New Standards Fund money for school therapy p2

Vocal nodules: 80% improve with SLT p10

Electrical stimulation for dysphagia p8
Letter from the editor

January can be a depressing month. But speech and language therapists have news to brighten the winter days. New Standards Fund money will support work in education in England and the profession's profile has been raised by James Law's research and by two debates in Parliament. In Scotland, there will be a review of speech and language therapy with adults with learning disability and questions have been asked in the Scottish Parliament about extending the role of SLTs in prisons. In Wales, the professions allied to medicine have been raising their profile with the Welsh Assembly and are developing therapy materials in Welsh. RCSLT is in the thick of projects for change.

The problem is that therapists struggling in their own patch won't immediately see the results of all this good work. When you face a huge caseload and the inevitable challenges of multidisciplinary working, it can be hard to relate to what is going on nationally. But changes at the top, and in public perception, do affect therapists' lives and work, though this takes time.

In turn, therapists’ actions can powerfully influence important individuals and organisations, locally and nationally. It was an SLT seizing an opportunity who sparked the parliamentary debates.

We all need to keep that sense that our individual actions matter, that we are not helpless in the face of bureaucracy or lack of interest. Sometimes what a therapist says to a parent may change their whole attitude to their child. The life of an aphasic individual may be turned round by the actions and attitude of their SLT. That matters.

On a larger scale, health minister John Denham (page 4) has encouraged therapists and other interested parties to influence local health care (through health improvement plans. Politically aware managers will want to pursue this.

I am planning an article on career changes inside the profession. Please get in touch if you have changed specialty, moved from management to research or clinical work or vice versa or if you have made other changes, either positive or negative. If you are a manager who has facilitated change or challenge, please contact me. Jenny Sheridan

NEWS

ICAN launches new look at early years

Jaqui Smith elaborated on the kind of projects the Standards Fund money may be used for: more therapists, joint training for SLTs and teachers, buying in services from voluntary organisations, disseminating good practice and providing information for parents. The minister said that the DfEE had accepted and implemented some of the working party’s recommendations and would follow up others in discussion with the Department of Health.

The spectre at the feast was the difficulty in recruiting speech and language therapists. James Law’s team found agreement that there are just too few therapists. Their research suggests a shortfall of 2,000 in the field of education alone. Dr Law concluded, “Although a great many issues can be dealt with straightforwardly, good quality, equitable intentions will only be effectively provided if there are enough therapists and appropriate, adequately trained skill mix within the system.”

Commenting later, Dr Law said, “I am optimistic that there is a climate of change but local services in the end will be the ones that implement it.”

How do local managers see the way forward? “James Law’s research made me think that we ought to do more in pre-schools and nurseries, though it’s important not to lose touch with mothers,” said Christine Nendick, speech and language therapist manager in Scarborough. Cathy Timothy, SLT manager in Basingstoke, attended the conference with her local SEN team leader for the education authority. “It focused our minds on the need for common goals and vision.”

We are looking at carrying out needs assessment across the special schools in our area. The focus on working collaboratively is very positive, but funding is still a big problem. It’s OK to say you should pool budgets, but that’s not easy when budgets are so stretched.”

Joint strategies

Rob Spence, SLT manager in Riverside, west London, commented, “The extra Standards Fund money sounds very positive, though there are still some unknowns. The idea that LEAs should be the lead commissioners is a good one, but it will involve a lot of organisation to work out joint strategies which encompass children with and without statements. There is much less emphasis anyway on statements in the draft revised Code of Practice.”

School therapy gains millions

Ten million pounds for English education authorities to spend on speech and language therapy: that is one of the first outcomes of the DfEE/DH working party on provision of SLT. Schools minister Jaqui Smith announced the new Standards Fund money at the Communications Forum conference in Droitwich last November. In 2000-2001, 20 authorities are running schools-related projects in partnership with their local SLT service. In 2001-02, all English LEAs will be able to benefit.

There was a feeling at the conference that as Gill Edelman said in these pages in November – “we’ve never had it so good: the time is right for building alliances with education”. The DfEE/DH working party report and James Law’s research (see last month’s Bulletin) were launched at the conference. There was a clear message from the minister that the government – or at least the DfEE – is not only aware of the problems but wants to help find solutions.

Speech and language therapy managers present felt that attitudes may now start to change, with the DfEE’s new enthusiasm, even reluctant local education authorities may accept the need for collaborative working.

Therapists were pleased that the minister had included all children with communication needs – not just those with statements of SEN – in her speech.
Use local influence to put SLT on the map, says minister

The inequity of access to speech and language therapy and the shortage of SLTs were the topics of two parliamentary debates in November 2000. In the House of Commons on 24 November, Oona King, MP for Tower Hamlets in London, secured an adjournment debate. Emphasising the importance of speech and language therapy in fighting social and educational exclusion, she spoke about the variability of access to the service, due partly to the lack of therapists. In her own constituency, the NHS trust chief executive had admitted that the service is operating "beyond crisis point", because of high levels of need and deprivation, the time-consuming challenge of managing cultural diversity and huge case loads.

Long waits
Ms King said of the long waits for assessment and treatment: "Astonishingly, even the under-fives in Tower Hamlets are having to wait for about a year for assessment." She raised the problem of GPs being the main influencers of health priority-setting but the lack of therapists. In her own constituency, the NHS has a high number of children with special needs as a result of increased survival rates of premature babies.

SLT shortage
Turning to the shortage of SLTs, Mr Denham talked about the government's commitment to increase SLT university places, with funding for 50 new places this year and more to come. The current workforce planning exercise will be used to inform recommendations on the future number of places. He commented on the low number of SLTs from black and ethnic minority communities and spoke about an RCSLT strategy to tackle the issue.

Recruitment
In the House of Lords on 22 November, Lord Faulkner of Worcester asked the government whether the levels of SLT recruitment were satisfactory. Health minister Lord Hunt replied that there had been an increase of 310 SLTs between 1997 and 1999 and referred to the increase in current and future funding for university places. He expected that the need for therapists would increase in the future and promised a review of requirements in conjunction with the professional body. In the meantime, he said, the satisfactory Health

In reply, health minister John Denham described the wide caseload of speech and language therapists with adults as well as the 1.2 million children in the UK who have speech and language difficulties. He acknowledged that demand had grown faster than the supply of therapists, due both to a lack of growth in the profession and to greater knowledge about SLT services and the larger number of children with special needs as a result of increased survival rates of premature babies.

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The NHS Plan signalled a step forward in the NHS's relations with the independent health care sector. The agreement on partnership between the sectors, signed by health secretary Alan Milburn in November, solidifies that relationship. It covers some elective care, including intermediate care, and gives independent providers a role in local health care planning.

The agreement has come in for some relatively muted criticism from Labour backbenchers and from unions. Roger Klina, head of health at MSS, commented that the arrangements were sensible in the short term but "our members – both as NHS staff and as NHS users – can see to reason why the NHS should subsidise the private sector on a permanent basis."

Some managers take a robust view. "It's insulting to NHS staff that the government is prepared to put money into the private sector, where salaries are generally higher, but will not raise pay in the NHS," says Deborah Harding, coordinator of the West Kent Neuro-rehabilitation Unit. "It certainly won't help NHS recruitment and retention, especially in nursing. If the money is available, why not invest it in current services?"

The NHS currently spends around £1.25 billion on services from the independent and voluntary sectors, mainly in the areas of mental illness and learning disability. It receives about £290 million from treating private patients.

Primary care research

A new research programme for primary care in London will have investment of £1 million a year for the next three years. The NHS Executive London is inviting outline proposals in areas including older people, children, culture and ethnicity, consumer involvement and mental health.

For more information, visit www.doh.gov.uk/introl.dom
The deadline for proposals is 16 February 2001.

NHS/private embrace criticised

A new tool is available to help staff in early years education identify children at risk of speech, language and potential literacy difficulties. Language and literacy: Joining together is a training package developed by Joy Stackhouse, Janet Wright and Janet Wood, funded by Glaxo Wellcome and the Department for Education and Employment and managed by the British Dyslexia Association and Afasic.

Launching the pack, Professor Stackhouse explained that though there is much research on early language development, less than a third identified children who work with children. The training pack aims to influence practice through disseminating research. It helps staff to see speech and language difficulties, to understand the potential effects on reading and writing and to know how to refer on for further help.

Influencing practice
Part of the development of the pack was a survey of all the staff involved in early years provision in the London borough of Bromley, which piloted the pack. While most practitioners identified hearing impairment and the home environment as influences on speech and language development, less than a third identified developmental delay. Only 22% mentioned speech and language delay as a factor affecting literacy. Few staff felt they knew how to encourage language development. They were keen to learn more.

The course consists of four-two hour sessions for up to 30 multidisciplinary participants, qualified or unqualified. It is designed to be delivered by two local trainers, preferably one from speech and language therapy and the other from education. There are learning objectives for each session and a workplace assignment each week.

Dr Wright said that one of the outcomes of the courses run so far was that they had helped explain participants' stereotypes of other disciplines: "They realised that playground workers don't just mix paint, health visitors don't only weigh babies.” Another outcome had been the realisation that no staff, including SLTs and teachers, feel fully confident when faced with literacy problems. Professor Stackhouse welcomed the DfEE-funded I CAN project to develop a framework for joint post-qualification training for the two professions.

The pack was launched on 29 November 2000 to an enthusiastic audience from educational action zones, Sure Start schemes, local authority early years departments, children's centres, organisations and speech and language therapy services.

Language and literacy: Joining together costs £175 plus VAT from the British Dyslexia Association, 98 London Road, Reading RG1 5AU
Can hearing-impaired children learn to speak through listening?

Jacqueline Stokes introduces auditory verbal therapy

Over 90% of babies with hearing impairment are born to parents with normal hearing. Parents frequently feel shocked, confused, angry and often bewilderingly isolated. Most parents want to do everything possible to alleviate their concerns that their child may not learn to talk.

One parent commented: "It seems very usual that parents feel devastated (and beyond control) when their children are diagnosed with a hearing loss. But I guess the trick is to move on ASAP. It is certainly a strength of the auditory-verbal approach to be positive from the start: let's do this, let's do that. The bit in people that wants to make it work responds to that approach to be positive from the start: let's do this, let's do that. The bit in people that wants to make it work responds to that approach to be positive from the start: let's do this, let's do that. The bit in people that wants to make it work responds to that approach to be positive from the start: let's do this, let's do that. The bit in people that wants to make it work responds to that approach to be positive from the start: let's do this, let's do that."

Parents want and need to make well-informed choices on behalf of their hearing impaired child. Unfortunately, information about communication and placement options, assessment and statements is not easily accessible or available.

Audiological management

Once the hearing loss has been confirmed, the medical and audiological management is critical. The selection, modification and optimal maintenance of appropriate hearing aids are essential requirements of the auditory-verbal approach. Vigorous audiological management in conjunction with AV practice leads to the development of spoken communication. It may also provide some of the specific diagnostic information necessary in selecting candidates for cochlear implantation.

We have known for years that many children with hearing impairments have normal residual hearing. Now, with the advent of new hearing aid and cochlear implant technology, even more children can have access to spoken language. However, being able to make sense of the amplified sound gives children a head start in more difficult listening situations.

The development of auditory-verbal practice and listening skills are organized on a hierarchy of auditory difficulty from detection to comprehension. All children will be both auditory and visual. The emphasis on listening during individual sessions enables the child to become a skilled listener.

Skilled listener

Auditory-verbal practice encourages the maximum use of hearing in order to learn language through listening rather than watching. The memory system communicates in everyday life, they will be able to make optimal use of auditory cues in combination with other visual cues available.

Most AV programmes offer weekly sessions lasting for an hour or an hour and a half. Throughout parents acquire the confidence to try out techniques and strategies to read the specific goals in audition, speech, language, cognition and communication development. The success of auditory-verbal practice is in the way parents carry over these goals into their ordinary daily routines and play.

Parents are taught to use the overlapping developmental stages. In the early stages parents learn to help their child pay selective attention to sound rather than to visual information. Infants quickly learn to associate the loud clatter of a shaken plastic barrel with the idea that it contains something to play with. The child learns to respond to that sound by actively looking for the barrel. Such loud noises are quickly replaced by quieter noise makers until detection levels are reached.

Emphasis is placed on the child detecting and responding to voice. Parents are taught to highlight their voices so the child has the best chance of detecting them. Once children discover that voice sounds come from the mouth they move on to realize that turn-taking is a feature of communication. We then expect to see the child begin to associate a sound with its referent. In the early stages this is at the level of pattern recognition and gradually becomes refined to incorporate discrimination of speech sounds. Learning to listen sounds is quickly introduced and reinforced through singing, nursery stories and songs in everyday play and caregiving at home.

Children with residual hearing across the speech frequencies have the potential first to detect, then to discriminate and eventually to identify the Ling sounds. (These sounds represent the speech spectrum of Western languages. The most commonly used are ah, oo, ee and sh). The sounds are used to assess the child's ability to discriminate between the phonemes [Ling, 1976], and as a quick check for hearing aid function or cochlear implant systems.)

References:

Auditory-verbal professionals understand that no one approach can meet the needs of all children with hearing loss. It is cause for celebration when families find an approach that meets each child's individual needs and wants.

Nicola is three and has had a cochlear implant for four months. "Nicola was crying last night so I went and put on her processor and she calmed down and so on and I only really realized it was dark and we were doing it all by sound. She is great."
DYSPHAGIA

www.miracle.com

How can we tell if electrical stimulation is effective in dysphagia management? Julie Dick and Christine McCormick discuss the issues.

Our experience with electrical stimulation (E-stim) started with a telephone call from a child's mother in February 1998. Mrs. M emotionally told us that her 11-year-old daughter, Karen, who previously was totally gastros-tomy fed, was eating. Karen had received a two-week period of E-stim; a treatment technique pioneered by Marcy Freed, a speech and language pathologist then working in the Meridia Swallowing Center, Cleveland, Ohio.

What is E-stimulation?

We quote from information posted on the internet, taken from Ms. Freed's patient literature:

"Electrical stimulation of the neck is an investigational treatment for chronic oral pharyngeal dysphagia. Treatment consists of electrodes placed on the patient's neck and a small current introduced to the surrounding tissues. Although the specific neurophysiology associated with E-stim and its effects on swallowing are unclear we have found consistent positive results as compared with traditional modalities... Patients with crioparyngeal involvement, a narrowing of the PF segment, will also require dilations of that area by a gastroenterologist...electrical stimulation, to improve laryngeal function, and esophageal dilations, to open cricopharynx, together, allows many patients, at risk for aspiration, the ability to swallow all consistencies safely.

There is little published data. Currently, there is only one abstract (Freed et al., 1996) that describes its inception and development over 15 years. Trials established safe and effective levels of electrical stimulation (Freed, unpublished data). Stimulation to the neck area has always been considered dangerous, due to the potential for hyperstimulation of the vagus nerve and subsequent cardiac arrhythmia and arrest. Writing to a colleague, Freed says: "E-stim should not be attempted without proper education and specially modified equipment, so that no patient will be at unnecessary risk."

The Meridia Swallowing Center reports that it has been auditing its outcomes with E-stim since 1996. Treatment was initially offered only to adults, but in 1996 it was extended to children.

In a recent telephone contact with us, Freed quoted a current database of 900 patients, with an age range of five days to 104 years. Patients receive an average of six treatment sessions, with a range of 4-50 sessions. Therapy is intensive, occupying several times a day and completed over one to two weeks. Using electrical stimulation and Boogie oesophageal dilatation E-stim reports successful recovery of oral intake in 97% of all cases and suggests that their short average treatment makes the therapy a cost-effective alternative to traditional therapies, including long-term tube feeding. The potential financial gain for service purchasers is clear, as are the obvious quality of life benefits for patients and their families. Mrs. M said, "It's a miracle; it has transformed our whole family life."

Karen's story

Karen's neurological difficulties started in 1989 when she was two years old, with ataxia, facial weakness and squint. A posterior fossa cavernous haemangioma was diagnosed. In July 1991, Karen had surgery at The Royal Victoria Hospital (RVH), Belfast, to obliterate the venous malformation, which was resulting in persistent haemorrhaging. She had surgery to remove the haemangioma in July 1994 and again in January 1996 at Great Ormond Street Children's Hospital. Karen's post-operative dysphagia symptoms in 1994 largely resolved before hospital discharge. However, post-operatively in 1996, her residual neurological deficits were severe. Difficulties included, bilateral sixth nerve palsies, bulbar pulsat, apraxia, dysarthria, and oral-gastro feeding.

Clinical evaluation indicates minimal laryngeal elevation. Gag, palatal and swallowing reflexes were absent. Karen had severe dysarthria, which improved over a six-week period. However, there was no improvement in her swallowing profile, despite thermal stimulation therapy.

In April 1997, Karen was re-admitted before having a PEG tube inserted. Videofluoroscopic swallowing study indicated severe oropharyngeal dysphagia; initial trials with 3ml thickened water indicated poor bolus formation and control with delayed transit. Karen's base of tongue to pharynx wall contact was poor, with no reflexive swallowing activity and minimal laryngeal movement. She had pooling above the cricopharynx which resulted in overspill into the trachea and silent aspiration below cord level. Karen had a PEG tube inserted and was transferred back to her local team.

We had no further contact with Karen until February 1998 when Mrs M informed us of Karen's successful treatment in Cleveland. Karen had received twice daily E-stim for approximately 30 minutes per week, in addition to four dilatation procedures. She started to eat successfully after one week and tube feeds were discontinued within two weeks.

Karen had a clinical feeding review six months post-E-stim in the Royal Belfast Hospital for Sick Children, which showed a significant improvement in eating. She demonstrated slow, effortless but effective oromotor movements, with moderate reduction in speed, range and strength of muscular activity. She was able to eat a cheese sandwich, yoghurt and drink milk from a straw with no obvious signs of aspiration.

Despite obvious functional improvement, the radiological findings on a repeat videofluoroscopy were disappointing. Karen's swallowing patterns were similar to those in the 1997 videofluoroscopic swallowing study. There were two differences: Karen's efforts at swallowing attempts as evidenced by repeated posterior tongue pumping into the pharynx and a slight criocopharyngeal opening allowing eventual passage of the bolus into the oesophagus. Based on this study, we would normally have recommended significant dietary restriction, but it was considered that Karen was not yet able to overcome the success of oral feeding for the preceding eight-month period, as supported by the dysphagia severity scoring system (figure one) (Dick, 1996). It is difficult to explain such functional change in the light of such definitive videofluoroscopic evidence of continuing severe dysphagia. The very significant increase in respiratory health and weight gain points to substantial improvement in swallowing safety and efficiency. Ms. Freed agreed to send us some information on Karen's post-treatment status. We sent her a copy material, but have received no further information from her.

The Belfast Telegraph headed an article about Karen 'Internet answers parents' prayers'. Information and knowledge access increases daily: parents understandably look for help through every medium. In May 2000, another family asked our opinion of E-stim. They were angry that we had not considered exploring the option of their baby going to America for E-stim treatment. During several emotional sessions, we explained that professionally and ethically we could not give an opinion on techniques with no peer-reviewed evidence of patient benefit.

Karen's story is one of personal success for a motivated, sensitive little girl who felt a 'freak' because she was unable to eat. Karen's parents received the resolution of Karen's dysphagia as a miracle. She continues to eat everything, with no respiratory compromise, however, the second family's frustration in not being able to access E-stim treatment seems overwhelming in the light of their baby's severe difficulties.

FDA approval

In February 2000 application was made for Food & Drug Administration (FDA) approval for use of E-stim with adults. This rigorous, expensive process is not usually undertaken without some anticipation of success. Professor Michael Cray and Professor Michael Grocher, specialising in dysphagia at the University of Florida, plan to expand their research interest next year into the field of electrical stimulation. Like other experts we have consulted, including Logeman, they want to see hard evidence of the successful outcomes reported.

Professor Cray commented (personal communication) said: "I believe there is a substantial body of literature on electrical stimulation and swallowing using animal models but, unfortunately, very little meaningful information regarding human swallowing. Our group is aware of the efforts in Cleveland and we wish that group would publish scientific based information on their procedure and results. We are also aware that others have experimented with electrical stimulation to facilitate swallowing behaviour. One of our future aims is to study electrical clipping as a mechanism to facilitate swallowing behaviour in healthy adults and subsequently in adults with acquired swallowing disorders."
Treating vocal nodules: are we measuring up?

Eimear McCrory evaluates treatment efficacy in patients with vocal fold nodules

All areas of speech and language therapy need to investigate the effectiveness of therapy and to look at clinical outcomes. In the field of voice disorders, voice therapy is often curative; easily definable outcomes of intervention include vocal fold status, objective measures of voice and patient ratings of voice pre- and post-therapy.

The literature indicates that behavioural voice treatment is a significant factor in improving vocal quality and in reducing recurrence of laryngeal pathology such as vocal nodules post-surgically (Ramig and Verdolini, 1998). Lancer et al (1988) in their study of 34 patients concluded that voice therapy with or without surgery reduced the incidence of recurrence of vocal nodules. They recommend voice therapy for patients with vocal nodules as well as or instead of surgical removal of nodules. Similarly, McFarlane and Waterson (1990) reported on 44 patients with vocal nodules which resolved with voice treatment using a combination of vocal hygiene, abuse reduction and vocal re-education. Murray and Woodman (1992) stated that voice treatment should be considered as the first line of treatment for nodules, as the results of treatment with or without surgery may be comparable.

Controversy

In their review of treatment efficacy in voice disorders, Ramig and Verdolini (1998) discuss the controversy of voice therapy for children with nodules. They state that although some studies suggest that voice treatment is neither helpful nor necessary, the consensus is that children with nodules should receive voice treatment. Pannbacker (1988) in her review and recommendations for outcome studies in voice treatment techniques, states that there is very limited data about the effectiveness of voice treatment and which treatments are the most effective. This author highlights the problem that treatment and which treatments are the most effective. This author highlights the problem that treatment and which treatments are the most effective. This author highlights the problem that treatment and which treatments are the most effective. This author highlights the problem that treatment and which treatments are the most effective. 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Outcome measures

These included:

1. Vocal fold status pre- and post-therapy
2. Objective assessment pre- and post-therapy (electroglarynlography, pitch analysis)
3. Objective assessment pre- and post-therapy (electroglarynlography, pitch analysis)
4. Number of therapy sessions

Summary

In over 90% of cases, vocal nodules were eliminated or reduced. Normal vocalisation returned, without surgical intervention. After therapy, over 90% of patients presented with a normal voice quality or mild dysphonia.

In over 80% of the clinical records audited, patients required 2-12 sessions of therapy, with over half of these requiring six sessions or less. Therapy was carried out on a weekly basis with each session lasting one hour. This compares favourably to Lockhart et al's (1997) study of timetables for treatment for various pathologies. These authors cite a range of 2-16 sessions of voice therapy in the management of vocal fold nodules in their two-centre study.

Following therapy, 80% of patients rated their voice as normal or as mild in severity. Their ratings correlate with my own perceptual voice ratings post-therapy.

In almost 70% of the records audited, ENT referral information did not indicate the stage of pathology. Whenever possible, there needs to be information on how established vocal nodules may be before SLT intervention starts. This can help to explain the outcome in those patients whose pathology did not fully resolve, and who required surgery followed by further voice therapy. It is generally agreed that patients with established nodules benefit from a combined approach of surgery and voice therapy (Lancer et al 1988; Ramig and Verdolini 1998). The main ENT method of examination of vocal nodules was via mirror examination. None of the 26 patients was examined using videostroboscopy, a recognised tool in differential diagnosis of laryngeal pathologies and in provision of patient visual feedback. Reasons for this included unavailability of equipment and lack of training in its use as a diagnostic tool in voice disorders. It is now employed on a routine basis in diagnosis by the ENT consultant who operates the joint ENT/SLT voice clinic. Other ENT medical staff are undergoing training in the clinic.

Objective assessment of mean fundamental frequency, using the electroglarynlography pitch analysis programme was carried out in over 75% of patients pre-therapy and in just under half of patients post-therapy. This discipline was due to equipment not being available. In patients who underwent ELG pitch analysis pre-therapy 68% of patients' mean fundamental frequency was outside normal limits for their age and sex, with 8% being within normal limits (14% not assessed). Post therapy improved the fundamental frequency within normal limits, with 8% outside these limits (42% not assessed). This audit suggests the following recommendations:

1. Better baseline monitoring would include more detailed information from ENT on stage of development of vocal nodules. Where possible, videostroboscopy should be employed as the routine method of examination before and after SLT intervention (Woo et al, 1991).
2. Objective measurements in all patients pre- and post-therapy.
3. Further examination of specific treatment techniques such as Emi's compensatory figures and Voicecraft (which I now use in addition to other voice management techniques) to determine those most effective in managing vocal nodules.

This audit contributes to the evidence base for clinical effectiveness in the management of patients with vocal fold nodules. It reinforces the message that voice therapy is effective in eliminating and/or reducing vocal nodules, in restoring normal voice and improving voice quality in the majority of patients, therefore removing the need for surgical intervention. Care pathways, audit of interventions and national guidelines on the management of vocal nodules would contribute to best practice in patient management.

Eimear McCrory

The Royal Group of Hospitals, Belfast

References:


Table 1: SLT perceptual assessment pre- and post-therapy

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<td>0</td>
</tr>
</tbody>
</table>

Table 2: Vocal fold status post-therapy

<table>
<thead>
<tr>
<th>vocal fold status</th>
<th>no of patients</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>elimination</td>
<td>14</td>
<td>54</td>
</tr>
<tr>
<td>reduction</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>no change</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>not reported</td>
<td>4</td>
<td>16</td>
</tr>
</tbody>
</table>
COMPUTERS

The Kiwi computer experience

Sarah Gilks explains what she learned from setting up a clinical computer system in New Zealand

On September 1999 I arrived in Auckland, New Zealand, to experience life as a speech and language therapist on the other side of the world. This gave me the chance both to enjoy the relaxed New Zealand lifestyle, food and wine festivals, surfing, walking in the beautiful countryside, dolphin in adrenaline sports - and to expand my knowledge and skills as a therapist. I worked in the community in a multidisciplinary team, mainly with older clients with acquired and progressive disorders, and I was involved in designing assessments for a clinical computer system and the package’s subsequent trial. I hope that others may benefit from our trials and tribulations.

The clinical computer system

Whether we like it or not, we are all aware of the increasing use of computers in our working life, for example, client databases, therapy packages and daily administrative duties. However, computerised notes and care plans were new concepts for me, although I believe that similar packages are being used in some areas of the USA and the UK. In the UK, I understand that the government has set out objectives for all trusts to work towards computerised, single patient records.

When I arrived in Auckland, the multidisciplinary team was busy preparing assessments for the launch of the clinical computer module. The project’s overall aim was for clinicians to have hand-held computers to take with them on their visits.

They would enter clinical data during the day and on returning to base they would download the information via a network link to the main computer. This concept is still some way off as the amount of time and planning needed to get the system up and running was certainly underestimated.

All our assessments were presented in Microsoft Word Table format. The type of data entered into the system included the client’s general information, medical history, previous treatment history, home environment, social and lifestyle aspects, the type of data entered into the system included the client’s general information, medical history, previous treatment history, home environment, social and lifestyle aspects, the type of computer programme being used.

Initial expectations of what we thought the programme could do were very different from the reality. This ranged from the layout of the form to the use of drop down menus. We were encouraged to reduce the amount of free text in the forms where possible and to use tick boxes and drop down menus as an alternative.

Part of the reasoning behind this was to make the assessments easy to use when out on the road.

Once we understood the different way information could be presented, we saw the benefits and used the system effectively.

The IT department later distributed clear guidelines that were by now acutely aware of our team’s lack of IT skills. They gave us support in the form of newsletters, training sessions and information on how to create assessments. Later two members of the multidisciplinary team were given extra training to bridge the gap between clinicians and the IT staff.

Dysphagia approach

Following discussions with other community SLTs throughout the Auckland area, we realised that an ad hoc approach was being used when documenting the results of dysphagia, assessment, although we agreed that summary of difficulties and recommendations were the main components in the assessment.

In designing the computer assessment we had to record all stages, providing a systematic approach to assessment. This involved the SLT team examining our procedures for dysphagia assessment. We analysed numerous cases with its many variations as possible and recorded the different approaches that were used and included them in the form. Our discussions were open and allowed SLTs to be critical and honest. Our aim was to produce a comprehensive and objective assessment.

The other area of great deliberation was how our dysphagia work in the community differed from that of our colleagues working in an acute setting. The assessments we were reviewing all centred on the care of the client in hospital. Some components of a bedside assessment are common to both settings, for example, alertness, cranial nerve function and fluid/fluid trials. However, in the community it is vital to consider environmental factors when creating successful care plans.

Coping with disability

Once the client has been discharged from hospital, the way in which they cope with dysphagia can vary. In some cases the client will follow the SLT’s recommendations. At other times the client/carer may have decided to make modifications which may or may not be appropriate. The way in which our clients are living with their disabilities is an important issue for community therapists.

This led us to develop the ‘mealtime environment’ section – which is largely based on observations – and also the Client/carer perspective’ section, which asks the client probing questions on the problems and their expectations of the referral.

In the mealtime environment section, the SLT indicates the method and technique of assessment used:

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>method</th>
<th>technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>trial of textures</td>
<td>observation</td>
<td>meal</td>
</tr>
<tr>
<td>meal texture assessment</td>
<td>cervical auscultation</td>
<td></td>
</tr>
</tbody>
</table>

We often found that we were observing a client eating a meal in addition to or in place of a formal tactile assessment, particularly in nursing homes. This gives the SLT an invaluable perspective on the situation. Observations included:

- location: sitting at table, armchair, bed
- position: upright, leaning forward, lean to one side
- method of feeding: fed by hand, fed by other, combination

The information gained guides the speech and language therapist’s future intervention, such as working with a significant other to modify the rate of feeding or referring an OT to improve posture by making adaptions to furniture.

From my experience some points to consider before embarking on a similar project are:

1. Try and ascertain how much time will be needed to devise and pilot the system, as patient contact time will be affected.
2. Make sure you have basic computer training, including keyboard skills – this was probably the main stress factor for our team.
3. Include all team members if possible for decisions on devising acceptable assessments.
4. Liaise with the IT department to ensure that your assessment can be accommodated by the software available – you may need to make compromises.
5. Test your system before technology takes over.

This whole exercise was a learning process for me – I started in some trepidation and ended up being quite excited by the advantages. These included:

- Single patient records enable all members of the team to gain instant access to a full case history, knowledge of which professions are involved and what their goals are for the patient.
- This encourages a client focused approach to therapy.
- The goal-planning aspect of the package supports clinical effectiveness and encourages the clinician to evaluate therapy critically.
- All therapists use a consistent approach, enhancing communication between SLTs and giving an opportunity to collect data for audit purposes.
- The system allows you to transfer a case to another therapist quickly, as either a temporary or permanent measure. This client will then be transferred to the relevant SLT’s ‘to do list’.
- Once therapists are familiar with the system, it may be used to assist the Assessment Management.

I was lucky to be supported by a husband who happened to be working for a computer firm (and is now an expert on dysphagia), and also a supportive management team.

If you require further information, please feel free to contact me. If you are starting on a similar adventure, good luck.

Sarah Gilks
Speech and language therapist, Worcestershire NHS Community and Mental Health NHS Trust

Special thanks to Stephanie Grieve and the rest of the team, AV Links, Home and Older People’s Health, Auckland Healthcare Services Limited.
Regulating the health professions

A joint conference at the College of Occupational Therapists, London

Wednesday, 1 November 2000

Each profession should strike a balance between professional artistry and technical rationalism

The government’s ‘better regulation’ task force, which looked at diverse industries such as building, advertising and GPs, inspired much of the thinking behind this concept of regulation. So, too, did the change in public expectations. This led to the inclusion of lay representatives, who should keep regulators’ feet firmly on the ground and their activities more open.

The Health Professions Council (HPC) will replace the Council for Professions Supplementary to Medicine and its 12 boards, which currently regulate a majority of one professional over the lay representatives

...health and welfare of patients to be paramount

...wider powers on disciplinary matters

...linking continued registration with continuing professional development

...Natalie Bewshereth, chair of the Allied Health Professions Forum (AHPP), summarised its response to the HPC consultation document. The AHPP wants:

...a willingness to listen and to adjust government proposals (Lord Hunt, the minister involved, has emphasised the importance of consultation)

...improved patient protection

...strong representation by patient organisations

...self-regulation

...multi-professional development of policy and strategy but

...uni-professional working on education and disciplinary cases

...accountable to both public and professions for its work

...equal treatment with doctors and nurses with a single overarching board over all three groups.

The HPC will probably have a configuration of a full council with statutory committees, with hearing panels, non statutory committees and non statutory working parties. Current registrars will stand and those on the register will transfer to the new council’s register.

Strong foundation

Auldine Aboak presented a framework for continuing professional development. It was pleasing to know that our profession has a strong foundation in place, as continuing professional development (CPD) is central to our work ethos. However, signing up to CPD does not necessarily mean that one is competent to practice. RCCHT’s Kath Williamson firmly grasped the issues of competency. In a challenging, thought-provoking presentation, Kath said that the CPD outcomes should be targeted at reaching competency standards. Each profession, she said, should strike a balance between professional artistry and technical rationalism.

Lay representation

Lay representation is another key issue and Gwilym Roberts spoke on behalf of Mencap, Scope and Mind. These groups support the idea of working in partnership for the benefit of all practitioners and the people they serve. However, there are questions over the criteria for lay representatives: can they truly be representative of either specific clinical areas or a wider population? Like all good conferences, it raised more questions than it answered.

Anne Baseby

SLT manager

Royal Surrey County Hospital NHS Trust

Mary Law lecture: Speakability

London 14 November 2000

Stephen Small’s dream is to eradicate aphasia. Both researcher and clinician, Professor Small believes that the way forward for people with aphasia is through what he calls a ‘biopsychosocial model’, a combination of pharmacological and SLT interventions. A strong advocate of group therapy and support, he also points out that drug therapies are cheaper and have an as yet barely explored potential for improving both cognitive impairments and associated mental health disturbances, such as depression.

Giving the 16th annual Mary Law lecture, the director of the Comprehensiv Aphasia Center in Chicago said that his treatment philosophy was to treat all the problems around aphasia, and to treat it as a chronic condition. He criticised the resource-driven trend towards shorter periods of therapy: “You wouldn’t treat diabetes just for a couple of weeks and then give up because therapy wasn’t effective.”

Drug damage

Professor Small discussed the role of the cerebellum, which he believes may have unsuspected importance in language, and evidence that brain function can be both enhanced and damaged by drugs. Some medication, including haloperidol, diazepam and some anti-depressants, has been shown to have harmful effects on language. Doctors should consider the consequences of continuing to prescribe such drugs after an aphasic stroke. On the other hand, there is some evidence that piracetam, a drug in regular use in Germany and Holland, can have beneficial effects if its use is combined with speech and language therapy.

Looking to the future, Stephen Small saw the future for pharmacology in stroke as one of increasing perfusion in the acute stage, removing agents that impede recovery and treating depression. He also saw positive uses for gene therapy and cell or tissue transplantation. He foresaw speech and language therapy teaming up with pharmacology, with outcomes extending into the biological as well as functional changes.

One hundred people attended the London Mary Law lecture, with over 50 attending in Manchester and Stirling.

Jenny Sheridan
Teaching Children who are Deafblind

Arkins, S, Butler, S, Clark, C, Emmett, P, Peace, L, (Eds)
David Fulton, 2000
£18.00 ISBN: 1-85346-674-3
This book, aimed at teachers, residential staff and students, is potentially useful to those working with multiply disabled visually impaired (MDVI) children and multiply disabled hearing impaired (MDHI) children, as well as those who are deafblind. Not much has been written about these groups, but, unfortunately, this book does little to fill the gaps for all five groups concerned.

Chapter two (Creating a communicative environment) is particularly disappointing, as the discussion of the communicative development of deafblind children is too brief; object reference receives little attention, the discussion of AAC (which, given its brevity, is good) focussing on verbal rather than non-verbal systems. Chapter three in chapter six; assessment is too brief; objects of reference receive little attention, thus what is meant by pragmatics and pragmatic meaning, and relevancy. The authors draw on recent research and discuss theoretical concepts clearly and comprehensively. As new concepts are introduced they are illustrated with examples, and each chapter has exercises/comments based on clinical data. These would be a good starting point for discussion groups, although they are at a more basic level than the main body of the text. Current debates are included and well supported by research. For example, should pragmatic disorder be viewed as a feature of autistic spectrum disorder or specific language impairment? It is not a “how to” book of therapy ideas. Instead, it guides the reader to think in detail and to ask questions about pragmatic difficulties, applying theory to practice.

This well-organised book gives the reader access to a range of research, and field of pragmatics, and would be of interest to students and to more experienced clinicians.

Contents

Pragmatic Difficulties of Communication

Gill Terry, Joan Wilson

The teaching of pragmatics, some of which fit rather well with brief case studies. The outline descriptions of therapists, by therapists on this subject area. developing children from many case studies are translated into French, Spanish and German. It is an invaluable tool for SLTs working with language delays, language disorder or learning disability.

Contents

Science and Language Therapist, Mountain and Spinthorne NHS Trust

Teaching Children with Pragmatic Difficulties of Communication

Gilbert MacKay, Carolyn Anderson (Eds)

This book will be of most value to modern classroom assistants rather than for SLPs. Compaions would find the overviews and extensive references useful, but most therapists will be interested in those with any interest or experience in pragmatics, will find little new.

The opening chapters provide a detailed overview of the historical and theoretical background to the study of pragmatics, which might interest SLP students. Compaions would find the communication to a traditional ballroom dance is, however, less useful. The focused analogic tries to encompass all aspects of pragmatics, some of which fit rather uncomfortably in the imposed sequence. This comparison tends to distract from the main argument rather than facilitate understanding. The detailed observation and many case studies illustrate the extent and complexity of children’s pragmatic difficulties. However, almost all are drawn from specialist schools and units. There is little mention of the needs of the increasing numbers of children now being placed or mainstream schools.

Occasional ideas for helping children with specific problems (for example, word-finding) are sometimes buried in theoretical chapters, but the central section has clear ideas for classroom management (for example, TEACH programme, SLP programme, objects of reference, use of observational elements to develop interaction). Attempts are made to link these approaches to the seven functions of language, defined by Halliday and explained earlier on.

The outline descriptions of therapists by therapists on this subject area. developing children from many case studies are translated into French, Spanish and German. It is an invaluable tool for SLTs working with language delays, language disorder or learning disability.

Contents

Value

Readability

Kwok Ricewicz

Speech and Language Therapist, Mountain and Spinthorne NHS Trust

Halliday and explained earlier on. The outline descriptions of therapists by therapists on this subject area. developing children from many case studies are translated into French, Spanish and German. It is an invaluable tool for SLTs working with language delays, language disorder or learning disability.

Value

Readability

Liz Buckles

SET, University of Hull

The research therapist, a practical guide to planning, performing and communicating research

Swinson E, A, Kershaw, G, A, Church, E, J, B, L, (Eds)

Therapists are under increasing pressure to provide evidence of the effectiveness of their practice, and many therapists are becoming interested in undertaking research. A book which is written for therapists by therapists on this subject area. developing children from many case studies are translated into French, Spanish and German. It is an invaluable tool for SLTs working with language delays, language disorder or learning disability.

Value

Readability

Liz Buckles

SET, University of Hull

Test of word and use and score, giving an indication of the child’s awareness of words and understanding of word semantics, sentence meaning and general language. The test is easy to administer and score in about 20 minutes. Testing can take place over a number of sessions. Although the manual provides some data on test reliability, but there appeared to be no information on test validity. In addition, it has a brief separate section on the assessment of children with pragmatic difficulties.

Value

Readability

Dickson Garbato

Chief SLT (pandemic) Portsmouth HealthCare NHS Trust

The manual provides some data on test reliability, but there appeared to be no information on test validity. In addition, RAS is a brief separate section on the assessment of children with pragmatic difficulties.

Value

Readability

Dickson Garbato

Chief SLT (pandemic) Portsmouth HealthCare NHS Trust

The other chapters are likely to be of limited value to SLTs. A serious drawback, regardless of the reader’s profession, is the book’s failure to explain parent-child verbal interaction, either in the main text or in the glossary. The book is mostly readable, and well illustrated with brief case examples. However, there is inadequate cross-referencing between chapters, the index and tables are very poor, and there are insufficient references.

In general a disappointing book, although it must be remembered that it is not aimed at SUs. Those newly involved with deafblind, MDVI or MDHI children may find parts of it instructive and supportive; more experienced clinicians will be disappointed with the lack of depth and detail. If you work with these children, you should probably at least dip into this book, but get your department or school to buy it.

Contents

Value

Readability

Ian P. Re

Speech and Language Therapist (specialising in visual impairment), RMS Sunshine House School, Southport

Children’s Pragmatic Communication Difficulties

Eva Lenholme, Carolyn Letts, Benita Rae Smith

This book explores in some depth what is meant by pragmatics and pragmatic language impairment, focusing on verbal rather than non-verbal aspects of communication. Several areas are covered in detail, each in separate chapters. However, some themes run throughout the book, in particular the idea of the ‘meanings of utterances going out of the words themselves and of creating meaning in context. This gives rise to a discussion of where semantics and pragmatics begin, and recent research is used to clarify the boundaries.

The aspects of pragmatics covered include: communicative use of language; discourse and conversational analysis; narratives and storytelling; comprehension and pragmatic meaning, and relevancy. The authors draw on recent research and discuss theoretical concepts clearly and comprehensively. As new concepts are introduced they are illustrated with examples, and each chapter has exercises/comments based on clinical data. These would be a good starting point for discussion groups, although they are at a more basic level than the main body of the text. Current debates are included and well supported by research. For example, should pragmatic disorder be viewed as a feature of autistic spectrum disorder or specific language impairment? It is not a “how to” book of therapy ideas. Instead, it guides the reader to think in detail and to ask questions about pragmatic difficulties, applying theory to practice.

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Value

Readability

Jacky Mann

Specialist speech and language therapist, Southern Derbyshire Community NHS Trust

Pocket Colourcards: early actions, early opposites, early sequences

Winson Press, 1999 £5.95
Winson provides a contemporary language resource aimed at developing both comprehension and expression in the early stages of language development. It consists of four sets: early objects, early actions, early opposites and early sequences. Each set contains 36 pocket size modern images of every day objects and actions. Most are a part of the child’s surroundings and everyday routine. The photographs are simple, bright and appealing. The resource also provides a list of ideas of how to use Colourcards to help children’s language skills. These are translated into French, Spanish and German. It is an invaluable tool for SLTs working with language delays, language disorder or learning disability.

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Kwok Ricewicz

Speech and language therapist, Mountain and Spinthorne NHS Trust

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Occasional ideas for helping children with specific problems (for example, word-finding) are sometimes buried in theoretical chapters, but the central section has clear ideas for classroom management (for example, TEACH programme, SLP programme, objects of reference, use of observational elements to develop interaction). Attempts are made to link these approaches to the seven functions of language, defined by Halliday and explained earlier on. The outline descriptions of therapists by therapists on this subject area. developing children from many case studies are translated into French, Spanish and German. It is an invaluable tool for SLTs working with language delays, language disorder or learning disability.

Contents

Value

Readability

Liz Buckles

SET, University of Hull
Unless otherwise stated, all replies should be addressed to the speech and language therapy departments.

Students who qualified from Leeds Poly (now Leeds Metropolitan University) in 1976 are holding a reunion in Leeds on 12 May. We have contacted 20 members of class, and are searching for Maggie Emslie, Jane Frost-Smith, Erica Endacott, Sue Pureell and Tina Gregory. Would any other 1976 students like to contact Barbara Hollis (nee Wolliams) Pauleine Lowe (nee Bailey), Manor House, Brant Broughton, Lincoln LNS 0SA.

Information wanted on language databases which mainstream school staff can implement with small groups of nursery and reception aged children. Linda Wright, The Bungalow Longshott Health Centre Scholes, Wigan tel: 01254 495189.

Planning to pilot a drop-in service to address parents concerns about their child's speech and language development. Does anyone have experience with this approach? Rachael Hughes, Helen Mellor, Sandringham House, Castle Courts, Windsor Street, Salford M5 4DG tel: 0161 212 4022 fax: 0161 212 4051.

I'm trying to set up a multi-disciplinary feeding team in an ALD service. Is there any information about how to go about this? Amanda Sharp, Keresforth Close, off Broadway, Barnsley, S70 6RS tel: 01226 730 000 ext 3406.

Willing and wanting to share ideas, approachers or providing responses, particularly on training and involvement of health visitors.

Sue Ward, Halton Clinic 2a Primrose Lane, Leeds LS15 7HR tel: 0113 295 1883 fax: 0113 295 1809.

Our paediatric SLT service wants to set up a departmental database networking our many sites. Considering options of buying tailor-made software or adapting existing database packages, such as Microsoft Access. Have any paediatric SLT departments done this? Ed Hooke, Shrewsbury Centre, Shrewsbury Road, Forest Gate London E7 6QP email: database@speicr.screaming.net.

Information wanted on standardising our service to clients. We wish to develop a protocol for prioritising new referrals. Does anyone have experience, particularly on systems that are working? Judith Anderson, Farnham Hospital, Hale Road, Farnham GU9 9QL tel: 01483 758000 fax: 01483 782950 email: JudithAnderson@UKGateway.net.

Urgent: seeking studies/information on the comparative effectiveness of on-going, weekly therapy and scheduled, short courses of therapy separated by periods with no intervention.

Angela Abell, 105 Woodland Way, London N21 3PY tel: 020 8868 9402 (even), 01779 278331 (work) email: angelaface@live.net.

SLTs in small independent special school seek models of working and advice on pay restructuing, especially from those working in ICA schools.

Rachel Berwick, 8 Fordbrook Road, Didsbury Manchester M20 2TH tel: 0161 445 9399 email: r_berwick@hotmail.com

Setting up a city-wide early prevention/intervention package. Is anyone currently using innovative programmes other than Haven or Manchester

much value being a member of the Special Interest Group (SIG)?

What are the pros and cons of not exclusively treating dysfluency clients? How is it different from specialising in dysfluency? On the positive side, I keep sight of dysfluency as only one communication disorder, sharing many features with others. On the down side, there are limited training funds for a non-specialist (though I would like to acknowledge generous training received over the past 16 months) and I have to balance competing case-load demands. Is it beneficial to work only with dys-fluent adults, rather than the whole age range? I enjoy working with adults, because of the direct relationship it offers between therapist and patient. The disadvantages are the lack of opportunity to see the whole picture; of no continuity for the stammerer, particularly around the age of 16; and the lack of opportunity to develop skills with children. In these circumstances, being in the SIG has been a very valuable source of support, information and contacts. I have attended several excellent study days and receive a stimulating bi-annual newsletter, Signal. Why not join? To join the SIG in Disorders of Fluency contact Claire McNell at West Swindon Health Centre, Link Avenue, W. Swindon, SN5 7DL tel 01793 872523.

Win Ashmores, Oldham.

Mental health

The SIG Mental Health currently provides SLT training packages in response to requests from trusts. To discuss your training needs, or to make a specific request, contact Sarah Kramer, 12 Courtleigh Gardens, London NW1 9JX tel: 020 6455 1768.

I have given you some insight into what a relative small profession we recently, I have been asked by Alan Milburn to sit on the Modernisation Task Force for Children. This strategic group will oversee implementation of NHS policies for children and develop robust, two-way means of communication between clinicians and the DoH. More about this will appear in a future edition of Bulletin.

I hope you have given some value to the services that my profession at the moment. I look forward to keeping you informed of future developments.

Pats Parsons, Chair, RCSLT

The following reports have been received from members awarded RCSLT grants. Send an A4 to Glenn Palmer at RCSLT for a copy of any report.

Joan Stansfield Speech pathology education in USA Sarah Hughes, Isaac 2000 Jo Robson Meeting the Millennium: Best practice in speech and language therapy. Mike Clarke, Isaac, 2000

Ilia Papathanasiou International Aphasia Rehab Conference

Correction

The research report by James Law et al. Provision for children with speech and language needs in England and Wales is available as not, as stated in last month's Bulletin, from City University but from the DfEE publications department, PO Box 5050, Shefwtown Park, Aylesbury, Buckinghamshire HP21 1DU (tel 0845 60 222 60). The DfEE have also put the research brief on the website where you can download a free copy (www.dfe.gov.uk/research or home).
AAC
Communication aids January
Conference report March
City & Guilds certificate Rappell, Junghanns September
Scope campaign November

Aphasia
Cochrane review Greener et al February
Cochrane review Code March
Narrative therapy Barrow April
Raising awareness Torney, Crozier June
Assessment Mackenzie October

Children: general
Working in the Caribbean Clegg et al January
Emotional and behavioural difficulties: conference February
Social services nurseries Beech Mistry March
Play therapy McLellan May
Screening and early intervention July
STEPS research project July
Social services nurseries Chotai, Habgood August
Hanen, Wilstaar, playgroups Hall September
Videoconferencing October
Emotional & behavioural difficulties Dickens October
Nurseries Doyle, O'Brien November

Children: education
UK/US experiences James February
Groups in mainstream Manz March
Statements Luscombe April
Literacy Wren May
Literacy hour Mann June
Collaborative work Gaile June
Literacy Slater July
Literacy Withey July
Narrative therapy Shanks November
Building alliances Edelman November
DFEE/DoH working party report December
Provision in schools research December

Cleft palate
Breastfeeding Willis February
Breastfeeding Brookman February
Cleft care reorganisation June

Dysphagia
Training nurses Pownall, Parker May
Conference report May

Head injury
Personal experience Hampson March

Hearing impairment
Neonatal screening April

Learning disability, adults
Models of service delivery Money January
Facilitated communication June, September
Hearing impairment Green October
Staff development Evans December

Learning disability, children
Autism Bleeks September
Autism Ringrose October

Mental health
Child psychiatry Jones, Chesson July

Visual impairment
Language development Bell November

Voice
Teachers' voices Bufton June
Radiotherapy Jones, Carr October
Voice training Shewell November

Other
Tertiary/local services Russell et al January
Mental incapacity Jenkins January
Criminal justice Forshaw, Chapman August

Dysarthria
Developmental dysarthria Chan December