. He followed instructions more quickly by the end of the trial, and was better at recognising differences in the school spelling tests. He was able to attend for longer periods to someone speaking to him, and was more reliably able to discriminate vowels from the exercises.

"Child T showed a dramatic improvement in her general ability across the board. From being a child who would cry at the slightest challenge to her attention and listening, she is becoming more of classroom member in her mainstream school. She is now able to follow classroom instructions at the 50% level; previously she rarely could recall and act. Her piano teacher, who did not know she was on the trial, commented that there had been a dramatic change in her listening and ability to follow rhythm.

"She has also begun to develop some reasoning skills. This was noted during the trial exercises; she listened to the target sound and was starting to predict where her cursor should go dependent on the sound the first gonk made. This behaviour started to show itself at the 2½ week stage. As her scores increased she gained in confidence and co-operative determination."

We also asked the trial participants for their opinion on this type of training and about Phonomena in particular. Their comments fell into three main categories:

- they experienced technical problems, especially with older computers: the games software will run only on more modern computers (Pentium II+)
- more variety and positive feedback was needed in the game: development at the moment is at a research stage, and clearly, the more enjoyable the game, the more children will be inclined to play it
- welcome for the development of a phoneme discrimination tool because of the great need in this area.

Eighty per cent of the SLTs indicated they would recommend Phonomena to professionals, and 70% said they would recommend it to parents, after software improvements were made.

Joy Rosenberg
Research co-ordinator
MindWeavers
David Moore
Director and founder
MindWeavers
Previously professor of auditory neuroscience, Oxford University

More information on Phonomena and SLTs' views is available from MindWeavers, Oxford Centre for Innovation. Tel: 01865 81112; website: www.mindweavers.co.uk

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Solid success

Surgery to divide tongue ties can dramatically improve some children's feeding abilities, says **Mervyn Griffiths**


PHOTO: MERVYN GRIFFITHS

Tongue tie: he won't "grow out of it". Evidence shows surgery can help

There is little published research on tongue-ties in infants, and studies that have been undertaken focus on their potential effect on speech, or breast and bottle feeding. Another aspect of the subject, the effect of tongue-ties on the ability of a child to eat solids (see table one overleaf) appears to have attracted no research.

I had experience of dividing tongue-ties on babies under six months of age, some of whom had problems with solids, but had not done any follow up. However, an increase in referrals of infants with tongue-ties, who had problems breast feeding, laid conditions for a large prospective study on division of tongue-ties.

Between January 2000 and December 2001 we enrolled 521 children, 63 of whom had primary symptoms related to eating solid food. The age range was 4 to 127 months (median 12, mean 21). Twenty-eight children (44%) had had no problem with either breast or bottle feeds. Thirty-five (56%) had had some difficulties, but had not been offered tongue-tie division, nor had their parents requested it. Twenty-two (35%) had had problems breastfeeding, of whom 12 (12/22, 55%) had been breastfed for less than four weeks.

A tongue-tie division without anaesthetic was carried out on 27 babies (43%) under 10 months of age in an outpatient procedure (OPD). The other 36 children (57%) were older than 10 months. They were seen as outpatients, their symptoms noted, and put on a routine waiting list (range 1–14 months, median 4) for a tongue-tie division. This was done as a day case under general anaesthetic (GA), as restraining older babies and children adequately and humanely is impossible. Any change in the symptoms between booking and division was noted. We did not use local anaesthetic in either group, as it had previously been observed to cause more bleeding on division. The parents were advised to give paracetamol elixir, as required, and I telephoned them 24 hours and three months post division to assess progress.

Results

The tongue-ties were graded as diaphanous (see-through, 13%), moderate (non-see-through, 40%), or thick, (47%).

While on the waiting list, the feeding of 30/36 (83%) of children did not improve at all, while 4/36 (11%), actually deteriorated. The remaining two (6%), had improved slowly. None was eating normally pre-division.

Postoperatively, 17 (27%) fed better immediately. By 24 hours, 37 (59%) fed better, often dramatically. Of those divided in the outpatient procedure, 22/27 (81%) had improved compared with 15/36 (42%) of the older children divided under general anaesthetic.

At three months post division, 60 (95%) were feeding normally. Two children (originally aged 10 and 38 months) were very much improved, but not quite perfect. The sole remaining child (originally aged 59 months) had been admitted for combined paediatric, psychiatric and speech and language therapy assessment.

Overall, 66% were completely pain free (24/27 OPD and 7/36 GA), 21% had Calpol for 24 hours, while only 13% were sore for more than one day.

One child had a little blood on day two, and one had an ulcer under the tongue for a week. Twenty-three children (36%) had speech problems (mean age 42 months). Eleven (11/23, 48%, mean age 30 months) had improved enough at three months to be said to be talking normally, while 12/23 (52%, mean age 53 months) had improved, but were still requiring speech and language therapy. None of them had deteriorated .

Discussion

As table one shows, we found that the 63 children in the study who had problems eating solid food seemed unable to move the food bolus from side to side to chew it properly or to move it efficiently from the front to the back of the mouth and then swallow it without choking. Some ate, rather than licked, ice cream and others had problems with cleaning the roof of their mouth and between their lips and teeth, so they used their fingers instead.

Most professional advice given to parents had been unhelpful - "He'll grow out of it" - and parents were uniformly concerned that a curative procedure had not been suggested earlier. This was because no one knew the potential for cure existed.

The children who were on a waiting list acted as their own controls. They failed to improve pre-operatively, but improved at the time of operation, just like the younger ones divided in outpatients. This suggests that the critical improvement in feeding is related to the tongue-tie division, not simply to time permitting 'stretching', 'loosing' or 'partial division'.

Table one: problems with solid foods
(Number with each symptom. Some children had more than one symptom)

lumps impossible	21
thrusts solids	20
choking on solids	13
ice cream eaten, not licked	12
spoon has to be put to back of mouth	8
oral hygiene	7
poor chewing	6
others	5

Most tongue-ties in the study referred for division were diaphanous (242/521, 46%), whereas only 13% of the tongue-ties causing problems with solids were diaphanous. This could be because the diaphanous ones are torn on the lower incisors as they erupt, permitting problem-free solid feeding.

Thirty-five children (56%) had had problems with either breast or bottle feeds, but this had not been thought to be due to the tongue-tie. If these tongue-ties had been divided earlier, the babies might have been able to breast or bottle feed better initially. The problems with solid feeding might have been avoided as well, as these vanished following division.

Our study suggests that if a child has a tongue-tie and the primary symptom is related to solid feeding, division of the tongue-tie is a safe and successful treatment.

Mervyn Griffiths
Consultant paediatric surgeon
Wessex Regional Centre for Paediatric Surgery
Southampton General Hospital

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SLTs working
members of t

A two-year diploma course in speech and language therapy has been running in Sri Lanka for the past four years (Wickenden *et al*, 2001), and as part of the overseas support for the course, we assisted with teaching and clinical supervision during the past academic year.

During this time we came to realise the degree to which assumptions and expectations about the behaviours of others were directing our professional decision making, and that this approach is highly environment specific. In the UK, our professional decisions are generally appropriate. However, in an unfamiliar environment results were often unexpected and disappointing. As Lees (2002) states, "The profession seems to have cultural blinkers and be poorly equipped to communicate across cultures."

Here are some examples of the false assumptions we made and the subsequent outcomes we observed while working in Sri Lanka:

Students will embrace functional approaches to therapy as much as impairment-based ideas.

In fact, the students preferred to write goals aimed at addressing the client's impairment, regardless of the likely success and impact of this approach. This may be because of the pressure they felt to provide a 'cure', and to avoid explaining the reasons for needing to introduce augmentative means of communication (ie that improvements in the core area of communication difficulty were unlikely).

Students, clients and their families would see that involving families in carrying out therapy tasks at home was a good idea, considering the difficulties in accessing clinics.

The students continued to favour a medical model approach, despite the balance of teaching across different models of practice. They favoured the one-to-one therapy model and were reluctant to involve family members in their management. Likewise, families seemed to prefer to leave the therapy to the 'expert'.

Following postgraduate training, multidisciplinary team (MDT) members will see multidisciplinary working as a good idea.

All the disciplines expressed the need for heavy role demarcation, even after workshops on the advantages of MDT working and joint

k before you leap

in different cultures may find they have communication difficulties with heir own profession, as **Melanie Adams** and **Katrina Clarkson** discovered

training with other disciplines. In one case, after SLTs and occupational therapists had attended a joint course in basic dysphagia management with a view to working in a multidisciplinary way and we agreed how the professions could work together, we discovered joint work was not taking place. SLTs and OTs were competing on individual cases, rather than collaborating.

Employees, including managers, have a certain level of authority, which enables them to take initiatives and make decisions

In reality, people were afraid of getting ‘scolded’ by senior colleagues, and did not feel able to make decisions for themselves. This resulted in tasks being carried out to the letter; general principles were not used to apply to other tasks. This led to tasks being completed differently from how we expected. It also meant that seeking permission for something could be a very lengthy process, as the decision was deferred from one person to the next. Furthermore, therapists sometimes did not dare to request things from their hospital managers for fear of appearing to be making a criticism of the status quo.

Students will actively participate in the classroom and ask questions if they have not understood something.

In Sri Lanka it is considered rude to tell your teacher that you have not understood something, or to ask a question. In fact, the Sinhala word for ‘question’ is the same as the word for ‘problem’. Asking a question to clarify something implies your teacher’s skills are not satisfactory. With the added fear of scolding, we found the students were naturally very quiet in class and required a great deal of facilitation to participate or to indicate when they needed help.

Conclusions

One way to limit the potential misunderstandings and inefficiencies caused by making wrong assumptions is to perform a mental checklist when entering a new environment. For example:

- be aware of the assumptions you already hold as an individual
- double check that any communication has been interpreted correctly by all parties concerned
- inform yourself about:
    - local working practices and philosophies
    - organisational and family structures
    - rules of communication within organisations/families
    - local attitudes to medical approaches (medical model vs social model, impairment vs limitation and participation) and expectations of healthcare
    - local attitudes to disability
    - local attitudes to interdisciplinary working and interdisciplinary respect
    - local perceptions of health workers from your ethnic group

Many of the issues we found are similar to those experienced by therapists in the UK. The process of learning about another culture has to be ongoing and should be pursued indefinitely.

Melanie Adams
Lecturer and clinical tutor, City University
Researcher, Institute of Child Heath, UCL
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Supported specialist SLT
Guy’s and St Thomas’ Hospital NHS Trust

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Talking partners

Alex Stirling's project aimed to improve access to healthcare for people with aphasia in an acute hospital

The initial impetus for this project came from the trust's disability adviser. We had worked together to implement changes in a ward environment, including making signage aphasia friendly. She wanted to involve speech and language therapy in implementing the communication related goals of the 1995 Disability Discrimination Act, which now applies to health care settings.

Our initial goal was to formulate a communication strategy for the trust, to identify the needs of all the users requiring any kind of communication support, and to devise a plan to meet these needs. We were turned down for trust funding but managed to secure funding from Merseyside Health Action Zone (MHAZ) which supports 10 research fellowships annually. This allows staff to engage in research that feeds directly back into their clinical area. The fellowship allowed me to be seconded two days a week for a year and the HAZ advised me to narrow the scope of my project. HAZs, which were set up to tackle health inequalities in deprived areas, may be an under-used source of funding for SLT research.

Inaccessible health care

My clinical experience in an acute hospital setting has highlighted the inaccessibility of health care, hospital procedures, information provision and so on for people with aphasia. They are isolated from basic social interaction, often excluded from decision- making, and deemed incompetent to give consent (for example, they are excluded at source from medical stroke research in the trust).

Over time, my role has changed greatly, due both to the impact of the social model of disability and the limited time and resources available in the acute setting. I spend more time working with other team colleagues, and also acting as a communication supporter for the person with aphasia in case conferences, at medical appointments, and on ward rounds.

Speech and language therapists often complain that our role is poorly understood by other disciplines. I feel we have to take responsibility for this, by being visible, by communicating in language that everyone can understand, and by teaching and modelling communicative behaviours.

We are frequently asked, "What can we do with the person with aphasia?" My answer has changed from giving impairment-based advice, to saying, "Have a conversation with them." However, the onus then lies with us to enable staff to feel able to have that conversation.

These considerations, and my increasing exposure to the work of the communication disability network Connect and of Aura Kagan in Canada, influenced my decision to focus on teaching staff how to engage in supported conversation (Kagan, 1993). Supported conversation emphasises the central role of conversation in all our lives: "In all spheres of living – family, work, social, and societal – conversation, in its broadest, interactional sense, is the common currency that enables people to function normally." (Kagan, 1993)

An inevitable consequence of aphasia is reduced opportunity for conversation, with resultant psychosocial consequences. Supported conversation emphasises the dual responsibility for successful communication. The non-aphasic conversation partner provides 'ramps' to communication (drawing, pictures, writing, gestures). These enable the person with aphasia to engage in conversation and to take part in major life decisions as a competent individual.

Training content

The training was based on that of the Aphasia Institute, Canada, and Connect in London, with some adaptations in content for the acute setting. It covered a brief definition of aphasia, emphasising the psychological and participative consequences for the individual. I discussed the importance of conversation followed by detailed description of support methods, illustrated by video clips from the supported conversation video (Kagan, 1996b) and the 'Dysphasia matters' video (Woolf, 1999). At Connect and the Aphasia Institute, practice is vital: trainees have conversations with people with aphasia, and, crucially, people with aphasia evaluate their competence as a communication partner. This was difficult to replicate authentically: the people I work with are often still in the phase of shock and chaos. They have not yet developed a sense of themselves as a person living and coping permanently with aphasia; nor have they had the opportunity to build up a body of real life successful and unsuccessful communication experiences with which to give feedback to the non-aphasic partner.

I did not feel, therefore, that I could ask current clients to participate directly in the training (although in retrospect I realised that I could have asked ex-clients). I did, however, ask people with aphasia for their input and comments regarding training. I also included role-play in pairs: while this was in no sense realistic, it was fascinating and vital. People said that it made a real difference in terms of their readiness to try techniques.

Illustration: Hilary Tranter

Participants were also taught the principles of making material aphasia friendly. During the project I consulted key staff and helped develop materials for use in their clinical areas, for example explanation sheets and consent forms for medical procedures. Staff responded very positively to the pictographic materials (Kagan and Winckel, 1996a) shown in the session, and demonstrated their ability to create their own individualised material during the role-play.

Training delivery

I targeted three key areas of two hospital trusts on the same site: the acute and rehabilitation wards of the stroke unit, and the neuro-rehabilitation unit. I chose these because they were likely to be most involved with the care of people with aphasia, and, because I work there clinically, it would enable me to build on the training individually with staff. Personal relationships with ward managers were important in encouraging them to release staff for training, as was ensuring that the timing of training fitted their timetables.

The aim was to involve everyone with any input to the wards, and to offer equal access to training for all. The training was therefore targeted to suit the largest and most important group, nursing staff (whose attendance at training is notoriously problematic because of understaffing). After liaison with all ward and department managers, we agreed training times, and multiple repeat sessions were clearly necessary (17 in total). Training sessions were two hours long. One hundred and eighty five staff attended training (covering 24 jobs, including domestics, chaplains, medical staff, social workers, volunteer workers).

I evaluated the project by a questionnaire, which was completed before training and one month after training. It was intended to gauge knowledge, perceived confidence and competence in communicating with people with aphasia, and it asked staff to contrast the service they felt able to offer people with aphasia, as opposed to people without a language problem. I also obtained qualitative comments through evaluation sheets, and a videoed training session, and I documented all reported and witnessed changes in clinical practice.

Results

The questionnaire showed significant positive changes. Participants' comments emphasised the value of the practical component, and, pleasingly, the change in attitude towards people with aphasia. Comments included:

> "Demystifying skills. Giving permission to try various approaches. Value given to forward thinking and planning."
>
> "Make my assessment and interaction with aphasic patients much more beneficial to both them and me."
>
> "Able to question and involve pt more effectively."
>
> "Stop and think prior to communication with person with aphasia."
>
> "More aware of need for me to change my behaviours to help them communicate."'
>
> "Very useful. Concentrates upon practical advice for us across all disciplines and does not dwell upon neurophysiology for aphasia which I feel would be less useful."
>
> "Better understanding of patient needs…with means to interact confidently and successfully with them."
>
> "Simple concepts that vastly improve difficult situations."
>
> "I have always felt frightened and reluctant to try to communicate with aphasic patients. I feel a lot more confident to put these skills into practice."'
>
> "I will always assume a high level of cognition despite severity of language problem."

There were changes in practice (for example, a medic clerking in a person using supportive techniques), and several requests for more detailed input to different departments.

However, it was still difficult to get certain staff (doctors, for example) to attend training, and attendance was determined by the attitudes of different managers. It is obviously vital to know the ward system, and to make sure the training time suits staff. Previously, few nurses had attended my training – this time there was 80% nursing attendance from one ward.

It is very positive to step outside one's normal clinical role, but time management can be difficult. I was fortunate to have administrative support: I had to learn to prioritise tasks, and communicate these clearly.

Future developments

There is a need for staff and carer training across the whole trust, as well as for ongoing individual input and support for those trained. The Connect and Kagan models have shown us that there is huge potential to take the training to community settings.

The project has radically changed my approach to staff training. I now emphasise the practical over the theoretical: instead of discussing different impairments, I focus on what the health professional can do as an individual with an aphasic patient. Genuine inclusion means thinking about how to involve an aphasic person in daily conversation, how to explain health care procedures to them and how to include them in major decisions such as following a course of medical treatment. Making the effort to use simple language is a lesson for us all.

Alex Stirling
Specialist speech and language therapist,neuro-rehabilitation
Aintree Hospitals Trust, Liverpool

Contact: Aphasia Institute: www.aphasia.ca
Connect: www.ukconnect.org

References: Kagan A, Gailey GF. Functional is not enough: training conversation partners for aphasic adults. In: *Aphasia treatment: world perspectives*. San Diego: Singular Publishing Group Inc, 1993: 199-225.
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Acknowledgements: I wish to acknowledge the help, advice and support of: Carole Pound, Aura Kagan, Jan Box, Merseyside Health Action Zone, Val Chisnall, Susan Rodgers, Lesley Leeds, Annette Zuydam and Eileen Gilmartin, colleagues, and most importantly, the people with aphasia whose insights informed this research.

Stammering study day

26 March 2003

The importance of developing a sound business case for improving stammering services should not be underestimated, RCSLT chief executive Kamini Gadhok told the second meeting of the working party who are developing a national framework for the services.

Speaking at a workshop in March reviewing the progress the working party had made, Ms Gadhok said it was vital to be able to make a coherent case for service development to trust directors. This could include information identifying areas of unmet need, such as figures for incidence/prevalence, current referrals and caseload size, and how meeting these needs would be cost-effective in the longer term, for example by preventing social exclusion — which would benefit both the patient and the whole health and social service system.

She said care pathways could be used to map current provision, analyse gaps and identify structure and workforce requirements. Also, knowledge of local planning cycles was essential for short and long-term planning.

Louise Wright (specialist SLT, West Cornwall PCT) and Mary Ann Tarver (specialist SLT Wandsworth PCT) spoke on the importance of care pathways in developing a national framework. Ms Wright presented examples of care pathways for children, with a summary of possible guidelines, and Ms Tarver considered the business case for a service framework for adults who stammer that would provide a recognised standard of treatment regardless of post code.

The results of a questionnaire on service provision revealed a very patchy picture, said Frances Cook (SLT, Michael Palin): some trusts had well-developed care pathways, while others had little provision. The information would be made available.

Trudy Stewart (specialist SLT, East Leeds, PCT) reported on the 'traffic light' system, currently being used in the NHS to measure and monitor service delivery. The meeting agreed markers that would signify a 'green light' dysfluency service, at individual, team and service level. Each service would determine its own markers, although common comparators across services would be useful.

The group agreed that much had been achieved in collecting information, formulating care pathways and developing business cases. A framework pack will be developed for discussion at a further workshop next year.

Frances Cook
Principal SLT, the Michael Palin Centre, London

A voice therapist's journey into the world of voice teaching

Julie McLean, one of the 2001 HSA award winners, found that giving one-to-one tutorials to vicars was just one of the many varied activities on her MA course

Sitting in my therapy room in North Wales, a half-eaten sandwich in my hand, I could hardly believe the words I was hearing on the phone, "Yes, you've got the award!" I had applied through College for the HSA's scholarship for a taught master's course – and I had got it.

With nearly two-thirds of my fees paid, I was able to start the course I had thought about doing for years – the MA in voice studies at London's Central School of Speech and Drama. This course provides training to work as a voice teacher, with a particular emphasis on working with actors. I had got through the audition and interview, and was trying to fund myself for the nine months – this award was going to be a big help. In October 2001 I travelled, with some trepidation, to London.

Rolling, shouting and writing

So what did I do with my year? Well, I rolled around on the floor a lot (in movement classes, you understand). I stood on chairs a lot too, yelling out text as I tried to be 'in the moment' and 'connect' with poetry and prose. I wrote an anatomy essay and one on voice teaching, produced a case study, and underwent several phonetics tests – a bit of a shock some 16 years on from my original training.

I did teaching practice at a drama school in Ealing and at the Liverpool Institute for the Performing Arts (LIPA). I taught one-to-one tutorials with vicars-in-training at a theological college. I did a practical teaching project and a dissertation on teaching vocal and communication skills to clergy. Although hard work, it was a treat to focus on my personal and professional development. Most wonderfully, no one told me about their mucus secretions all year!

Only about eight or nine SLTs have done the course in recent years. Being the only SLT in my year among actors and singers was daunting, but I helped them in the anatomy classes and they supported me in the performance-based activities. Unlike therapists, actors don't like to sit and talk, reflect and study – they like to do. My own natural learning style is to take time to reflect, so experiential learning has certainly been a challenge.

I know that my voice quality has changed a little – it's freer and bigger and I like it, but even though I am very motivated, that change did not occur easily or quickly. It is hard to change and we can all think of patients who just haven't been ready to do so, despite our best efforts. Having reminded myself of how vulnerable I felt in the learning environment, I also decided to be kinder to my students in future too.

I loved discovering new things, although going back to feeling 'consciously incompetent' is not always the most comfortable place to be. Working with groups has proved challenging and fun, and learning about coaching adults is proving helpful in my jobs. Perceiving and balancing an individual's needs with those of the group is a skill I am just starting to appreciate.

I have learnt about the vocal needs of the actor, a fascinating subject, and one where principles can be easily adopted in presentation skills training with both my patients and my 'voice teaching' clients. I have recognised afresh the difficult job that voice therapists can have. We take people from all walks of life and attempt to teach them how to change ingrained habitual muscle tensioning habits. We can use a lot of energy explaining what our role is and in discovering whether the person is not only able to change, but is also ready to do so.

What now?

I have now returned to work as an SLT. I finished my dissertation last October, and in January I reduced my therapy week to three days to branch out into voice teaching. I have begun with a few hours teaching BA acting students at LIPA. It's a lovely change at the end of the week, and also a steep learning curve.

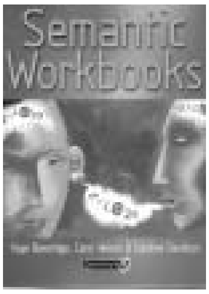
Finally, to any therapist with a dream I would encourage you to 'make it happen'. Apply for an HSA award through RCSLT – getting that award was an enormous encouragement for me.

Julie McLean
North-East Wales NHS Trust &
Liverpool Institute for the Performing Arts

Acknowledgements: Thanks to RCSLT, the HSA staff, my employing trusts and my colleagues and friends for their encouragement and support.

See page 18 for this year's HSA award winners

book reviews



Semantic Workbooks

Kaye Beveridge, Carol Nelson, Caroline Davidson

Speechmark, 2002
£90.00
ISBN: 0-86388-267-6

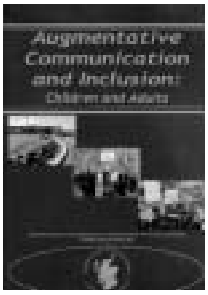
At last, therapy tools to support all that cognitive neuropsychological assessment. These six ring-bound workbooks are based on the cognitive neuropyschological model of language processing. They contain stimuli to address clients' specific strengths and weaknesses and a range of semantic therapy ideas and materials. Each book comprises sets of photocopiable exercises. These target different features of clients' semantic processing. They are designed for adults with acquired neurological disorders, although some of the picture exercises might also be suitable for semantic work with children.

The busy clinician will welcome this publication, no more rooting about in the cupboard for therapeutic material. Semantic Workbooks provide systematic stimuli, graded in order of difficulty and presented in a variety of ways. There are, for example, activities with pictures only, written words only, and pictures with words. All the activities are structured according to their level of complexity.

The package is suitable for language work focusing on both input and output, and activities can be adapted to suit individual clients. I have used parts of it, for example, both to inhibit the 'press of speech' of a client with jargon aphasia and to address semantic processing in someone with non-fluent, 'Broca's-type' aphasia. It is also suitable for groupwork. Practical features make the workbooks attractive in a clinic setting. The pictures are clear and the ring-binders are easy to use. A minor drawback is that there are no means to record clients' responses. However, this is not the aim of the package as it is therapy material rather than an assessment tool.

Semantic Workbooks is a 'must-have' for clinics where the caseload includes adults with acquired neurological impairment. It provides therapy material to complement cognitive neuropsychological assessment and I would recommend it to both therapists and students.

Contents ★★★★☆
Readability ★★★★★
Value ★★★★★
Ruth Nieuwenhuis
Member of RCSLT Critical Appraisal Network, lead clinician in aphasia, Cardiff and Vale NHS Trust



Augmentative Communication and Inclusion: children and adults

Allan Wilson (ed)

CALL Centre, University of Edinburgh, 2002
£9.00
ISBN: 1-89804-224-1

This is the latest in the series of collected papers produced as a result of the excellent 'Augmentative Communication in Practice' study days held (and organised) in Scotland. The book gives an excellent overview of inclusion at all ages, from the pre-school child to adults with learning or acquired disabilities. There are lots of good ideas to implement in our own practice as well as many questions still to be answered.

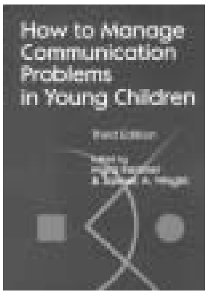
I particularly enjoyed the ten questions for 'achieving inclusive education for pupils with special educational needs'. These are designed to encourage everyone involved in primary education to question their own practice to ensure that inclusion will be a positive experience for all involved. This chapter is linked to another which discusses whether inclusion is 'the same or different for people with communication difficulties'. The discussion describes AAC strategies that work best in various situations to suit all ages of people who use AAC. There are clear, concise suggestions as to how to make situations more effective for all involved.

A stark case study shows the lack of recognition of the communication needs of adults with severe communication impairments in life-changing situations. However, this highlights the importance of providing communication opportunities in all situations. Certainly there is a lot more work to be carried out in this area.

Many chapters contain ideas to extend the communication skills of children or adults with learning disabilities. The ideas presented are practical and could be implemented reasonably easily, although you would need time to create the materials. The papers stress the active participation of all involved. This enables those who use AAC to participate fully in the activity's creation and planning stages, as well as benefiting from it.

This practical, thought-provoking book challenges all of us working in the field of augmentative communication. Inclusion can be difficult to achieve: this book goes a long way towards making it easier for all of us.

Contents ★★★★☆
Readability ★★★★☆
Value ★★★★★
Gillian Hazell
AAC specialist SLT, Scope Cap team



How to Manage Communication Problems in Young Children

Myra Kersner, Jannet A Wright (eds)

David Fulton, 2002
£16
ISBN: 1-185346-869-X

This useful updated edition is designed for a wide-ranging readership of practitioners, parents, readers, assistants and any other professional who is in contact with children who may, potentially, have a communication delay or disorder.

Individual contributors cover topics that include the development of communication skills, recognising hearing problems, identifying language disorders, stammering in young children and the links between communication difficulties and emotional and behavioural problems.

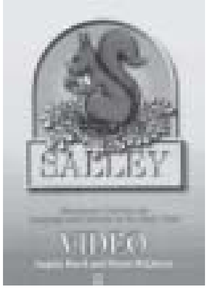
The material is sound and presented in an accessible format for the non-specialist reader, but would be familiar to a speech and language therapist.

The book offers standard practical advice to non-specialists on language development and also describes some of the most frequently met language programmes. The information is backed up by glossaries and other clarification of terms, that may be used by the SLT. The book explains the SLT role and possible service delivery methods. This is, therefore, a book that a therapist could recommend to multidisciplinary colleagues, particularly those in education or early years settings.

The multi-authorship of this volume helps to explain some repetition of material notably on language development and its encouragement. There are also some striking omissions. While entire sections are devoted to stammering and intermittent hearing problems, there are only passing mentions of expressive language disorders and social and interactional difficulties. Speech difficulties, in particular, are an area that both parents and schools frequently raise as they wish to be able to reinforce the therapists' programme.

Overall, this is a useful and well written book that many paediatric speech and language therapy departments might wish to have as a resource for students, assistants and possibly some parents. Only the final section on working with parents seems to be aimed at the therapists themselves and helps provide a reflective look at our own practice and service delivery.

Contents ★★★☆☆
Readability ★★★★★
Value ★★★★☆
Judy Crow
Specialist SLT
Northumberland NHS Care Trust



SALLEY, Structures Activities for Language and Literacy in the Early Years

Angela Hurd,
Diana McQueen, Bob Boucher
£95.00
Questions Publishing, 2002
ISBN: 1-84190-095-8

The producers of SALLEY describe it as a prevention intervention programme designed to teach phonological awareness skills to pre-school children. The kit consists of a handbook, manual, video, audiocassette and squirrel puppet.

Any childcare practitioner can deliver the programme to children in a variety of settings: pre-school; reception classes; children with learning difficulties; English as an additional language; specific literacy difficulties. The manual provides 100 days structured teaching of sessions no longer than 20 minutes, and the handbook provides data from a project carried out in the Sandwell area. The results of the project indicated that children on the SALLEY programme performed better on a phonological awareness test than the control groups. Although no evidence is yet available on the subsequent reading skills of participating children, the authors intend to follow this group of children through school.

Locally, we have introduced this programme into a SureStart nursery setting, attached to an inner city mainstream school. The nursery teacher, supported by our SureStart SLT, found the video a useful guide in carrying out the sessions. Our initial observations are that: the programme seems a big commitment at 100 days in length; sessions of 15-20 minutes have proved long enough; many children have been getting through the tasks very quickly; some of the tasks initially seemed rather basic (eg. good sitting; good listening). However, these ideas have worked and the children have responded well and the squirrel puppet is a hit.

Criticisms of the package are the inclusion of the audiocassette and outline pictures in the manual, when alternative sound lotto games of superior quality are available. We also feel the programme may be too long for many settings.

Nevertheless, initial impressions are that the programme is useful in promoting phonological awareness activities in a nursery that otherwise may not be doing them. The programme would be a useful resource for SLT departments working collaboratively with pre-schools, nurseries and other early years practitioners.

Contents ★★★★☆
Usability ★★★★★
Value ★★★★☆
Dr Deb Gibbard
Chief SLT (Paediatrics)
Portsmouth City, RCSLT adviser

Supporting Children with Speech and Language Impairment and Associated Difficulties

Jill McMinn
Questions Publishing, 2002
£14.99
ISBN: 1-84190-083-4

Jill McMinn is an SEN infant teacher with a background of supporting children with speech and language impairment (SLI). Her book gives an excellent overview of SLI and explains its implications for her pupils.

The link is made between their needs and the demands of the curriculum.

The theory is at too superficial a level to be instructional to SLTs, but it is very appropriate for teacher colleagues.

The book links SLT input to programmes for speech, stuttering and grammar and the importance of incorporating therapy targets into classroom work is emphasised.

Unfortunately there is no mention of the SLT's role in assessment and diagnosis of wider communication issues, nor is collaboration between teacher and therapist discussed.

The main criticism of the book is that the author tries to cover too much ground in a short publication and that more depth might have been helpful.

An excellent appendix provides a simplified handout on language development and a useful basic vocabulary list. There is also a parent handout, but this may be too unfocused and broad in scope for SLTs to use.

This book would be a very useful addition to the staff library of mainstream primary and special schools and SLTs will find much in it to recommend to the teachers they work with.

It would provide good resources for basic in-service sessions for teachers new to the field of working with speech and language impairment.

Contents ★★★★☆
Readability ★★★★★
Value ★★★★☆
Fiona Whyte
Lead clinician for SEN,
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RCSLT adviser on paediatric learning disability,
Scottish representative on RCSLT Education Committee

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London SE1 1NX; email: bulletin@rcslt.org

Please include your postal address and telephone number if emailing. Letters may be edited for publication.

Letters deadlines:
July 2003: 11 June   August 2003: 17 July

Working in harmony?

In response to Karen Davies' letter and ASLTIP chair Jenny Jackson's response (Letters, May *Bulletin*) on difficulties with private practitioners, I too find it disappointing and worrying that concerns are raised. I have been working independently for two-and-a-half years and have always been able to work collaboratively with both NHS and independent speech and language therapists and other professionals.

I have been able to liaise with NHS SLT managers to ensure that they know what I am doing, and to ensure that clients receive a seamless service where crossover between the two services is required. I have joint worked with some clients, where either the NHS SLT or I have taken the lead - as advised in 'Working In Harmony'. I often work in a multidisciplinary team with consultants, physiotherapists, occupational therapists, dieticians, teachers, nursery nurses and community nurses. If any issues have arisen, they have been discussed and resolved.

It is interesting that this same issue of *Bulletin* features an article called 'Are we communication specialists who can't communicate?' This title could equally apply to NHS and independent SLTs. Independent practice seems to be a growing area: as professionals we must sort out our differences and communicate with each other at all levels to ensure that all NHS and independent SLTs can work in harmony. If we cannot work together, we risk compromising the service that we provide to our clients, and surely, if we can agree on nothing else, we must all agree that this cannot happen.

Helen Woodrow
SLT, Oakthorpe
Derbyshire

I was concerned to read Karen Davies' misgivings about independent practice and independent SLTs (May *Bulletin*). I would like to address her six main grievances:

First she mentions 'unrealistic' amounts of therapy being recommended. In whose eyes are the recommendations 'unrealistic'?

As regards NHS therapists treating their local NHS patients privately, I believe that this is not recommended in 'Communicating Quality' and that the protocol is for patients to be referred to an organisation such as ASLTIP, which then provides the patient with a list of therapists. They are then free to choose a therapist who suits their needs. This therapist may then turn out to be the one with whom they already work, but at least other therapists in the area have been given the opportunity for the private work.

It is sometimes difficult to find out who and where the heads of service are in an area, and therefore to inform them about patients receiving therapy privately. To overcome this, it would be extremely helpful if RCSLT published a list in the Directory as they used to.*

It is unprofessional for independent SLTs to criticise local speech and language therapy services, but it can be more constructive to liaise and arrange therapy so that the two services (NHS and independent) complement each other. For example, individual therapy can be offered to children privately, while they attend an NHS group. Or a patient can be offered help privately, *pro tem*, while waiting on an NHS waiting list.

The question of working in partnership with teaching staff and in the classroom on a private basis is a difficult one. It is hard to justify billing parents for time spent in the classroom, particularly on a regular basis. There is a danger of becoming an expensive teaching assistant, or of taking over the lesson and jeopardising the relationship with the teacher. One-to-one therapy may be criticised as being old-fashioned and expensive but it is extremely effective, with a programme being tailor made for each patient. I believe that this approach works by providing a truly 'therapeutic' service.

Finally, there is no excuse for assessments being 'narrow' or in failing to consider the 'wider context' in either NHS or independent practice.

Sarah Evans
Sunbury-on-Thames, Middx

**This information is available from RCSLT's regularly updated database via info@rcslt.org or on 020 7378 3012*

I was most surprised to read Karen Davies's letter in May's *Bulletin* on independent practitioners.

I have worked in Bedfordshire and Hertfordshire for the NHS over the past four years and have always had excellent working relationships with private therapists who have seen children I have treated.

I have always had copies of reports and assessment results and have, more often than not, spoken with the private practitioner to agree therapy aims so that we are both working to meet the clients needs as effectively as possible. Obviously this has always taken place with full agreement of the child's parents.

I can appreciate that not all areas have such 'harmonious working' between the private and public sectors, but from my experiences, it is best working practice.

I have just set up an independent practice myself and fully intend to liaise with my NHS colleagues in order to fulfil clients' needs. Parents are usually keen for therapists to do this (obviously there are exceptions).

Finally, in setting up on my own, I have followed ASLTIP guidelines which clearly support 'Working in Harmony'.

Mary Smith
Baldock

Sure Start Scotland

We have been reading *Bulletin* articles about SLTs working in Sure Start in England, and we have been looking at the Sure Start website (England and Wales). We, therefore, have a better feel for what is happening south of rather than north of the border.

Why? Sure Start is organised very differently in Scotland. There are, for example, no designated Sure Start areas. The Scottish Executive allocates funding to local authorities, with emphasis on the importance of joint working.

Different agencies have put forward proposals and have been allocated funding depending on their particular authority's focus, and whether the projects meet Sure Start principles.

Therapists in Scotland can find themselves working in isolation, both from other SLTs and from a multidisciplinary team. There is no Sure Start website in Scotland. The networks that have emerged are the result of efforts of people working on the ground. Sure Start SLTs from Glasgow, Edinburgh and Forth Valley have met and found the exchange of ideas and support very helpful. We would like to contact other speech and language therapists working in Sure Start/Changing Children's Services in order to form a SIG.

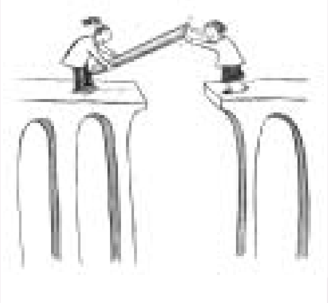

ILLUSTRATION: RACHEL BUSCH

Anyone interested please get in contact.

Elizabeth Scott, Glasgow
Tel: 0141 773 4108
Mary Elton,
Edinburgh 0131 536 8822
Suzanne Harvie,
Edinburgh 0131 537 7117;
email:
speech.therapy@zoom.co.uk

Aphasia guidelines consultation

As members may be aware, one of the guidelines outstanding from the Clinical Guidelines project is that for aphasia. We are currently consulting on a draft position paper/guideline following a consultation day on 12 May. If you would like to comment on the document, please contact me by the end of June on the telephone number/email below.

Anne Whateley
Deputy chief executive
Tel: 020 7378 3007
anne.whateley@rcslt.org

CLINICAL QUERIES

RCSLT holds a database of clinical advisers who may be able to help with many queries. Contact the information department 020 7378 3012.

Q Are any ALD therapists interested in meeting to discuss ways in which we are all making information accessible? Please send me your details and I will try to co-ordinate a convenient time and place.

Louise Barker, SLT ALD, Selby and York PCT
tel: 01904 781144 email:
Louise.Barker@EXCHA.YHS-TR.NORTHY.NHS.UK

Q Does anyone have experience in setting up a drop-in advice clinic for professional voice users? Has it been an effective way of working?

Carol Rieley, The Princess Royal Hospital,
Day Hospital, Lewes Road,
Haywards Heath,
West Sussex RH16 4EX
tel: 01444 441881 ext 4279

Q We are updating our training packs for teachers and school support staff and are looking for video clips of children using language at different word levels. Is anything available besides the Hanen videos?

Ann Wright, British Forces Germany Health Service, BFPO 40
email: Wrightfidler@msn.com

Q I am working with a 16-year-old who is a selective mute. He talks outside school and his understanding and expressive language are reasonable. He has used a Digimax communication aid. He has been exempted from oral aspects of his GCSEs. Does anyone have similar experience or suggestions for further work with him?

Jill Popple, Flat 4, 44 Steade Road
Sheffield S7 1DU
tel: 0114 2589466; mobile: 07739 403436

New Royal Patron for RCSLT

RCSLT is delighted to announce that Her Royal Highness the Countess of Wessex is to be the College's new Royal Patron. The countess follows the late Queen Elizabeth, the Queen Mother, who was the College's patron for over 40 years.

Chair of Council Caroline Fraser said: "We are particularly pleased that Her Royal Highness has shown such an interest in and knowledge of communication impairment. "We look forward to a long association with her."

College chief executive Kamini Gadhok commented: "Having met the countess, I was impressed by her commitment to supporting a range of charities representing people with disabilities."

It was announced last month that the countess is expecting a baby in December.

CPLOL Congress and RCSLT National Conference

5 – 7 September 2003

Your *Bulletin* this month is accompanied by a flyer for this year's CPLOL Congress which is being hosted by RCSLT at Heriot-Watt University, Edinburgh. The theme of the conference is 'Evidence-based Practice: a challenge for Speech and Language Therapists'. With three keynote speakers, 50 free papers, over 100 posters and an exciting gala evening this will be a terrific opportunity to catch up with new developments in SLT and to celebrate the work of the profession with colleagues from across the UK and Europe. Apply by the 30 June for your early bird discount.

HSA awards go to SLTs from N. Ireland, England and Scotland

In April, our HSA Major Scholarship winners, with friends and families, travelled from across the UK to the Dorchester Hotel, London, to receive their cheques from Rabbi Julia Neuberger at the annual HSA award presentation.

The photograph shows the six SLT award winners, with representatives from the HSA Charitable Trust and RCSLT. In all, 14 awards were made this year, including grants to assistants and co-workers, totalling £16,010. We are grateful to the HSA for their ongoing support and would encourage more members to apply for this year's awards. Information is available on the website: www.rcslt.org/grants.shtml, or from Glenn Palmer, policy lead for grants and awards: glenn.palmer@rcslt.org, direct line 020 7378 3003.

Award winners in the back row from left to right: Annabel Claxton, Chris Bailey, Kayrin Murray, Jan Baerselman, Melanie Adams and Maeve Grimes.

Update on Agenda for Change

Kamini Gadhok, chief executive, attended a meeting with union officers Colin Adkins and Sarah Carpenter and SLT union representatives on Monday 12 May. The latest update is that two job profiles (highly specialist SLT and manager) still need to be completed from the questionnaires undertaken at the workshop on 3 April at RCSLT. It is hoped that we will have a copy of all the profiles towards the end of May. The unions have advised that once the profiles have been agreed (assuming we are happy with them), it would be helpful for SLTs to re-write their job descriptions based on these and the factor plan for AfC. If we are not happy with the profiles, then we will need to consider further action/lobbying.

At the meeting the following actions were agreed for joint working between RCSLT and Amicus-MSF:

a) Development of joint guidance for the early implementer sites
b) Kath Williamson (project manager for the RCSLT competencies project) will be asked to look at developing competencies to support and inform progress for the 'gateways' (in line with the knowledge and skills framework) to enable practitioners to move within and across the bands. (Please note the competencies will **not** be used to inform the job profiles.)

A meeting will be organised in the near future to agree the programme of work to take this forward.

Dysphagia education and training

RCSLT has been receiving an increasing number of enquiries from members about dysphagia education and training, and whether there is a requirement from the professional body for therapists to attend accredited post-registration courses before working in this clinical area.

In 1999, Council approved a set of recommendations for pre- and post-registration dysphagia education and training. Speech and language therapy qualifying programmes were asked modify their curricula so that students are given the opportunity to acquire some basic theoretical knowledge and skills in dysphagia during the course of their studies. As with other clinical areas, the objective of pre-registration dysphagia education and training is to provide a basic level of competence to allow for the treatment of clients under the supervision of an appropriately experienced practitioner. The transition to independent working in dysphagia is made at a post-registration level.

RCSLT takes the view that a variety of models which include an experiential component (i.e. supervised clinical contact time with dysphagic clients and/or a supervisor over a 3-6 month period) can be used to deliver post-registration dysphagia education and training. These may include formal courses, in-service training programmes, or the use of specific training sites. This approach allows flexibility to meet the needs of services and to cater for individual learning styles. Some employers do require staff to have attended a dysphagia course registered with RCSLT. However, this is not a stipulation made by the professional body.

The responsibility for ensuring that an individual therapist is competent to work with dysphagic clients is held by the employing authority. Services should therefore ensure that they have a clear policy in place which incorporates education and training requirements for SLTs working at all levels within the service. Once a certain level of competency is reached, this should be documented in an appropriate place. Individual SLTs should ensure that the dysphagia work being undertaken is written into their job description. They should also understand their own responsibility to ensure that they are competent.

Short course registration

Courses with direct clinical relevance to SLT practice can apply for short course registration with RCSLT. This is the only means RCSLT has for giving recognition to post-registration courses and is overseen by the Education & Workforce Development Board. The process of applying for registration is entirely voluntary. The majority of applications for registration tend to come from dysphagia courses, although other short courses recently registered with RCSLT include those on student supervision, and cleft lip/palate. Successful participants are issued with a certificate indicating completion of an RCSLT registered short course.

RCSLT cannot approve an individual therapist's competence to work in a particular clinical area, this can only be done locally.

In order to be eligible for registration, a course must have clear aims and objectives so by the end of the programme an assessment can be carried out that will evaluate each participant's achievements and learning outcomes. The tuition/study element should normally amount to no less than the equivalent of one week (full-time). A period of experiential learning is generally expected. During this time, course participants would be required to demonstrate the application of knowledge acquired on the course and to develop the skills identified in the course aims. Tuition/ supervision/mentoring should be available during this period.

Reference: Dysphagia Working Group: Recommendations for Pre - and Post-registration Education and Training. RCSLT, 1999. See www.rcslt.org/cpd.shtml

Update on HPC disciplinary hearings

Many of you have been concerned about the publicity surrounding recent HPC disciplinary proceedings and the reporting of them in *Bulletin.*

I would like therefore to update you on events which led up to the HPC Disciplinary Committee issuing the following statement on April 24 2003:

"Let me make it clear immediately Dr Dean, that the committee will not be instructing the Registrar to remove your name from the Register and therefore no further action will be taken."

I met with Liz Dean before the initial proceedings and as her HPC registration had not been withdrawn discussed her return to work. At that time Liz felt she would prefer to wait until after the tribunal and pursue alternative work in the meantime. However, following her HPC appearance, I was officially appointed as Liz's mentor and HPC made it plain she should consider working again as an SLT.

Liz had met with an SLT manager in her area to discuss the situation. I also spoke to the manager to offer my support. We made several other contacts, and in the end Liz was offered two jobs. This I believe is a measure of the respect that Liz has within the profession and the calibre of our colleagues who understood the difficulties she has faced.We are delighted at the positive outcome of her case.

The disciplinary rules, that Liz had to deal with were those of CPSM. These essentially had two outcomes: guilty or not of infamous conduct. These terms have now been changed to allow for performance-related issues, such as health, to be taken into account.

RCSLT will always be willing to support its members, particularly those who understand the nature of their problems and who are willing to work hard to address them.

We have to be aware that as the body setting high standards for the profession we have a duty to the public as well as our members. This can be a difficult path to tread.

I look forward to hearing your views.

Caroline Fraser, *Chair RCSLT*
caroline.fraser@rcslt.org

Speakability

This month is the charity Speakability's 'Speak About Aphasia' Month. Cecilia Yardley, director of services, outlines its work

Speakability is the national charity for people with aphasia, a condition that affects around a quarter of a million people in the UK.

It is severely disruptive of normal life. Everyday tasks, such as shopping, phone calls, reading, or following a TV programme or having a chat, become difficult or impossible. People of working age with aphasia typically lose their jobs, and often suffer financial problems. Family relationships are frequently severely strained, and social isolation and frustration are common. Depression affects up to eight out of ten people with aphasia.

Speakability helps people with aphasia overcome the barriers that face them. Our agenda is broad, and encompasses health and social wellbeing, financial security, leisure and travel, accommodation and independent living, education and employment, as well as best treatment and therapy.

Our objectives are to:

- support people with aphasia and their carers through our information service, national network of groups and activities programme
- influence individuals, organisations and statutory bodies to improve services for people living with aphasia
- raise funds to support these aims.

We do not provide therapy, but do give out information and run campaigns to enable people with aphasia and their carers to access the services they need. We also keep up to date with the latest developments in aphasia therapy, through involvement with the British Aphasiology Society, and are in contact with many organisations and individuals actively developing and delivering therapy.

Speakability was founded as Action for Dysphasic Adults in 1979 by Diana Law, who had aphasia. We relaunched under our new name at the House of Commons in 2000, and since then each year we hold a parliamentary event with the aim of raising awareness of the needs and interests of people with aphasia at the highest policy-making level. At our most recent outing to Westminster we launched the 'consultation around the patient's passport', a personalised healthcare communication book and new guidelines for carers called 'rebuilding communication' and its updated website.

We are also active on behalf of people with aphasia through our membership of the executive committees of bodies such as the Intercollegiate Working Party on Stroke, the Neurological Alliance and the Communications Forum.

We benefit enormously from our excellent links with speech and language therapists around the country. Each June, during 'Speak about aphasia month', armed with materials, supplied by Speakability, speech and language therapists put up eye-catching displays in hospitals and shopping areas, raising awareness of the condition and the help available for it.

Another fixture on the Speakability-SLT calendar is the Mary Law lecture series that runs in London, Manchester and Edinburgh each November. In the 2002 lecture, Lisa Hirst, manager of Salisbury SLT services, stimulated a lively discussion and feedback on the topic of care pathways for people with aphasia. A follow-up event this month called 'putting people with aphasia at the heart of their services', will distil the main issues so they can be presented to policy makers.

We are delighted that RCSLT deputy chief executive Anne Whateley will be speaking to bring us up to date with the development of the RCSLT's aphasia guidelines that we are contributing to as a stakeholder organisation.

PHOTO: SPEAKABILITY

Past President of RCSLT Lord Ashley cuts the cake with Margaret Hodge, former minister for Disabled People, at the launch of Speakability in 2000.

Much of our partnership working with speech and language therapists takes place locally, and many of our support groups for people with aphasia have been started or supported by SLTs. The level of involvement varies from group to group, but our field-based development managers would be delighted to hear from any SLT interested in helping to start a new group.

As to the future, the consultation process around the 'patient's passport' has given us the opportunity to form links with a wide range of organisations outside our traditional sphere of aphasia therapy, and we will strengthen and broaden these links in the future. At the same time, we will campaign for people with aphasia and their carers to receive the support they need to rebuild their confidence and communication skills. Our partnership with SLTs will continue to be at the heart of this work.

More information from Speakability,
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