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SUMMER 1997

Speech & Language Therapy in Practice

Your clinical companion

A preventative approach

Introducing WILSTAAR in Epsom

Enjoy your meal!

Use of thickener in dysphagia

Fluency - Promoting early referral

Primary Healthcare Workers Project

Focus on Derwen

Objective setting in a specialist Trust

Minimally responsive state

A team approach to severe brain injury

How I ... manage dysarthria

Three therapists discuss a case

Naming - more than just right or wrong?

Responses to cueing in aphasia

Information for contributors

Common queries answered

A positive approach for committed professionals.

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Derwen is a specialist Trust in West Wales for people suffering from mental illness and distress and learning disabilities. Objective setting and support workers are vital to the speech and language therapy department.

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The team approach to minimally responsive state
Recent publicity has highlighted the controversy surrounding the long-term management of clients with severe brain injury. Sophie MacKenzie describes her role with one such group at the Royal Hospital for Neuro-disability.

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Epsom Healthcare Trust has been awarded £70,000 to fund a WILSTAAR early intervention project. How did they do it? Sue Oakenfull gives details.

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Three therapists set out their management of a client, Bert. Exploring the client's needs and expectations, providing clear information and offering a range of therapy options are important.

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24 Naming - more than just right or wrong?

Linda Armstrong and Michelle Brogan argue that therapy for aphasic clients with word finding difficulties is improved by closer examination of picture naming errors made spontaneously and in response to cues.

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As with other magazines, Speech & Language Therapy in Practice has a specific and consistent style on which its readers depend. Common queries from potential contributors are addressed.

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Time for change

Working at the Royal Hospital for Neuro-disability with people with severe brain injury, Sophie MacKenzie is at the cutting edge of speech and language therapy, where careful assessment over a long period of time is vital in pinpointing a way of accessing communication. Even when communication is established, learning to use the chosen method effectively is a painstaking process needing hard work and perseverance in the long-term by clients, staff and carers. In recent times we have seen a huge improvement in the sophistication of technology available to assist such clients and we can be confident this will continue in the future.

Another big change has been the swing in the role of speech and language therapists towards involvement in dysphagia. I have unpleasant memories from my first job of daily diets for dysphagic clients of mashed potatoes with gravy and congealed thickened drinks. Fortunately, this need no longer be the case as manufacturers of thickeners such as Thick & Easy have worked on products to make them safer, more palatable and able to be used more imaginatively. Many therapists find challenges working with kitchen staff who have their own pressures to deal with, so hopefully the article by Sarah Barton and Sharon McLaughlin will be of assistance in that process.

With adults, such as those discussed in Linda Armstrong's article on the effects of cueing in aphasia, we often need sustained involvement to bring about change. For children we seem to be moving more towards finding a 'right' time for intervention. Elaine Christie of the British Stammering Association's Primary Healthcare Workers Project quotes research indicating there is an optimum time to provide intervention, direct or indirect, with children who appear to be stammering. The BSA is giving therapists much needed information resources and opportunities to share experiences to try to ensure a more equitable service within and across departments.

Early and timely intervention is also the message of the WILSTAAR project in Epsom. Many other departments have requested information about how the funding for this was achieved; Sue Oakenfull provides the answers.

As this magazine changes ownership, I find myself with a unique opportunity. Time will never change the need for practical, accessible and up-to-date information for speech and language therapists who have much to do and not enough time to do it. I look forward to continuing and extending Speech & Language Therapy in Practice's role in meeting this need and extend thanks to Elinor Harbridge of Hexagon Publishing for conceiving and publishing this magazine over the past twelve years. If you can find the time to contribute to the magazine in any way (see page 27), I would be very pleased to hear from you.

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It would be appreciated if you could call evenings, Fridays or weekends as I am also a practising therapist from Monday to Thursday. If leaving a message, please leave your home and work numbers.

Michael Palin Centre referrals: New funding policy

All full consultations of children referred to the Michael Palin Centre are now being funded by the Association for Research into Stammering in Childhood.

Following this specialist and detailed assessment involving the whole family and their local therapist, funding for further involvement will continue to come through the extra-contractual system between the Camden and Islington Community Health Services NHS Trust and local district purchasers. If therapy at the Michael Palin Centre is felt to be the best option for the child, it will not be offered until funding has been agreed.

As referrals for the consultation service come from speech and language therapists across the UK, in many instances the local therapist is given a detailed action plan with the opportunity of continued support and follow up.

Details: Diana de Grunwald, The Michael Palin Centre for Stammering Children, Finsbury Health Centre, Pine Street, London EC1R 0JH, tel: 0171 530 4238

Alzheimer's drug gets clearance

A new drug for the symptomatic treatment of mild to moderate Alzheimer's disease (AD) is the first to be licensed in the UK specifically to treat Alzheimer's disease.

Whilst providing neither cure nor the ability to stop or slow down the progression of the disease itself, ARICEPT™ (donepezil hydrochloride) may allow a greater concentration of acetylcholine - associated with memory and learning and in short supply in AD - in the brain. Controlled clinical trials in over 900 patients in the USA demonstrated more than 80 per cent either improved or exhibited no further deterioration in tests of cognition over the course of the studies. Patient function, including behaviour and activities of daily living, was rated by clinicians as improved in approximately two times as many patients on the drug in comparison to a placebo after 24 weeks of treatment. It is hoped donepezil hydrochloride will also ease the stress the disease causes in carers. Results of UK and European trials are expected in the autumn.

Information on all aspects of Alzheimer's disease is available from the Alzheimer's Disease Society, Gordon House, 10 Greencoat Place, London SW1P 1PH, tel. 0171 306 0606. Information sheet 11 describes new treatments.

Clear speech

Independent hearing aid audiologist Cubex is offering 'clear speech' training sessions for relatives to support their hard of hearing clients. Managing director Adam Shulberg said "Once a client has been fitted with the hearing device, we encourage family members to take the session. It only takes ten minutes to learn but, with a little practice, can improve the patient's ability to follow a conversation". The 'clear speech' technique involves using a slower and louder speech pattern with no missing syllables or dropped word endings.

Details/leaflets: Danielle Fisher, tel. 0171 247 0367.

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Equal value decision

Pam Enderby has urged caution while welcoming the Department of Health's decision to equalise her pay with Clinical Psychologist comparators.

Professor Enderby said, "I am particularly pleased at the recognition that the work of speech and language therapists is of equal value, but concerned there hasn't been the political will to address the issue of low female pay and poor career structures. Good lip service has been paid with little difference seen over the last decade. However, the case does demonstrate that women have access to law and that there are anomalies in professional structures which are probably related to gender."

The Union backing the claim, MSF, hailed the decision as a victory for women staff throughout the NHS and other industries. National Secretary Roger Kline said "It is a landmark decision and is the biggest single breakthrough on equal pay for women for many years. It will oblige the NHS to consider carefully the grading of all women staff in all professions."

Legal arguments continue over who should pay Pam Enderby and how much and she believes it will be another two years on top of the 11 already spent on the case before the wider effect, if any, is felt.

The Department of Health said in a statement, "A further sixteen cases are due to be heard by the tribunal. It is unlikely that the tribunal will be able to hear all these cases by the time rises on 18th April, in which case the conclusion could be expected sometime after the tribunal reconvenes in September. It would be premature to speculate on the implications until a final conclusion is reached." The Department plans to consider each of these lead cases on its own merits, thereafter considering 1500 further cases.

International Dyslexia Conference

The role of phonemic awareness in dyslexia was one of the main themes of the British Dyslexia Association International Conference. Over 150 speakers included Vicky Joffe who explored the interaction between reading ability, language development and phonological awareness in a group of specific language impaired children and a matched control group, and the therapeutic implications. The metalinguistic theme was continued by Liz Dean and Janet Howell reporting on their study into the changing nature of phonological awareness as a child develops.

The importance of working together for early identification and intervention was highlighted. Speech and language therapists from the Helen Arkell Dyslexia Centre looked at working with teachers on teaching oral language skills. Andrew Newton, a GP, discussed whether and how GPs should become more involved in early diagnosis. Liz Nathan, Joy Stackhouse and Nata Goulandris considered the identification of the child at risk of speech and literacy problems and the implications for the role of speech and language therapists and nursery staff. John Locke described a longitudinal study of infants and young children born to dyslexic parents. They showed general features such as less advanced vocal development and expressive language, significantly lower recall of word and non-word strings and less awareness of rhyme.

A selection of the papers presented at the April event in York form a new book from Whurr Publishers: *Dyslexia - Biology, Cognition and Intervention*. Editors Charles Hulme and Maggie Snowling point to the dominant view of dyslexia as a form of language disorder which runs in families and can be effectively remediated if identified early. The core cognitive deficit is believed to be a phonological one and there is a strong genetic component to the phonological skills that underpin reading development.

Teletubbies say hello

A new daily BBC-2 series has been "specifically designed to aid children's speech development" in a technological age.

The Teletubbies are four full-size costume characters like soft toys, which are linked to technology by the television screens in their tummies. Co-creators Andrew Davenport - who studied speech sciences - and Anne Wood used the first words and phrases children make for the Teletubbies' vocabulary. The Teletubbies attempt to imitate the Narrator, inserts in the programme are repeated and time is left for children to talk back to the screen, all features aiming to encourage thinking and speech skills.

Research for the programme is ongoing through a specially designed shop in Stratford upon Avon and seven focus groups with nursery school children all over the country. The target audience is two to five year olds. Anne Wood says "We should remember that many little ones spend a great deal of time indoors in small spaces for much of each day. We may deplore the conditions in which some children live, so we must always remember that television can be a window to other possibilities."

RESOURCE UPDATE...RESOURCE UPDATE...RESOURCE UPDATE...

Dysphasia Matters
A Medical Teaching Pack

Action for Dysphasic Adults has produced a medical staff teaching pack for use by speech and language therapists experienced in working with people with dysphasia.

Consisting of a 20 minute video, lecture notes, workshop ideas, overheads and handouts, it can be used flexibly to accommodate different audiences.

The video gives a simple explanation of dysphasia and illustrates its impact on people's lives. Author Celia Woolf of City University has prioritised the key information. The pack aims to improve the skills and confidence of hospital doctors, GPs and other professional staff working with dysphasic people and to show the benefits of learning communication techniques.

Cost: £100 inc. p&p

Details: ADA, 1 Royal Street, London SE1 7LL, tel. 0171 261 9572

A VOICE for the deaf

Concerned at high levels of illiteracy and underemployment among the deaf community, Morton Warnow has developed a system to address this.

The VOICE program involves children round a table with a teacher touch typing on linked keyboards to communicate with each other.

Details: Morton Warnow, Educational Technology for the Deaf, 19 Main Street, Apt. #703, Danbury, CT 06810

Co:Writer for Windows

The Co:Writer intelligent writing assistant software is now available in a Microsoft Windows 95 compatible version. Previously only available for the Apple Macintosh, the software is used in conjunction with a word processing package. After keying in one or more letters, prediction of the required word is provided based on word frequency, subject / verb agreement, word relationships and grammatical rules. Speech feedback and built in scanning for single switch users helps people with reading and physical disabilities respectively.

Details: Don Johnston Special Needs tel. 01925 241642.

New from Signalong

Continuing its work on development of sign resources specific to the workplace, a new manual for Hotel and Catering occupations will be available soon, containing over 630 signs, about 60 per cent of them new.

Sign and Play , a collection of traditional nursery rhymes in a format designed to involve the whole family, is also near completion. *Details: tel. 01634 819915*

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Enjoy your meal!

Thickener is a vital element in diet modification for people with dysphagia, and manufacturers are making efforts to overcome its previous limitations. Sarah Barton and Sharon McLaughlin explore the versatility of one such product, Thick & Easy, which allows patients on a puréed diet to eat sandwiches, cakes and even crisps.

There is a well recognised link between dysphagia and malnutrition. This is hardly surprising when it is considered that many dysphagic patients are served a murky diet of puréed food, generally unappetising even to people in good health.

Limitations

Puréed diets are far from satisfactory in many ways. Frequently, they do not meet nutritional requirements as the addition of fluids in preparation dilutes the nutritional content. Even when the puréed meals do in theory meet requirements, their palatability is usually so limited that they are rarely consumed in adequate quantities to provide optimum nutrition.

The use of separate bowls and plates to serve individually puréed meal items, rather than an all-in-one slurry, does improve the attractiveness of the meal by adding colour and interest. However, there are still problems.

The safety of puréed foods is a major cause for concern. This is because, after food is puréed, water separates from the food pulp and this water may be aspirated (Fleming and Weaver, 1987). Further, it has been suggested that long-term use of puréed food can decrease swallowing performance due to mechanism disuse (Groher, 1990).

As well as the nutritional and safety issues of puréed diets, there are also important psychological, emotional and social elements which must not be forgotten. When a patient is presented with a dull, unidentifiable liquidised bowl of food day after day, he is bound to feel unenthusiastic, demoralised and unsatisfied.

Improvements can be made

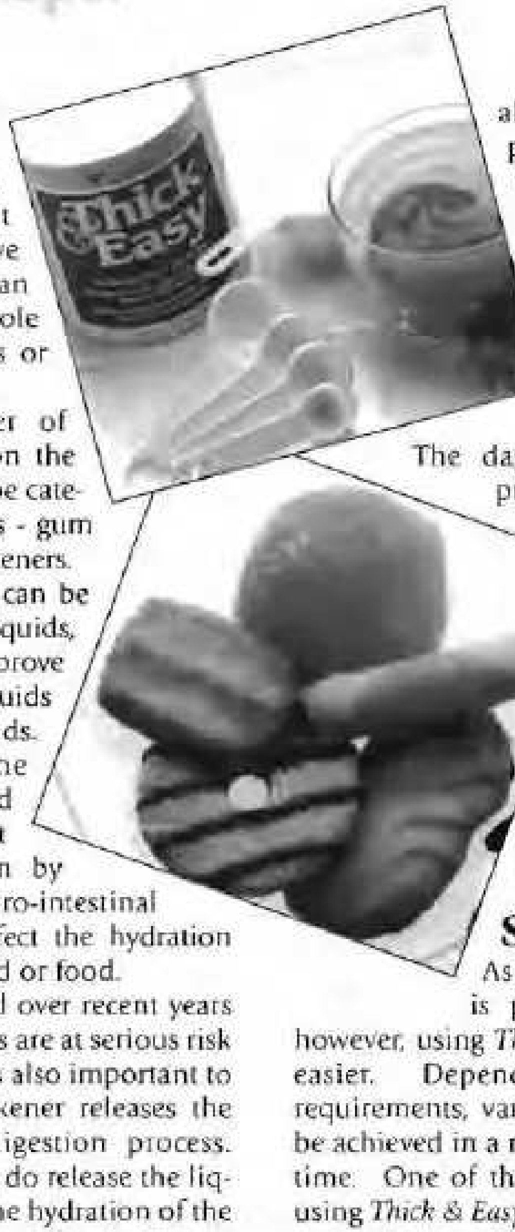
Puréed diets can be improved considerably, not only from a safety aspect, but also the appearance of the food, with the simple addition of a food thickener. Food thickeners, although they are a fairly recent phenomenon, have proved to play an extremely important role when used in liquids or puréed foods.

There are a number of thickeners available on the market and they can be categorised into two areas - gum and starch based thickeners.

Gum based products can be dispersed easily into liquids, and are used to improve the safety of both liquids and puréed foods. However due to the structure of gum based products they are not readily broken down by enzymes in the gastro-intestinal tract and this can affect the hydration properties of the liquid or food.

It has been recognised over recent years that dysphagic patients are at serious risk of dehydration, so it is also important to ensure the food thickener releases the liquid during the digestion process. Starch based products do release the liquid and can assist in the hydration of the patient without the fear of aspiration.

One starch based product available on the market which releases up to 98 per cent of the liquid is *Thick & Easy*.



Variety - the spice of life

Thick & Easy is already used in thousands of healthcare facilities around the world. First established in the United States, the product successfully thickens liquids and puréed foods and many people who have impaired swallowing now enjoy a variety of appealing meals without the fear of aspiration.

Everyone likes variety in their diet and, although traditionally puréed diets have an unappealing and unappetising appearance, by using a food thickener such as *Thick & Easy*, the variety of foods that can be prepared is endless.

The days when foods were puréed together, and the patient presented with a bowl of unrecognisable mush should be gone. Now foods can be presented that are colourful, tasty and above all appealing to the patient's eye.

Stability

As with anything, change is perceived as difficult; however, using *Thick & Easy* couldn't be easier. Depending on the patient requirements, various consistencies can be achieved in a relatively short space of time. One of the major advantages of using *Thick & Easy* is that it can be added to any hot or cold liquid or puréed food and it will start to thicken after 30 seconds and remain stable and cohesive after 60 seconds.

This stability can save time during preparation and also ensures the correct consistency is achieved without guess work. Something as simple as fruit juice can be prepared in large quantities and be left refrigerated until required. It will remain in a liquid state and will not thicken to a solid form.

When mixing *Thick & Easy* into any liquid it is always important that a whisk or fork is used, as this disperses the thick-

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ener into the liquid and does not form lumps, even when using hot liquids. Imagine adding corn starch to a hot gravy - you would have to have a sieve at hand. However by following the instructions on the back of the *Thick & Easy* packaging as to the quantities required, lumping can be a thing of the past.

The versatility of the thickened liquids is endless. They can be used as a drink, as a sauce or even as a pudding. One particular technique which increases variety in the patient's diet is the soaking solution technique.

Cakes and sandwiches - the soaking solution

By soaking biscuits, crackers or cake for a few seconds in a solution made up of liquid and *Thick & Easy*, the patient can enjoy ordinary foods without the risk of choking or aspiration. This ingenious method softens the food while it retains its shape, flavour and appearance. Once soaked, the food has to be refrigerated for one to two hours to reach the correct consistency. However, due to the stability, it can be prepared in advance. By using the various liquids such as fruit juices or sugar syrup, flavour can be enhanced and the calorific value for the patient increased.

Sandwiches are usually a thing of the past for a person on a puréed diet. By soaking the bread in the soaking solution for a few seconds, and spreading a thickened filling such as tuna and cucumber, the patient can now eat what they recognise as a sandwich and enjoy a variety of fillings. The soaking solution can also be used for crisps to add to the plate and improve the appearance of the meal served.

Enjoyment

We all look forward to meal times and are often tempted by the appearance of food on a plate before we taste it. The person who has dysphagia is still motivated by the appearance and it is extremely important the food is well presented and recognisable.

Nowadays it can be difficult to distinguish between a traditional and puréed meal when food thickener has been used. Once the food has been puréed, often the most time consuming process in a puréed diet, food thickener can be added quickly and easily with effective results.

Scooping

One way of using a food thickener is with pureed vegetables such as carrots and broccoli. Once thickened, they can be scooped onto a plate, providing a texture which is safe to swallow. Scooping is a fast, effective way of serving vegetables and is less time consuming than ladling the food as was the case years ago.

Moulds

Fresenius, the company which markets and distributes *Thick & Easy* in the United Kingdom, also provides a range of moulds that can be used to re-shape puréed foods. Using the moulds can be time saving, by freezing the puréed foods in the mould and using when required. As *Thick & Easy* is freeze-thaw stable it can be heated without separation, and the food still retains its attractive appearance.

Over the next few months Fresenius is carrying out a number of presentations within healthcare facilities, showing the use of the moulds and the versatility of *Thick & Easy*.

Cost-effective

Patients rarely consume a complete traditional puréed meal. In fact, large volumes are wasted. To counteract the nutritional deficits, many hospitals and residential nursing homes encourage the use of commercial nutritional supplements such as *Fresubin* and *Entera* (Fresenius Ltd). These products do have a valuable role to play. However, the use of *Thick & Easy* results in increased consumption of the regular meals which reduces waste and reduces the amount of supplements required (Figure 1).

Looking at reducing costs is very important, as is improving the quality of the patient's life. By providing a variety of interesting and appetising meals, the person not only can benefit in health terms, but also psychologically. It can be extremely frustrating for someone feeding themselves when the food drops off the utensils, the person loses dignity and becomes de-motivated. Thickened puréed food is much easier to handle and can also reduce the amount of the time required for feeding at meal times.

	Without *Thick & Easy**	**With** *Thick & Easy**
Daily Supplement Intake (No. of 200ml packs of high energy product eg. Entera)	4	1
Cost of Supplement/Day (£1.40/200ml)	£5.60	£1.40
Daily Cost of Thickener (based on average intake of 60g/day *£3.75/225g tin)	-	£1.00
TOTALS	£5.60	£2.40

Thick & Easy is approved by the Advisory Committee on Borderline substances (ACBS) and is available on prescription in the community.
For further cost savings a *Thick & Easy* catering pack (10lb/£63.75) is also available

***Figure 1 Estimates of savings for patient requiring puréed diet and supplements, with and without* Thick & Easy**

Food for thought

Food thickeners will continue to be extremely important in the area of food preparation for puréed diets. By presenting meals which are palatable, attractive and safer for the patient to swallow, food thickeners certainly give everyone food for thought.

Sarah Barton is a Nutritionist and Sharon McLaughlin a Home Economist with Fresenius. For further information, tel. 01928 579444.

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Fleming, S. and Weaver, A. (1987) Index of Dysphagia : A Tool for Identifying Deglutition Problems. *Dysphagia* 1 (4).

Groher, M.E. (1990) Managing Dysphagia in a Chronic Care Setting. *Dysphagia* 5.

Questions & Answers

What are common problems with puréed diets?	Safety, nutrition and palatability can all be compromised in a puréed diet.
Can people on a puréed diet eat sandwiches, cakes and crisps?	By using a soaking solution of liquid with Thick & Easy, food is softened without any loss of taste or appearance and can be eaten with a spoon.
How does a versatile thickener save time and money?	Less supplements are required when using a versatile thickener, and stability allows preparation of large quantities in advance.

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The British
Stammering
Association

Primary Healthcare Workers Project - Promoting early referral

The British Stammering Association would like more dysfluent preschoolers to be referred to speech and language therapy. Through its three year Primary Healthcare Workers Project, health visitors and GPs in particular are learning the value of early referral. *Elaine Christie* explains.

"At that age, it's just a passing phase."

"Children just grow out of it, don't they?"

"I tell parents not to worry about it, or to ignore it."

"I don't refer to speech and language therapy immediately, the likelihood is that it will have passed by the time he goes to school."

"I tell parents to wait and see how the stammering develops."

These are just some of the comments from health visitors in different parts of the UK when asked their opinion on stammering in young children. Their former beliefs about making referrals for this client group became apparent after they had received a training session and accompanying leaflets on stammering. Other health visitors admitted to being unsure how to identify dysfluent speech and unaware of the importance of early intervention with young dysfluent children.

Parental concerns

However, it was not this lack of awareness and knowledge that first persuaded the British Stammering Association (BSA) of the need for a project to provide up-to-date information and training for health visitors and GPs. The initiation of the Primary Healthcare Workers Project in April 1995 was a result of the continuous flow of letters and telephone calls from parents throughout the UK expressing their experiences of the 'advice' they had received - "don't worry", "ignore the stammer", "he'll grow out of it" - from other healthcare professionals and primary educators.

Late referrals

Many of the parents reported their child had shown signs of dysfluent speech from a young age, but a referral had been put off because of the 'he'll grow out of it' theory. Now at seven, eight, nine years old, the parents of these children were asking BSA where they could get help and why action had not been taken earlier in their child's life. Many of these children were being referred to speech and language therapy for the first time at school age, at which point their dysfluency was more established.

Small window of opportunity

Why don't we just 'wait and see' who will remit, and treat those children who don't once they are of school age? Much of the current research in the US on early stammering and studies on the efficacy of early intervention have demonstrated the benefits of working with preschoolers and their parents (Fosnot, 1992; Fosnot, 1993; Starkweather et al, 1990).

Studies of dysfluent preschool children have shown therapy is most effective when begun within 12 months of the onset of the dysfluency (Meyers and Woodford, 1992). Yairi and Ambrose (1992) provide evidence that children who stammer for longer than a 12 month period are not likely to 'outgrow' their stammer. There appears to be a small window of opportunity / short time span when therapy can be most effective, but for that opportunity to be available to clinicians, we need to get referrals closer to onset than is currently the practice. Only when children are referred to speech and language therapy as soon as there is concern over their speech - rather than a wait and see approach - can therapists provide early intervention.

Health promotion

Therapists have an important role to play in supporting healthcare professionals and participating in their informal and formal training (Communicating Quality 2, 1996). The Royal College of Speech & Language Therapists recognises "the extension of this role into appropriate health promotion activities". Clinicians should ensure that "advice and / or training is available and provided for any individuals, other professionals and voluntary agencies relevant to the individual client or care group" (p180), and that "local general practitioners are informed of the services available for those with fluency disorders".

Project implementation

The UK-wide phase of the Project began in April 1996, following the completion of a pilot year in two contrasting locations - an inner city and suburban / rural area - which differed both geographically and socio-economically. During this period, referral data on dysfluent children was collected from these areas, training was offered to GPs and health visitors and refined, and two leaflets for parents and professionals (figures 1 and 2) were distributed to these groups.

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For the Project to be implemented at a national level, a series of one-off regional talks is being held throughout Britain. This allows SALTs to learn how they can get involved in running the Project in their Trust and provides an opportunity for them to meet up with the therapist/s in their neighbouring Trusts who are involved with young stammering children and the Project. The issues discussed are listed in figure 3.

The information collected on dysfluent referrals has helped therapists consider several important aspects of their service delivery to this group (figure 4). An example of a study of referral patterns is in figure 5.

figures 1 & 2

- The different methods of service delivery to this client group local Trusts provide.
- The value of monitoring referral patterns for this client group and a framework for collecting this information.
- Accessing GPs, health visitors, school nurses and nursery staff through recognised professional routes to offer training sessions and improve attendance at these.
- Disseminating current information on stammering to the above groups and the various paths for successful leaflet distribution.
- How, by doing the above, you can influence your referral patterns.

Figure 3 - Issues discussed at regional talks

1. Is there equity of service across a Trust? What possible explanations are there for differences?
2. How many dysfluent children are referred compared to other developmental disorders?
3. Who are the main referring agents? Are there groups who are not referring because they are unaware of the preventative role SALTs can provide with dysfluent under fives?
4. Which groups - who might be in a strong position to help ensure these children are referred earlier - are not referring? (For example, nursery staff in an area where most children have a nursery place can quickly identify a problem and recommend or make a referral.)
5. Are current policies - such as prioritisation / active reviews - working? Are they providing more opportunities for children and their parents to be seen closer to onset, therefore making therapy more cost and time effective than waiting until school to begin intervention?
6. Are there delays between onset and referral and / or between referral and assessment? Could more of the children have been referred when the dysfluency was first noticed?
7. How many children are being re-referred at school age or referred for the first time?

Figure 4 - Considerations following data collection

Variability in referral patterns

Within a twelve month period, a therapist collected various data on all new child referrals for dysfluency. For the under fives group, the department received 35 new referrals and 23 referrals for school age children (up to 16 years old). Of these, five of the school age children had been previously referred to speech and language therapy, leaving 18 who were referred for the first time.

The latter group did not present with consistently later onsets which may have accounted for the delay in referral. Most had reported onsets of under five which supports the research that average onset is around 32 months, with 68 per cent of onsets occurring between 25-41 months (Yairi, 1993). There are several possible explanations for why these children may not have been identified and referred earlier despite the dysfluent speech being present, including:

- the dysfluency may not have been viewed as a problem while the child was under five, with the parents / professional giving the child time to outgrow it
- the child may have become adept at concealing the dysfluency
- the stammering may have been mild, or not come to the school / parents' attention until the emphasis on oral skills increased.

At the under fives level, it was useful to identify the varying time periods between reported onset to referral to assessment to therapy / input, and to consider how delays in the process affect clinical decisions regarding timing of intervention, or whether to monitor and review. In each example, two children referred to the same Trust have very different experiences in waiting times. For child 1 and child 3, action is taken immediately to refer to speech and language therapy. This provides the SALT with the opportunity to provide advice and close periodic monitoring from near onset. However, for child 2 and child 4, the delay is considerable and - as for any child who appears likely to continue to stammer - a decision to intervene should not be deferred (Yairi et al, 1996).

Example 1

	Child 1	**Child 2**
reported onset	**3;03 years**	**2;06 years**
referral age	**3;04 years**	**3;11 years**
assessment age	**3;05 years**	**4;02 years**
age at therapy	**3;05 years**	**4;02 years**

Child seen within two months of onset vs. 20 months after onset

Example 2

	Child 3	**Child 4**
reported onset	**2;08 years**	**2;04 years**
referral age	**2;09 years**	**3;04 years**
assessment age	**2;10 years**	**4;00 years**
age at therapy	**2;10 years**	**4;00 years**

Child seen within two months of onset vs. 20 months after onset

Figure 5 - Example of a study of referral patterns

Changing referral patterns

There is a very real need for up-to-date information on early stammering and the children at most risk to be made available, both in writing and through training sessions, to the main referring agents of under fives. This is largely health visitors and GPs but, for other NHS Trusts, Clinical Medical Officers, nursery nurses and teachers, school nurses and playgroup leaders have a key role in early identification and referral.

The feedback from health and education professionals who have received information and training has been overwhelmingly positive. Most importantly it has

1) challenged their notion that stammering goes away if you ignore it
2) augmented their knowledge of what to listen for and what questions to ask
3) increased their awareness of the need to make an early referral
4) broadened their perceptions of speech and language therapists' work with parents and dysfluent children under five.

Qualitatively, changes are becoming apparent also. GPs and health visitors are providing more accurate information when referring a dysfluent child and are emphasising to parents the importance of attending an initial assessment and not delaying it because the child experiences a fluent period. GPs are acknowledging the episodic and fluctuating nature of early dysfluency and the need for advice to be given by a professional.

Getting involved

For this Project to run effectively and be implemented by SALTs, the need for suitable resources was identified, and these have been developed over the past two years. All therapists involved receive a resource and information pack to help them implement the Project in their Trust. SALTs can order quantities of two different leaflets which can be given to parents, therapy colleagues, other healthcare professionals and primary educators.

The first leaflet is a referral guide for professionals which contains information on children at greatest risk from developing a stammer. The other provides parents with some background information on dysfluency, ways to help whilst waiting for an appointment and who to contact if they are concerned. These are available free of charge as are two different posters. Translations of the leaflet for parents are being produced. These will be available as audiotapes and as written translations in Bengali, Gujarati, Punjabi, Somali and Urdu.

The purpose of the one-off meetings and opportunities for discussion, and the distribution of resources, is to enable therapists to save time on what would otherwise seem an insurmountable job, even though these health promotion activities are perceived as worthwhile. BSA is endeavouring to take out the time-consuming tasks, allowing SALTs to get this job done more quickly and easily than if they had to start the whole planning process themselves.

Through the Primary Healthcare Workers Project, the BSA wants to ensure preschool dysfluent children in the UK are identified and referred earlier than has been previously the practice. By providing speech and language therapists with the tools and support they need to increase awareness and knowledge of stammering in young children among healthcare professionals, we will begin to see changes in their referral patterns. This will benefit young dysfluent children and their parents, as earlier referrals provide the opportunity for earlier intervention.

Elaine Christie is a speech and language therapist. She is fieldworker for the British Stammering Association's Primary Healthcare Workers Project.

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Further information on participation in this national project and copies of the leaflets for parents and professionals from Elaine Christie or Norbert Lieckfeldt (Project Administrator) on 0181 983 1003 or 0181 981 8818.

Questions & Answers

Why is training of preschool referral agents so important?	BSA research indicates that, before receiving appropriate training and information, preschool referral agents believe in a wait and see attitude and that most children simply grow out of stammering.
What is the advantage of early referral in dysfluency?	Early referral allows early intervention, direct or indirect, with therapy provided at the time when it is most efficient and effective, preferably within 12 months of onset.
How can a voluntary organisation such as the BSA best support practising therapists?	The BSA can provide materials, resources and information-sharing opportunities so speech and language therapists can use their time for implementation.

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Pieces of the jigsaw

Objective setting and support workers are vital pieces in the jigsaw of a specialist Trust in West Wales for people suffering from mental illness and distress and learning disabilities.

Nigel Miller examines the speech and language therapy role.

Since the formation of Derwen NHS Trust in 1994, the speech and language therapy service has been providing assessment, treatment and support so the people of West Wales with a learning disability and their carers are helped to lead as fulfilled a life as possible.

The Derwen NHS Trust (West Wales) is a specialist trust providing a wide range of home-based, day-time and in-patient services for those suffering from mental illness and distress and learning disabilities. These services include:

- mental health for adults
- mental health for the psychiatry of old age
- rehabilitation for those with enduring mental illness
- psychotherapy
- child and family consultation
- learning disability
- substance misuse.

The trust provides services to people living in the Ceredigion, Carmarthen, Llanelli and Dinefwr areas and on an in-patient basis to Pembrokeshire residents.

The current team of six speech and language therapists (SALTs) and five support workers work as part of three Community Teams Learning Disabilities (CTLDs) based at Aberystwyth, Carmarthen and Llanelli. The service is headed by Nigel Miller, the Professional Head of Speech and Language Therapy who joined the service in 1986 and is part of the Learning Disability Service Senior Management Team.

• People with a learning disability have a right to normal patterns of life within the community.
• People with a learning disability should have a right to be treated as individuals.
• People with a learning disability require additional help from the communities in which they live and from professional services if they are to develop their maximum potential as individuals.

Figure 1 - Principles of the All Wales Strategy

Over half Derwen's SALT services are purchased by Dyfed / Powys Health Authority and the remainder by GP Fundholders.

The Learning Disability Service follows the principles of the All Wales Strategy (fig.1).

The Learning Disability Service's Senior Management Team provides direction for all staff through an operational plan. Each profession is involved in producing the plan so the service is integrated and meaningful for each discipline. The plan gives the service's vision:

- A range of community orientated services.
- A skilled workforce of qualified professional staff with trained support staff.
- A co-ordinated, client-centred, multidisciplinary approach.
- User-friendly systems which meet the requirements of our purchasers, users and Trust Board.
- A high quality, efficient, effective service, which contributes a unique expertise to the support of people with learning disabilities and their carers.

In addition the plan sets out specific service objectives, for example,

- To develop research based practice which is shown to be clinically effective.

These objectives are devolved to each community team and each member of staff. Each of the three CTLDs has a Community Clinical Manager to ensure the objectives set are achieved. The Professional Head of Speech and Language Therapy is also a Community Clinical Manager heading up a team consisting of community nursing, physiotherapy, psychology, speech and language therapy and a challenging behaviour service.

To achieve the objectives, each member of staff has a Performance Development and Review (PDR) Strategy and a Performance Development Plan (PDP). This is primarily a two way process between the individual and his or her manager. The CTLD's objectives are discussed and the member of staff and manager agree individual objectives for the forthcoming year. In this way individual members of staff know the Trust's aims, the Learning Disability Service's objectives and the profession's objectives (fig. 2).

The objectives on a PDR are key to the success of the speech and language therapy service. They are sufficiently challenging to ensure progress, but achievable to avoid frustration through failure. So each SALT has few objectives - a maximum of 10 - which are:

1. quantifiable (whenever possible they are measurable)
2. capable of being tested (the constraints within which they are to be achieved are defined)
3. within a definite time scale
4. precise (clear, well-defined)

This is because the objective:

- *Improve the communication skills of people with learning disabilities*

may not get you far but

- *Provide Hanen training in order to facilitate a family-focused approach to language intervention by January 1997 and an evaluation report by March 1997*

will hopefully get you further.

The service objective:
• To develop research based practice which is shown to be clinically effective
becomes a speech and language therapist's individual objectives:-
• To assess what practice is research based for speech and language therapists working with people with a learning disability through professional journals, literature and Internet facilities by end of March 1997
and
• To recommend to the Head of Speech and Language Therapy changes in clinical practice required to ensure clinical progress which is shown to be effective by end of August 1997.

Figure 2 - examples of objectives

The PDR process consists of regular and frequent informal review discussions and a formal annual review. It is supported by a PDP which identifies training and development needs for the year based on the objectives. For example, in order to achieve

- To develop research based practice which is shown to be clinically effective

a speech and language therapist may need to attend appropriate

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training and have time allocated to undertake research, so this would be identified in the PDP.

PDPs detail career and priority personal development needs and any formal training planned. PDPs may reflect flexible working, rotational posts, secondments and shadowing. The PDR objective topics for the Derwen SALT service are in figure 3.

1. Clinical effectiveness
2. Audiology - providing an integrated audiological service to clients with a hearing loss
3. Hanen training
4. Evaluating staff and carer training
- sign language
- communication skills
5. Evaluating the dysphagia service
6. Developing an interview package for people with a learning disability seeking employment
7. Evaluating client signing groups
8. Evaluating social skills groups
9. Expanding the use of ENABLE
10. Evaluating the special care service
11. Evaluating the dual diagnosis (people with a learning disability and a mental health problem)service.

Figure 3 - PDR objective topics for the Derwen SALT service

Further information from:
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12 Bay View, Capel Road, Llanelli, Carmarthenshire SA14 8SN

KEY POINTS

- **Derwen is a specialist NHS Trust providing services to those suffering from mental illness and distress and learning disabilities.**
- **A high priority is placed on staff working to objectives in line with the aims of the Trust, the learning disability service and the profession.**
- **Support workers allow clients to be seen more regularly and free qualified staff to do more specific work.**

SUPPORT WORKERS Releasing qualified time

Since the service introduced support workers in 1992, many more clients are receiving regular speech and language therapy and fears of 'deskilling' have been allayed.

The support workers (not speech and language therapy assistants as they are paid on an Admin and Clerical Pay Scale) have competency based job descriptions taken from level 3 of the National Vocational Qualifications (NVQ). Their primary role is to support clients and carers in the delivery of care under the supervision of a speech and language therapist. Duties include:

* *assisting clients to communicate by following individual therapy programmes*
* *supporting the SALTs during treatments and investigations*
* *carrying out delegated group therapy sessions eg. signing.*

The support workers will be expected to gain the new qualification NVQ 'Speech and Language Therapy Support' when it is available.

Fears of 'deskilling' at the initial suggestion of support workers were quickly dismissed as time was released allowing the SALTs to concentrate on what they are qualified to do: assessments, advice, training and investigation of issues such as clinical effectiveness. This did not all happen at once as support workers require a great deal of training and supervision, but they are now vital to the team.

The evaluation of the support worker role undertaken by the health authority highlighted that "the development of the support worker concept in the field of learning disabilities is a logical extension of the move from institutional to community care" and that clients and carers without exception supported the concept and welcomed the increased input.

WORKING WITH PARENTS The value of video

One of the PDR objectives for the year was to run one Hanen Parent Programme. This family focused approach to language intervention with young children focuses primarily on the importance of parents in the intervention process.

In a joint venture between the Derwen NHS Trust (therapists Amanda Davies and Yvonne Miller) and the Llanelli Dinefwr NHS Trust (therapist Helen Griffiths) a course was successfully run over an 11 week period prior to Christmas 1996.

Parents of six children experiencing a delay in their language development attended seven evening sessions to gain a better understanding of how children develop language and of the conventional strategies which would help promote their children's language development.

Parents also received four home visits interspersed between the evening sessions which involved videotaping the parents interacting with their children. During these visits, parents were encouraged to use the strategies learnt in the evening sessions. The parents then received feedback on the video interaction.

Initially parents were very reluctant to be videoed. However, at the end of the course all felt that they had benefited from it.

In the final session the early videotapes were compared to the videotapes made towards the end of the course. A considerable difference in child and parent interaction could be seen in all cases. Parents were now actively maximising language learning opportunities.

Parents were very positive about the Hanen Parent Programme. They felt they had gained support from other parents and often commented it was good to talk to other people "in the same boat". The final session involved re-capping on things previously learnt and - at the parents' suggestion - a meal at the local pub.

Both parents and therapists involved in the Hanen Parent Programme felt it was a success. The parents would strongly recommend attending a programme to other parents of children with language difficulties. It is an excellent therapeutic tool which we will use further in the future.

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Minimally responsive state: exploring communication potential

A minimally responsive individual may have the potential to communicate effectively. Sophie MacKenzie describes how, as a speech and language therapist at the Royal Hospital for Neuro-disability, she works as part of a team exploring different methods of accessing communication.

Recent publicity has highlighted the controversies surrounding the long-term management of clients with severe brain injury. Giacino and Zasler (1995) discuss the subtle but fundamental differences between patients presenting as comatose, in vegetative or persistent vegetative state, minimally responsive and those termed 'locked in', following injury to the brain and / or brain stem.

Minimally responsive

This article focuses on the role of the rehabilitation team with patients in a minimally responsive state - those who, following neurotrauma, are no longer deemed to be in coma or in vegetative state, but who nevertheless remain very severely physically and cognitively impaired. Individuals may present as minimally responsive following a wide range of cerebral damage due to traumatic brain injury (diffuse or focal), hypoxic / anoxic episodes, infective, toxic or metabolic disorders, or vascular lesions.

Patients defined as minimally responsive post-brain injury typically fall within the Rancho Los Amigos Scales of Cognitive Functioning (1974) levels III and IV. They may localise consistently to a stimulus, for example, they may track an object visually or turn to a sound, and they may show a limited awareness of self by, for example, responding to the physical discomfort of a catheter. They may also respond to their own internal confusion, showing agitation and sometimes incoherent vocalisations. Individuals who are termed minimally responsive typically present as tetraplegic, with poor sitting balance and head control. They are usually incontinent of both urine and faeces. They show spontaneous eye opening and the ability to track visually, if vision per se is not affected by the brain injury. They demonstrate the ability to carry out auditory commands if these are within their physical capabilities, but auditory comprehension abilities vary from patient to patient. These patients are typically anarthric and often aphonic.

The team challenge

The challenge to the speech and language therapist working with this client group is

a) to ascertain the level of residual linguistic and communicative functioning and

b) to provide a means of helping such individuals express themselves to the best of their ability.

With patients who have such limited physical function, this is no easy task. Management of all aspects of an individual's functioning is necessarily a team affair with this client group. Responses are often so limited, subtle and variable that the specific skills of all disciplines must be brought into play in order to maximise these responses. The team at the Royal Hospital for Neuro-disability includes:

- clinical psychologist
- consultant
- dietitian
- medical officer
- music therapist
- occupational therapists and assistants
- physiotherapist and assistants
- social worker
- speech and language therapist
- trained nursing staff and health care assistants.

We work together through joint therapy sessions and liaison, both in twice-weekly structured meetings of the whole team and as necessary between different disciplines.

Finding a viable method of communication with minimally responsive individuals is a priority of the interdisciplinary team, particularly as the physical disabilities of this client group are normally profound, and thus to discover some residual cognitive and linguistic skills and a way of accessing these is of paramount importance both to the professionals and, of course, to the relatives.

Support for relatives is also a team affair in that we all need to be particularly sensitive to the grief and devastation they inevitably go through. However, counselling and structured support sessions are carried out primarily by the social worker. We also have regular evening relatives' meetings where a member of the team normally gives a brief talk about their role on the unit and then relatives and staff are left to mingle and to discuss particular worries or concerns.

It appears from clinical experience that, despite huge physical limitations, some individuals following severe head injury do still show awareness and some residual linguistic functioning which, if accessed, can result in a viable communication method being established (Andrews et al 1996).

Yes and no

The speech and language therapist working with minimally responsive individuals is reliant on two distinct responses to command being established before a communicative response can be considered. At the Royal Hospital for Neuro-disability, this is achieved by the occupational therapists, who determine whether an individual is able to execute consistently two movements to command; these may include

- two distinct motor responses
- pressing a single switch with auditory feedback once and twice
- looking at two different objects/pictures/words (ie. visual discrimination)
- producing two distinct phonemes.

These two responses are then linked to yes and no, so the individual is taught to associate one response

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with 'yes' and the other with 'no'. For example, an individual might be encouraged to press a switch once to indicate 'yes' and twice to indicate 'no', or to give one motor response, such as looking up for 'yes' and another, such as a hand movement, for 'no'.

Once an individual is able to produce 'yes' and 'no' to command, using whatever modality is felt to be the most reliable, assessment of their residual linguistic functioning can begin in earnest. Language assessment using closed questions does of course have its limitations, but, as can be seen from the example questions in figure 1, the speech and language therapist can use word levels as well as some syntactic concepts to gauge an approximate idea of an individual's receptive functioning.

1. Are you sitting down?

2. Do fish have fur?

3. Are lemonade and gin both drinks?

4. Is a feather heavier than a man?

5. Is Big Ben the tallest building in the world?

Figure 1 - examples of closed questions to assess auditory comprehension

If a patient has a yes / no response and / or the ability to access a switch, assessment for a suitable alternative/augmentative communication system (AAC) which would further increase his or her output can take place. Again, the entire team will have accrued information which will help in the correct choice of AAC.

Pooling information

Information regarding a patient's auditory comprehension skills is pooled with information gleaned by other members of the team, most notably the occupational therapist and the clinical neuropsychologist. For example, is the patient able to recognise letters, presented either auditorily or visually? Is s/he able to recognise colours or pictures? What are his / her learning ability and memory like? Is s/he able to initiate to any extent? With all this information about the patient's functioning, the speech and language therapist can begin to make decisions regarding potential AAC options.

Alphabet strategies

If a minimally responsive patient has shown the ability to recognise letters and some single words, further assessment is carried out to determine whether text-based AAC might be viable. Typically, a string of letters is recited and / or shown in alphabetical order and patients are asked to signal when they hear or see a given letter. If a patient is able to select single letters in this way, s/he is then encouraged to identify short sequences of letters, such as C-A-R. If s/he is able to identify sequences of letters from a limited selection, the choice of letters is gradually increased, with the aim of providing the entire alphabet, split into manageable chunks. The most commonly used layout of the alphabet is known as the A-E-I-O-U layout, where the alphabet is split into rows, each beginning with one of the vowels (figure 2). The rationale behind using this layout is that it is presumed that the patients have some residual knowledge of alphabetical order, and thus would possibly know when the vowels occur in relation to the other letters.

Listener scanner technique

At the Royal Hospital, this method is usually employed with the facilitator actually reciting the letters, the so-called 'listener scanner' technique. This was initially introduced with visually impaired clients but has since proved useful with other minimally responsive individuals, where positioning of an alphabet chart in the correct line of vision is problematic, or where it is felt that input to both the visual and auditory channels is beneficial. The listener refers to each row of the alphabet by its vowel and the client then indicates the correct row has been reached using his / her most reliable response. This might be a head nod, pressing on a buzzer switch or vocalising. The listener then scans across the selected row, until the client indicates that the correct letter has been selected. Depending on other cognitive abilities, the client may need constant reminders as to the letters already selected or his / her attention may need redirecting to the task.

If the patient shows some ability to spell using this method, his / her writing skills can begin to be assessed as one would for patients using handwriting. The PALPA (1992) writing assessments can be adapted for listener scanning, although administration is necessarily time consuming. Patients showing high level written language ability may be assessed for 'high tech' communication systems, if this is felt by the team to enhance independence. Such systems include the Ke:nx software (Don Johnston Special Needs Ltd.) and Lightwriters (Toby Churchill Ltd.), both of which can be used by single switch users. For those patients who are unable to use text-based systems, other AAC options are explored, such as picture charts (using scanning or pointing) or simple word charts to express basic needs. These types of low tech AAC also have their high tech counterparts, such as the AlphaTalker (Liberator Ltd.) and the Macaw (Zygo Industries Inc.), which may be appropriate for some.

The role of the speech and language therapist in relation to other members of the interdisciplinary team when endeavouring to establish a meaningful response with this client group is represented in figure 3.

A B C D
E F G H
I J K L M N
O P Q R S T
U V W X Y Z

Figure 2: A-E-I-O-U alphabet layout

Because of the inherent complexity of this client group, each discipline relies heavily on the others to implement patients' management programmes. Thus, the speech and language therapist relies on information regarding response to auditory and visual stimuli supplied by the occupational therapist in order to begin assessment for AAC. The interdisciplinary team in general relies on the language assessments carried out by the speech and language therapist in order to pitch their interaction with the patient at an appropriate level and so on.

Very profoundly brain-injured individuals may present as minimally responsive either because of their severe physical deficits or because of their severe cognitive deficits, or both. The speech and language therapist working in this area, however, has to be open to exploring possible communicative ability which may be present, even in such damaged individuals.

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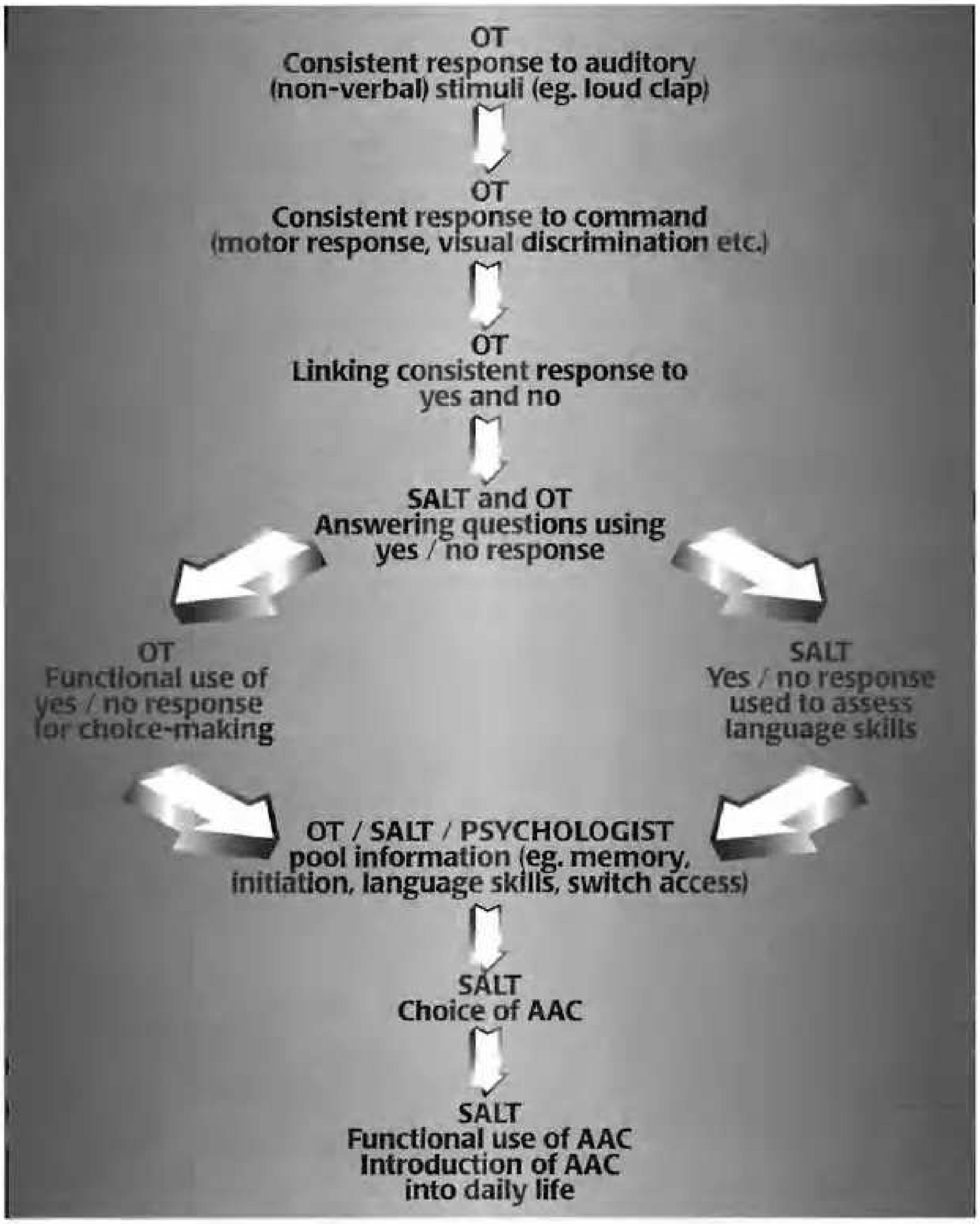

Figure 3 - The interdisciplinary team

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Sophie MacKenzie is a specialist speech and language therapist at the Royal Hospital for Neuro-disability in London

Questions & Answers

What does a minimally responsive state mean?	Patients who are minimally responsive are no longer in a coma or vegetative state but remain severely physically and cognitively impaired, with problems accessing residual communication skills.
How does assessment begin?	The establishment of a reliable yes / no response by occupational therapists allows other disciplines to begin their assessments.
What specific contributions are made by the speech and language therapist?	The speech and language therapist assesses residual communication skills and explores ways of accessing these effectively, to the benefit of other staff and relatives as well as clients.

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Service Development

Introducing a preventative approach

A health visitor asking Wilstaar questions

WILSTAAR is a detection and intervention programme for use with children under a year old. In 1996, following a successful Health Gain Fund bid, Epsom Healthcare Trust was awarded £70,000 to fund a WILSTAAR project. Project Co-ordinator Sue Oakenfull details how the project came about.

WILSTARR (Ward Infant Language Screening Test Acceleration and Remediation) was developed in Manchester by speech & language therapists Dr Sally Ward and Ms Deirdre Birkett (full report of the screen in Ward, 1992). WILSTAAR enables infants aged eight to nine months to be screened quickly by health visitors as part of the routine hearing test. The screening questionnaire predicts children at risk of language difficulties and enables a cost effective preventative package to be delivered in the home to the child and their family over an average period of four months.

Epsom Healthcare Trust provides services to a suburban area which includes a wide social spectrum with around 2,000 births per year. The successful Health Gain Fund bid for £70,000 was used to create two full time speech and language therapy posts to cover the whole district.

Involving health visitors

Health visitors play a key role in WILSTAAR and it was important to have their support. We were fortunate in having a very good relationship with our health visitors. Several years previously we had audited our speech and language therapy referrals. The outcome had led to the introduction of a two and a quarter year screening check, a comprehensive programme of health visitor training in the use of this screening check and broader training in speech, language and communication difficulties in pre-school children (Bowers and Oakenfull, 1996).

In order to make the application for Health Gain Funding, it was necessary to discuss it with and win the agreement of the health visitor management. Several meetings were arranged with the General Manager and Locality Managers and they agreed to support our application, providing we were willing to continue on-going training of health visitors.

In July 1995 I attended a training session with Sally Ward and Deirdre Birkett at the University of East Anglia. Armed with the information from this training course I came back to my manager, Tricia McGregor, who started to prepare the application which was in two parts.

Applying for funding

The initial application form was quite straightforward. You had to

1. state what area of health would improve
2. give a brief description of the project, the resources required and the cost, and the time scale
3. list other agencies involved

and

4. explain how you would demonstrate that health has improved due to the project intervention.

We stated, as the area of health improvement, the early detection of and intervention in language difficulties and the consequent gain in overall development skills and progress.

In the brief description of the project, we emphasised the cost effectiveness of the preventative package. We stated the figures from the initial WILSTAAR research for 30 per cent reduction in 'failed to attends', a 60 per cent reduction in the treatment time and treatment length and that 95 per cent of children reached normal levels of language development.

For other agencies involved we included health visitors, and for demonstrating that health had improved due to the project intervention we had two points - that we would be able to show improved health firstly by the assessment of language levels of infants in the project and secondly by the measurement of our referral rates later on, which should reduce. The full effect on the referral rate will take longer than the two years of the Health Gain Fund to gauge, but we would wish to continue to monitor outcomes closely over a longer period of up to five years.

We heard very quickly that our application had been looked upon favourably and that we should be well prepared to move to the second stage. In this final phase of the application you have to give a more detailed description, including a project plan with reference to how it will be managed and monitored and who will implement it, and the target group, including the number likely to benefit.

For the evaluation of the project we said detailed information would be collated on

* the numbers of children screened, the location and age

* the numbers of children entering the programme and the assessment scores

* the amount of time taken for remediation.

In addition,

* children in the project would be identified so that we could follow them through the system and check for later referral to speech and language therapy

* a patient / health visitor satisfaction questionnaire would be used

* a sample of children would also be followed up for re-assessment.

In the early months of 1996 we heard our application had been successful.

The WILSTAAR team

(clockwise from top left) Frankie, Sue, Jo and Claire

The next step was to advertise and appoint two full time speech and language therapists. We decided that we would split their posts so that two of the ten sessions could be spent in general community work. I felt this was important for the therapists' future development as it might become too narrow a field to concentrate on WILSTAAR alone. In September 1996 the team was formed. We appointed Jo Stanhope and Frankie Ramtin. Claire Finlay, who was already working in the district, took up two sessions and I took the other two sessions as co-ordinator. We,were very fortunate in being able to train together during the summer of 1996 with Sally Ward and Dierdre Birkett at St. Christopher Place, where Sally now works. This was a perfect opportunity to start to build our team. (Frankie and Jo had agreed to come to the training session out of their own time as their posts did not officially start until later on in the year.)

'Partnership with Parents'

The next stage was to train the health visitors. We decided to do this in two parts. First, we met with the four senior health visitors. We described the WILSTAAR project and asked them how best to pass the information on to the large number of health visitors in the district. It was decided we would try to get a slot on an annual event called Partnership with Parents which is organised by our consultant community paediatrician. The timing was perfect as this event was due in a few weeks' time. By complete coincidence the next day we received a telephone call from the consultant community paediatrician, asking if it would be possible for the speech and language therapy department to talk at Partnership with Parents.

We took the opportunity of suggesting an introduction to the WILSTAAR project and this was agreed. We were very lucky; it saved an enormous amount of organisation of meetings and, as Partnership with Parents is a three-line whip for health visitors, we targeted about 95 per cent of them presently working the district. Partnership with Parents also targets clinical medical officers, local GPs, clinical psychologists and other healthcare professionals.

Two main issues were raised at this meeting :

1. How WILSTAAR would be administered to parents where English was not the spoken language.

2. The ethical dilemma of not telling parents that their child may be at risk. (WILSTAAR is presented as an acceleration programme and at no stage is the parent made concerned about their child's performance.)

These issues were taken forward to the Manchester meeting (see later).

At the end of this health visitors' training session, health visitors were given a pack we had prepared, with an outline of the WILSTAAR project and the forms and questionnaires necessary for them to start. Each clinic was also provided with a more detailed pack of information as a reference resource for health visitors.

We also produced a letter which was sent to all GPs, clinical medical officers and other healthcare professionals in the district to let them know about WILSTAAR and that it was about to start in their area. We received only one correspondence from a GP following this circular.

Several weeks into the start of WILSTAAR, the therapists made drop-in visits to local community health centres and clinics to talk to the health visitors and to answer any questions they had.

Follow-up

Once the Health Visitors had completed the questionnaires they were sent back to the WILSTAAR therapists for interpretation. Those babies identified as being at risk are visited at home by two speech and language therapists for a full language and development assessment then, if appropriate, invited to take part in the language remediation programme. An appointment is sent to the parent with a standard covering letter. Many of the standard letters needed are provided in the WILSTAAR manual. We transferred these onto Epsom Healthcare Logo paper.

As the questionnaire forms started to return to the therapists, we realised there was no designated place on the form for telephone numbers. We therefore had to contact all health visitors again for these to be included.

Health visitors found the form took longer to complete than the two minutes suggested. To save time, they arranged themselves for the clinic co-ordinators to complete the patient details when the hearing tests were booked in.

If we were setting up the service again we would use the training session to go through the questionnaire forms in more detail and spend some time with the clinic co-ordinators explaining the project and gaining their support, well before the start of the project.

Jo and Frankie attended a WILSTAAR meeting held in Manchester recently. The meeting provided a valuable oppor-

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tunity to ask questions and brainstorm problems. As a result we have been able to make several decisions (Figure 1).

1. For non-English speaking families, we will provide a letter explaining why it is not possible for them to be a part of the project. (In this area there are very few non-English speaking parents and out of 1,600 screens so far we have had none.)

2. The ceiling age for providing the remediation programme will be one year.

3. We are following WILSTAAR guidelines on the way the project is presented to parents - any health visitor feeling strongly about the issue of not telling parents that their child may be at risk will be able to withdraw.

4. Our future plans will take into account the evaluation measures outlined in the Health Gain bid proposal. We will also be arranging further health visitor training, to cover the arrival of new staff to the district.

5. We are looking for an alternative language assessment to the REEL (Bzoch & League, 1971), the language assessment used with parents of children who have been identified through the screen. We find it difficult to present this without leading the parent to give a response they feel we want to hear.

6. We are also very interested in the Checklist for Autism in Toddlers (CHAT)(1992) as the research for this instrument has been extended into an epidemiological study of 18 month olds in the South East Thames region and health visitors from Epsom Health Care Trust are taking part. We would be interested to see if any children given a diagnosis of autism using CHAT had previously been identified as at risk using WILSTAAR.

Figure 1 - Interim decisions about WILSTAAR

Positive response

It is now four months since we started WILSTAAR, still too soon to evaluate outcomes, but soon enough to know that the initial responses from both health visitors and parents are very positive. We have definitely raised awareness of the importance of early interaction and the benefit of parents playing with their babies.

The professional role

It has been suggested that WILSTAAR could be provided by health visitors or speech and language therapy assistants. We feel unable to support this suggestion at present as speech and language therapists are highly trained in the development of communication skills in young children and it is this professional training that offers the breadth of knowledge and practical skill to work closely with parents, to think quickly and accurately in order to answer questions, and subtly change an activity so that the child and parent experience success.

WILSTAAR offers a different approach for delivering a paediatric speech and language therapy service. It has required great sensitivity and flexibility and we are all enjoying the preventative aspect of the programme.

Sue Oakenfull, Jo Stanhope, Frankie Ramtin and Claire Finlay are the WILSTAAR Team at Epsom Health Care Trust, Epsom Clinic, Church Street, Epsom KT17 4PP.

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Baron-Cohen, S., Allen, J. & Gillberg, C. (1992) CHAT The Checklist for Autism in Toddlers. *British Journal of Psychiatry* 161.

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Ward, S. & Birkett, D. (1992) The predictive validity and accuracy of a screening test for language delay and auditory perceptual disorder. *European Journal of Disorders of Communication*. 27(1).

Details of WILSTAAR training from Dr Sally Ward, The Speech, Language and Hearing Centre, Christopher Place, Chalton Street, London NW1 1JF, tel. 0171 383 3834. Manuals and forms are available following training and accreditation with WILSTAAR.

Questions & Answers

What is WILSTAAR?	WILSTAAR is a screening, assessment and language remediation / acceleration programme used in a preventative way with children under a year old and their families.
How did Epsom go about setting up a WILSTAAR project?	Support of health visitors was obtained and a two-stage funding bid quoting data from the original WILSTAAR study made to the Health Gain Fund.
Why should WILSTAAR accreditation continue to be exclusive to speech and language therapists?	Speech and language therapists are the professionals with the training and practical skills to work effectively with parents on the development of communication skills.

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How I...

How I manage dysarthria

Three speech and language therapists, given the case history information opposite, set out their management of Bert.

Fiona Hewerdine is Adult Co-ordinator for the Speech and Language Therapy Department at Grimsby Hospital.
Richard L. Jouault is a senior speech and language therapist in Jersey. He is the Co-ordinator of Speech and Language Therapy Services for the Care of the Elderly and Rehabilitation Services.
Angela Moar is a speech and language therapist at Glasgow Royal Infirmary.

Practical points

1. Starting an assessment with a relaxed chat over coffee builds rapport and allows functional assessment of dysarthria and dysphagia. For more formal assessment, the Frenchay is preferred.

2. It is important to listen to the patient to find out their expectations, fears, needs and wants, so you can respond appropriately. Checklists may also help.

3. The client must be motivated and willing to take responsibility or he is unlikely to benefit from therapy; it is also important to know if the spouse will be supportive.

4. Providing literature and summarising what has been discussed ensures patients and their families can understand the problem and agree management.

5. Business cards are easily kept, provide important contact details and can have appointments written on the back.

6. Individual therapy, therapy groups, groups for carers, maintenance groups and volunteer groups can all be appropriate at different stages.

Bert

Two months ago, Bert had a mild stroke but didn't need to be admitted to hospital. Although his speech went completely at the time, **it came back quickly and everyone assumed his recovery would continue.** His GP has now referred him to you **as Bert is** embarrassed by the way he continues to slur words, **seems to have too much saliva in his mouth and generally sounds quite gruff.** He tells you he can't speak as loudly as he used to **and that he won't answer the phone** in case he is not understood.

Bert, who is a 78 year old retired joiner living with his wife who is hard of hearing, also reports he coughs and splutters more than he used to when drinking. **Together with the speech difficulties, this is putting him off going to his local as usual on a Friday night.**

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A functional approach

***Fiona Hewerdine* finds the packages of care prepared by her department a useful basis for building information for individuals.**

My first session to help address Bert's problems would be a joint interview for Bert and his wife at the Hospital Out-patient Department. Initial visits take about three-quarters of an hour and are vital for baseline gaining and goal setting. My current approach with clients is very functional - I do a lot of listening and detailed observing and find out about the patient's insight, expectations, fears, needs and wants.

Areas I would wish to cover include Bert's self-evaluation of his speech, his wife's perspective and description of need and Bert's view on her competence as a listener. I would also want to know what Bert and his wife know about strokes, and if they belong to The Stroke Association. Questioning would elicit details about the effects of fatigue and anxiety. To attain standardised baselines I still like the Frenchay Dysarthria test; this would represent the second section of information gathering in the session. I might also take a small taped sample to compare against a second tape in the final review.

Once Bert felt comfortable and relaxed in the initial session I would watch him drink and perhaps eat a biscuit and possibly take some thickened fluid. I would precede this by an oral / facial examination and dysphagia review. Over a period of five minutes I would observe the frequencies of secretion swallows. I would record these while he and his wife gave a run down on what diet he could tolerate.

At the end of 45 minutes I would have been able to gauge the severity of his dysarthria and the level at which it impacts upon his life. I would also have been able to make judgements about the nature of his dysphagia problem. Regarding a prognosis I would have insight into Bert's level of understanding and motivation and his goals and whether he faces his problems alone or if his wife is a team player.

Now we can talk treatment. I always clarify that speech and language therapists do not wave a magic wand for a cure and my role is to facilitate the patient's potential to maximise his communication skills and swallowing competence. So I describe therapy options which for Bert fall into four categories:

1. prepared package of care on dysarthria (figure 1)
2. adaptation and equipment (figure 2)
3. interactional dynamics (figure 3)
4. safe swallowing strategies (figure 4).

At this point a chilled half-pint in a dysphagia 'tankard', drunk with a chin tuck and no peanuts or crisps but mini cheddars would be a lovely way to end therapy - however, back to reality. After this session, I write to the General Practitioner to thank him for his referral and I describe our planned strategies of self-help.

Goal setting and time-frame planning at the beginning of treatment is motivating, realistic and avoids protracted bargaining over when treatment should end. If Bert opts for all of the above I'd be looking at three to four weeks of work, a month off and a review with a view to discharge. This final session would include looking back to where Bert was, what he has achieved and how this may help him to look forward and maintain his level of competence and self-esteem. I always provide contact point details on the package of care on discharge but this safety net is rarely needed or accessed.

Letter two now goes to the General Practitioner to let him know how Bert has minimised his dysphagia and saliva problems and has maximised his communication potential.

A summary of how I would manage Bert's case is in figure 5.

Resources

The Stroke Association, CHSA House, Whitecross Street, London EC1Y 8JJ, tel. 0171 490 7999.

Dysarthria clinical advice leaflet, Royal College of Speech & Language Therapists, 7 Bath Place, Rivington Street, London EC2A 3DR (£12.50 per pack of 50).

Amplifiers from Stanton (Addvox II), tel. 01942 517920 / Toby Churchill, tel. 01223 576117.

Thick & Easy thickener, Fresenius, tel. 01928 579444.

Kapitex Health Care Ltd., Kapitex House, Sandbach Way, Wetherby, West Yorkshire LS22 7GH, tel. 01937 580211.

1. Prepared Package of Care on Dysarthria
This includes:-
a) Instructions of PNF (proprioceptive neuromuscular facilitation)
b) The new Royal College of Speech & Language Therapists' leaflet
c) Work on lip seal and oral agility
d) Positioning prompts, to teach Bert to keep his mouth shut, nose breathe and to train himself to swallow saliva regularly to reduce pooling and tilt his head backwards.
I like to personalise instructions like these, and help clients see how this can be applied to themselves, eg. I would get Bert's son to move the television onto a higher table so that, in the evening when Bert is tired, he will naturally tilt his head backwards while looking at the television in it's new raised position; this will drain the secretions and keep his clothes dry.

Figure 1 - Prepared package of care

2. Adaptation and Equipment
Work on 1. over four weeks may dispel the need for modifications; however, I'd like Bert to tackle the phone again. What about an answer phone so that Bert can screen to whom and when he talks? This minimises failure and allows for rehearsal. Strategy two, the use of an amplifier. There are lots to choose from: Addvox / Lion / Toby Churchill's adaptation to Lightwriters / Amplicords. One of these may be a big bonus to Bert's daily interaction, phone use and pub visiting.
As Bert is not an in-patient, he may need lots of details regarding cerebrovascular accident, The Stroke Association, local information centres and special neighbourhood resources. A short spell at a high level dysphasia group, perhaps attending as a helper, may help him socialise again and regain his confidence and self esteem. Some personal details in his wallet on a switch style card attached to a small alphabet chart may minimise the risk of communication breakdown and failure occurring.

Figure 2 - Adapation and equipment

3. Interactional Dynamics
Bert's message passing success rate will be greatly improved if he:
a) takes his wife to a specialist for a hearing aid
b) trains his listeners to turn down / off the television / radio / hoover when talking
c) trains his listeners to come to his level when talking
d) learns to alert potential listeners to his planned message by
- a touch on the arm
- a clap, whistle, wave etc.
e) chooses his location to sit in the pub, away from the juke box and door and at a small round table so his listeners are near him, at his level and have a good view of his mouth, face and non-verbal cues.

Figure 3 - Interactional dynamics

4. Safe Swallowing Strategies
This topic will include a look at salvia control, texture, temperature, mixing of foods and fluids, knowledge of a safe swallow technique, a chin tuck and possible need for Thick & Easy and special dysphagia cups (see Kapitex catalogues).
Our department has produced a package of care for all dysphagic patients. This includes a section on a normal swallow. Information that equips the patient to feel more in control is always most helpful. These packages of care are really useful and time efficient; they represent a reference resource to the patient, a ready prepared topic for the therapist and a summary of clinical tips to prompt the patient and maximise carry over.

Figure 4 - Safe swallowing strategies

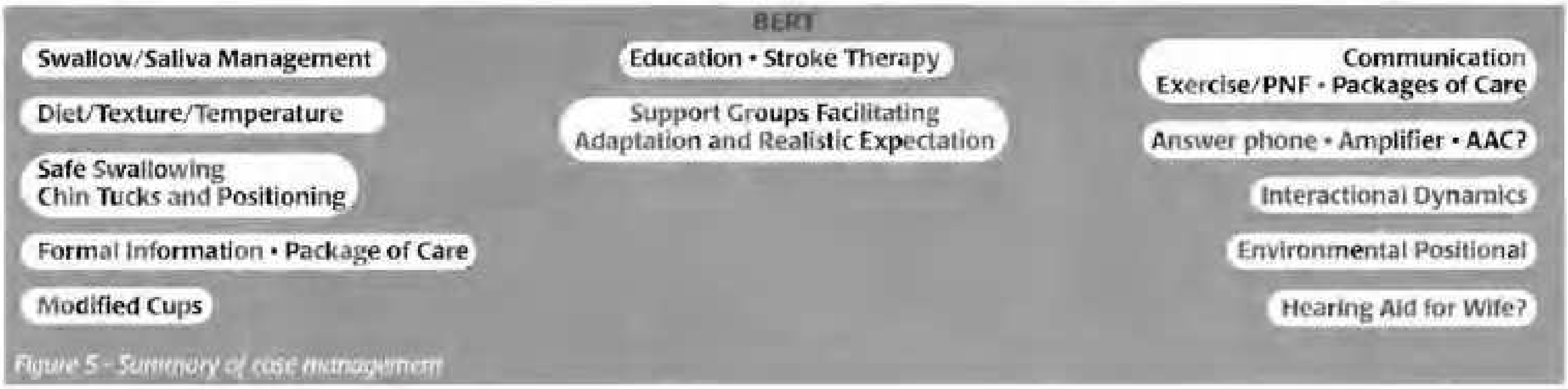

Figure 5 - Summary of case management

An exercise in empowerment

Richard Jouault believes patients' enjoyment of therapy can be a better indicator of success than quantitative assessment.

Figure 6

Bert attended the William Knott Day Hospital with his wife as an out patient for an initial speech and language therapy assessment. He would have been seen at home if he or his partner had found it difficult to attend clinic or if his speech / language problems were in some way specific to the home environment.

On meeting Bert and his wife, I offered them a cup of coffee and started to chat to them about their journey to clinic, the weather etc. I used this time to observe how Bert dealt with drinking whilst chatting and how he and his wife interacted verbally.

Rapport

I find this time is very important in developing a rapport with the patient and their partner. A subtle balance between medical / professional and confidante / friend is required to inspire confidence and encourage openness. Light refreshment can promote a relaxed environment and thus encourage optimum performance.

I explained to Bert that today was an assessment session which would last for about 45 minutes. In that time we would discuss what difficulties Bert experienced and what he could do to alleviate them.

Responsibility

I use this approach to set out from the start the patient's responsibility for their own therapy. This serves two functions. Firstly, it presents the therapist as a facilitator and not a magician and, secondly, it reduces dependence on the therapist, making the 'weaning' / discharge process more effective.

I started the assessment by taking a case history from Bert and his wife. To supplement this, I had his medical notes available, paying particular attention to any pre-existing medical conditions and any medication prescribed. The case history provided an opportunity to examine informally Bert's receptive and expressive language skills. It also highlighted Bert's perception of his difficulties and allowed him to explore his feelings about his speech. Bert's wife was included in this process as I feel it is imperative to gain the spouse's perspective and identify their needs. They can be as much of a barrier to progress as they can be a facilitator of change if their needs are ignored.

Summarising

Before moving on, I summarised for Bert and his wife what they had told me, to ensure that nothing had been omitted. This went as follows:

- Bert was embarrassed about his speech because it was slurred.
- His voice was gruff and too quiet.
- He coughed on free liquids and seemed to have too much saliva in his mouth.

The impact on his life was as follows:

- He was no longer using the phone.
- He was avoiding social situations.

His problems were exacerbated by:

- His wife's hearing difficulties.

I find a summary is helpful to ensure that all parties concerned are clear on what has been said. A great deal of information emerges during case history-taking, and subsequent assessment can be a bewildering whirlwind experience for the first time attendee. I try to ensure they leave from their first appointment knowing what we have discussed and what we are going to do next. I ask patients if they have any questions and will usually ask a few of my own if none are forthcoming to ensure there has not been any misunderstanding.

Clarifying

I write their next appointment on the back of a business card which also shows my name, title, qualifications and contact number (figure 6). I am amazed at how a simple business card can be so effective in clarifying who they have seen and when they will be seen again. Business cards seem to end up on kitchen pinboards or in wallets whilst appointment cards seem to disappear into the ether. Also, during multidisciplinary assessments, patients frequently lose track of who they have seen and what they did.

Dysphagia assessment

The case history allowed me an opportunity to investigate Bert's swallowing difficulties further, ensuring that he had not recently experienced any chest infections or problems with other consistencies.

I then carried out a 'bedside' swallowing assessment with a free liquid, biscuit and yoghurt. Particular attention was paid to voice quality and coughing post-swallow with any incidence being recorded. Bert's description of his voice and swallowing problems tended to suggest an abnormality / incompetence at laryngeal level although possible pharyngeal pooling could not be ruled out at this stage. Various postural techniques and swallow modifications were attempted on subsequent swallows to eliminate coughing. Particular attention was paid to Bert's ability to adduct and abduct his vocal folds, ensuring complete laryngeal closure during swallowing. Had these modifications failed to alleviate Bert's problems, I would have referred him for videofluoroscopy.

Reported increases in oral secretions required observation of spontaneous swallowing and consideration of current medication.

Dysarthria Assessment

I then carried out an informal assessment of Bert's speech. This encouraged him to experiment with contrasting loudness, phonation and rate. By varying his speech by these parameters, Bert began to experience control over his disability and therefore felt less of a victim of his impairment. In this way, assessment becomes an exercise in empowerment.

Following this, I administered the Frenchay Dysarthria Assessment as a baseline measure prior to therapy.

I explained my initial findings to Bert & his wife:

- *His rate and range of tongue movements were reduced which made his speech slurred.*

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- *It was as yet unclear why his oral secretions were increased and this would require further investigation. Likely causes were either reduced spontaneous swallowing or a side effect of medication.*
- *His gruff voice was a likely result of abnormal laryngeal movement and possible vocal abuse. I went on to explain that he may have strained his voice trying to compensate for his reduced intelligibility and his wife's hearing loss.*
- *His reduced volume was a result of poor breath control and weak phonation.*

Action

I recommended the following course of action for Bert:

1. *Referral to an Ear, Nose and Throat specialist regarding his voice to rule out any sinister pathology.*
2. *Referral to the on-site Hearing Resource Centre for Bert's wife to ensure she is fitted with the appropriate hearing aids.*
3. *A short course of individual speech and language therapy targeting swallow modification, articulation, phonation and respiration.*
4. *A home programme with exercises for the above.*
5. *Written advice regarding over-pronunciation, reducing rate and reducing background noise in the home.*
6. *A course of group therapy to follow on from the individual therapy to develop communicative confidence in a social setting. Specific telephone practice could be incorporated into this.*
7. *Information regarding the local stroke club.*

Bert and his wife were happy to take this course of action. Appointments were booked and an initial report was written to the GP referring agent with a copy to ENT, plus covering referral letter. The initial report outlined Bert's medical diagnosis, his speech difficulties, the further investigations I had initiated and my plans for therapeutic intervention.

Therapy attempted to encourage and reassure both Bert and his wife and to make maximum use of his remaining potential. It encouraged him to monitor his speech and to learn to listen to himself, look ahead and anticipate difficult phonemes and words.

Many aspects of therapy are transferable. I frequently find myself using techniques that were originally developed for completely different client groups. In Bert's case, a hierarchy of difficulty in using the telephone was identified and role-played as frequently done with clients with dysfluency.

Following the ten sessions of group therapy, Bert was seen for an individual session. He was asked to fill in a self-perception questionnaire looking at his feelings about his speech following therapy. I then repeated his Frenchay Assessment. This provided me with an objective and subjective evaluation of Bert's speech and language therapy.

I then asked Bert what he wanted to do. He felt that he did not need any more therapy at present but may want some in the future. I explained I would contact him in six months for a review appointment. If he did not want a review, I would discharge him from my caseload with the understanding that he could self-refer in the future if he had any further concerns.

Style

What is more difficult to write about - and what is perhaps far more interesting - is the style in which we deliver our therapy. I am sure we are all fairly similar in what we aim to achieve with our clients but the manner in which we do it is often very different. I seem to use a lot of humour in my therapy and I am aware this is not apparent from reading the above! I always try to appear enthusiastic and jovial, even after a night of disturbed sleep compliments of my nine month old daughter. I find laughter is perhaps my most utilised tool and sometimes feel that a patient's enjoyment of therapy is a better indicator of success than quantitative assessment.

Impairment and handicap

Angela Moar focuses on the psychosocial implications of dysarthria through client and carer groups.

Following a brief period on our 'neuro waiting list', Bert would be offered an initial assessment appointment, most likely attending as an outpatient. Domiciliary assessment could be arranged should out-patient attendance prove problematical. Bert's wife would also be invited to attend.

The initial appointment would include an assessment of speech, discussion regarding the level of the impairment / disability / handicap, and the various therapy options available.

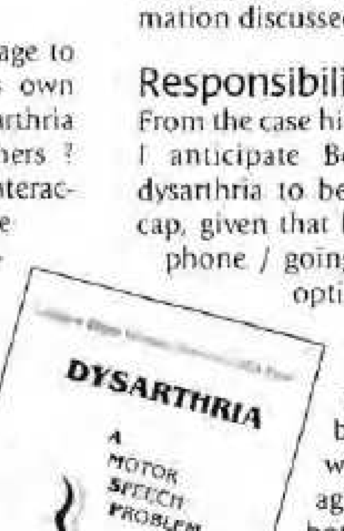
Initial speech assessment would involve an informal dysarthria assessment / oro-facial examination, the Frenchay Intelligibility subsections, and a tape recording of conversational speech. Given that Bert is reporting some swallowing difficulties with fluids, his swallowing would be assessed using clinical evaluation in the first instance, and appropriate advice would be given. A videofluoroscopy could be organised and carried out on site, should this be indicated from the initial clinical information.

Self perception

I would consider it vital at this stage to establish how Bert perceives his own handicap - how does his dysarthria affect his conversations with others ? how does it inhibit his social interaction? - as this has considerable implications for future management. Should Bert have no concerns regarding his communication, then further therapy may not be indicated at this stage.

Concrete information

Dysarthria would be explained and discussed using our departmental dysarthria leaflet for reference (figure 7). This covers topics such as 'Normal speech production', 'What is dysarthria?', 'Strategies to control speech', and 'How friends and family can help'. I find it is useful to provide clients and their relatives with concrete information to take home, as it can be difficult to remember all the information discussed.



DYSARTHRIA

A MOTOR SPEECH PROBLEM

figure 7

Responsibility

From the case history information given, I anticipate Bert does perceive his dysarthria to be a considerable handicap, given that he is not answering the phone / going to the pub. Therapy options would therefore be discussed in some detail. Both individual and group therapy can be offered, and Bert's wife would be encouraged to be involved in both. I would emphasise at this early stage that therapy offers practical strategies and exercises, but that the responsibility lies with Bert to employ these. I question how much direct therapy can offer a client who is not prepared to take an active role in rehabilitation.

I envisage that Bert would benefit from both individual and group therapy. Individual therapy includes specific advice and practice on breath support, reduced rate and so on, and group therapy tackles some of the wider psychosocial issues associated with dysarthria.

Psychosocial issues

Recent dysarthria groups held in our department have run for six to ten sessions either once or twice weekly. Clients attending are generally those to whom dysarthria is felt to be a considerable handicap, regardless of level of impairment. Some of the topics included in the group are:

- revision of the impairment of dysarthria
- self analysis of level of breakdown
- issues such as listener reaction
- feared situations.

The group would also give Bert the opportunity to address and share feelings associated with the communication loss.

Clients are encouraged to identify situations in which they find it difficult to communicate and brainstorm strategies which may help. These situations and strategies are then practised in role play and, when possible, real life situations. Bert has identified specific concerns about using the phone and going to the pub, and these may be ideally tackled in the group. Using the telephone is a common fear within the group and strategies frequently suggested include:

- ensure good posture
- reduce rate
- think about breath support
- plan what to say before making the call.

Role play would use a variety of situations with an increasing hierarchy of difficulty, initially phoning each other within the department and progressing to making outside calls to unfamiliar listeners, eg. the bus station to find out timetables. A similar approach would be taken with the issue of going to the pub, however, due to physical logistics it is unfortunately unlikely we would be able to practise specifically in the pub!

Carers group

When resources allow we also run a carers group concurrently with the dysarthria group. The carers group runs for three to four sessions. There may well be some communication breakdown between Bert and his wife, and therefore she may benefit from attendance at the group. Similar topics are included in the carers group, and again specific advice and strategies on how to help their relative / friend are identified. Obviously some of these issues would be tackled earlier such as how Bert's wife's hearing loss may also be contributing to communication breakdown, and how this could be resolved.

Checklists

Bert's progress in individual therapy would be evaluated by repeating the initial assessments and through discussion. Pre-group, Bert's knowledge and perceptions would be assessed using an informal 'Knowledge of Dysarthria' questionnaire and 'How I Feel About Talking' checklist. The results of these help identify the areas of difficulty to be targeted in the group, and are also used for reassessment post-group.

Bert's GP would be kept informed of his progress via written reports. For all clients, reports are sent to acknowledge the initial referral, following the first appointment, and on discharge. Reports contain information on levels of communication, strategies to help communication, intended therapy and, on discharge, success of intervention. Reports are also sent to any other interested parties such as the medical consultant.

Following therapy, Bert may feel ready for discharge, or he may wish continued advice and support.

Maintenance

We have very recently established a 'maintenance group' for dysarthric clients who have already gone through both individual and group therapy, but feel they still require some support from speech & language therapy. The group is held approximately every three months. Also, within our area the local Volunteer Stroke Scheme Chest, Heart and Stroke Group runs weekly, and several of our dysarthric clients have gone on to attend. Both groups would be available to Bert should he wish.

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Stammering controversy

The British Stammering Association has reacted to Queen Margaret College's decision to refuse a stammerer entry to their speech and language therapy training.

Tessa Clark received a letter in response to her application stating the College would not accept "anyone with a disorder of speech, language or hearing, even if it is a well-controlled stammer".

The BSA believes applications from people who stammer, like those from fluent people, should be considered on their merit and is hopeful policies may be reviewed in the light of the recent Disability Discrimination Act. It is writing to all speech and language therapy training establishments to ask for details of admissions policies.

New healthcare magazine

The UK is the unhealthiest country in western Europe according to a new quarterly business publication.

Healthcare International, from the Economist Intelligence Unit, aims to analyse and interpret trends and changes in the $3 trillion global healthcare industry.

The first issue also reports on the forthcoming Kensington experiment in London which will provide a one-stop medical shop for 100 000 patients and on the decline of the US health insurance industry, forecasting that more than 16 per cent of the population will be uninsured by 2001.

AD/HD Awareness Week

A multi-modal approach to working with children with Attention Deficit / Hyperactivity Disorder was the emphasis of a conference marking a National Awareness Week.

The European Conference for Health and Education Professionals held in April at Oxford University examined how AD/HD related to other areas of special need including dyslexia, speech and language disorders, autism, Asperger syndrome, Fragile X and emotional and behavioural difficulties. Speakers included speech and language therapist Jackie Harland.

The awareness week, aimed to educate professionals and the public about the highly controversial disorder and issues surrounding treatment.

Theatre of the Deaf

Students from Reading University have presented their deaf theatre project at a conference - Therapy and Theatre - in Poland.

Wall of Glass is a dramatic exploration of the nature of language. The tutor on the degree course Theatre Art, Education and Deaf Culture also led a workshop on the nature of non-verbal communication for those attending who included people who speak a variety of languages, are deaf and hearing and one who is blind.

REVIEWS *reviews*

SOCIAL SKILLS
A highly practical tool

Talkabout
Alex Kelly
Winslow
ISBN 0 86388 146 7 £32.50

Talkabout is a useful and practical package for therapists working on developing communication and social skills. The package sets out worksheets which would combine easily with existing social skills programmes. These sheets can be photocopied for instructional use, an essential feature of any practical therapeutic tool. It is good to see a resource which from the outset acknowledges that the therapeutic process needs to be responsive and does not prescribe either order or structure.

The package is well designed and the use of various cartoon figures allows information to be presented in a pictorial framework which is adult and not patronising. I particularly liked the cartoons and facial expressions on the passive, assertive, aggressive rating scale. Self-assessment of skills is integral, encouraging clients to monitor their own development and - hopefully - improvement from the beginning.

This resource would be useful for either adults or school age children with social communication difficulties. It should be borne in mind, though, that despite the use of cartoons there is still a high reliance on the use of the written word. This will restrict or need the therapist to adapt the material further for those without literacy skills.

As a resource it will be useful not only to speech and language therapists but also to colleagues in occupational therapy, education and social work establishments. It would form a good basis for joint planning and discussion.

Talkabout is a highly practical, easy to use resource and I expect my currently pristine copy not to remain like that for long, it will be well thumbed.

Lois Cameron, speech and language therapist, is Team Leader for Learning Disability in Central Scotland Healthcare.

VOICE
An additional resource

Vocal Pathologies - Diagnosis, Treatment and Case Studies
Dworkin, J.P. & Meleca, R.J.
Singular
ISBN 1-56593-623-X £33.95

This book aims to provide a comprehensive guide to the diagnosis, treatment and general management of a wide range of voice disorders. It is a well produced book which contains two CDs of speech and voice samples to accompany the fifty one case studies which make up half the text.

It contains numerous photographs of laryngeal pathologies and, in the case studies, pre and post therapy examples are included. Text is interspersed with clear illustration, examples of assessments and useful algorithms for aspects of voice therapy and management. The illustrations of vocal fold anatomy, neurological pathways for phonation and phonosurgery were particularly helpful.

The case studies of different vocal pathologies are supported by photographs, history details, examination findings, therapy results and discussion as well as the voice samples on CD. I was unable to avail myself of the benefit of the latter as I do not have access to a CD player.

In discussing therapy and management there was an understandable bias towards North American ways of working. I felt the authors were over-ambitious including Laryngectomee Rehabilitation alongside all the other vocal pathologies, reducing such a vast subject to eight pages. There were some unfortunate generalisations eg laryngectomees "were *reminded* to mastering use of an artificial larynx" (my italics), when the use of an electronic larynx can be the option of choice for some laryngectomees.

Despite the excellent illustrations and photographs the book would not provide enough depth and guidance for therapeutic planning for inexperienced clinicians. It would, however, be an excellent source book for visual feedback both in therapy and education of students, and would be an additional resource for a department which already has access to other voice therapy texts.

Eryl Evans is Head of Speech and Language Therapy at Singleton Hospital for Swansea NHS Trust.

VOICE
Inspiring and motivating

Organic Voice Disorders
Edited by Brown, W.S., Vinson, B.P. & Crary, M.A.
Singular
ISBN 1-56593-268-4 £45.00

The idea of yet another American book on voice failed to inspire me to make that cup of cocoa and sit down for a good read. If I had not persevered past the first chapter, then I might not have had to find the slice of humble pie and admit that this turned out to be an excellent voice textbook which I thoroughly enjoyed reading.

The first chapter only distracts from the standard of the rest of the text, making me want to whisper to the authors my own 'helpful' comments such as "please stop waffling" and, despite the historical interest, "what is the relevance of a Greek philosopher or a Padua anatomist to my typical nodule patient?" Should it have been omitted altogether?

Organic Voice Disorders is an academic textbook providing a wealth of information for the professional working with or interested in voice. The chapters are presented in such a way so as to focus the reader on the topic being discussed. The level of detailed information sets the standard as the 'all encompassing, all singing, all dancing' voice source book. This can make the reader feel somewhat daunted but it is important with this book to remember that it is obviously presenting an 'ideal' level of knowledge and practice which perhaps those of us working within NHS Trusts can only dream of. The clinician will, however, benefit from the level of expertise documented within this book.

For such an amazing level of information, the presentation of the written text was aesthetically dull. The illustrations were however generally of high standard and appropriate. Certain chapters such as that concerning anatomy and physiology were incredibly detailed and yet easy to revise from. The chapter looking at lifespan changes within the larynx would also help the professional with a typical voice caseload.

This book is obviously aiming for a thorough overview, but some of the measurements taken in analysis of voice, especially within the aerodynamic and acoustic range, would not be routinely available within British voice clinics, let alone the ENT or speech and language therapy departments. These chapters are not for the faint-hearted. Other chapters assume a certain level of medical knowledge. It is also important to consider the differences between American and British terminology.

In summary, this book does inspire and motivate the reader. It could have been presented in a more interesting manner with a more relevant beginning. Do not be put off by certain reference lists which can be terrifyingly long. This book will encourage each person to take their knowledge base further with voice assessment and treatment. An excellent book.

Jeanette Tyler is a specialist speech and language therapist in voice and dysphagia working for Mid Anglia Community NHS Trust at the West Suffolk Hospital.

GENERAL
Excellent stimulants

ColorCards: Emotions / What's Missing?
Winslow
£23.75 each

These new boxed cards have clear, colour pictures with up-to-date styles and multi-racial content.

I tried both sets of card as part of informal assessment and in direct therapy and found they were received well by adults and older children.

The 'What's Missing?' set were excellent stimulants for description and also challenged many clients' assumptions with many stating what they expected to see and not what was actually missing.

Emotional development and life experience are particularly difficult areas for people with learning disabilities who live in long-term hospitals. The situation cards in the 'Emotions' set were particularly useful to help explore different feelings, describe what they saw and consider their own reactions in a similar situation.

Using the ColorCards, my clients had a chance to consider, discuss and explore different situations and emotions in a clear, often light-hearted and non-threatening way.

Lorraine Gillies is a speech and language therapist working with children and adults with learning disabilities for Central Scotland Healthcare.

DYSLEXIA
1981-1996 - Has anything changed for client and family?

This book doesn't make ~~sens cens sns scens~~ sense: Reissue
Augur, J
Whurr Publishers
ISBN 1 897635 13 3 £10.95

Dyslexia - Parents in Need
Heaton, P.
Whurr Publishers
ISBN 1 897635 73 7 £11.95

Two books. One written in 1981 from a dual perspective, that of mother of dyslexic children and mainstream teacher. The other written fifteen years later and based on the answers to a questionnaire completed by parents of dyslexic children.

The former (Augur), written for parents and teachers, adopts an anecdotal style using an honest and open narrative to describe the formative years of the authors' sons. It follows the confusion leading up to diagnosis and problems faced following it. The latter (Heaton) uses a question and answer format to address issues such as how dyslexia has affected family life, advice, language skills and provision.

Both books give useful insights into the more poorly perceived characteristics of the dyslexics such as clumsiness, lack of organisational skills and higher level language difficulties. This is one of the features which would make these books particularly useful for undergraduate teachers alongside a useful section in Augur's book covering hints on how to help dyslexics and how *not* to correct their work!

Perhaps one of the most striking things about the experiences portrayed in these books was the difficulties parents had when dealing with professionals. Although the experiences of the parents interviewed in 1996 were a little more positive, many felt that their early concerns were too readily dismissed.

A whole chapter in Heaton's book is devoted to 'early signs'. Later in talking, speech problems and difficulties with rhymes and naming are all mentioned. The author concludes that "the well informed can recognise traits long before school". However, speech and language therapists are not mentioned amongst these and, in fact, do not figure throughout the text. With the current interest in phonological awareness within the profession, perhaps this might change if the author were to repeat the study in two years time.

The familiar incidence of dyslexia is highlighted in both books and the common scenario where the father and sons are dyslexic was brought home to the reader. What struck me was how difficult it must be to organise a family like this - perhaps something we should bear in mind.

I would recommend both books for parents; although Augur's book is a little dated it remains an easy to read book with a positive message. Heaton's book contains many handy hints on practical management and how to obtain the necessary support for these children as well as useful addresses and materials.

Kathleen Cavin works for Central Scotland Healthcare. Her caseload involves working with children with learning disabilities as well as Recorded children in mainstream.

ELDERLY
Discovering creative impulses

Creative Groupwork with Elderly People: DRAMA
Madeline Andersen-Warren
Winslow
ISBN 0-86388-147-5 £25.95

This is a practical manual for people working with the elderly in a variety of settings. The emphasis is on self expression both physically and emotionally, through movement and drama. The author intends it for use by those without specialist knowledge of drama or creative methods of working, but then recommends anyone planning to lead creative groups should attend a basic leadership course to "discover one's own creative impulses" before attempting to work with others'. Having read the manual, I would not feel at all comfortable leading a group of this type without further guidance and knowledge of the theory underlying this approach, even though I quite happily run a weekly group for elderly people with dysphasia.

The manual is usefully divided into three sections. The first provides an overview of dramatic art and its possibilities with all age groups - in fact, I feel the title of the manual is potentially misleading, as the activities do not seem to be specific to the elderly and could be used with other populations. It goes on to explore *benefits* specific to the elderly population.

The second section, consisting of carefully structured and photocopiable group activities, left me with mixed feelings. Although there were some excellent ideas, many activities I felt were potentially patronising and I personally would feel unable to use them with any client group. There was a suggestion at the beginning that such groups may be appropriate for people with mental health problems or neurological impairment such as dementia, but this wasn't followed through in any detail, and I was left with a feeling of great uncertainty as to the 'type' of elderly client who would benefit from such activities. It would have been helpful to have had much more specific guidance from the author regarding the selection of group members.

The third section is a collection of relevant contacts and addresses.

I don't think this book offers speech and language therapists anything over and above those designed for group work in general, and certainly felt it inappropriate for use with dysphasic clients. However, it did make me stop and think about the possible psychological and emotional needs of groups of elderly people who have difficulties other than communication disorder.

This is potentially a very useful resource for trained professionals wishing to offer a more creative therapeutic environment both physically and psychologically to their client group. I found it both interesting and thought-provoking.

Kate Rush is a speech and language therapist at Weston General Hospital, Weston-super-Mare.

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Naming - more than just right or wrong?

Linda Armstrong and Michelle Brogan argue that scoring picture naming responses as correct / incorrect gives inadequate information to therapists devising treatment plans and monitoring clinical change in clients with word finding difficulties.

Analysis of the picture naming performance of people with aphasia has provided important insights into our understanding of the cognitive and linguistic processes involved in normal and impaired word finding. The variety of picture naming errors produced by people with aphasia suggests naming failure may be related to a deficit at any stage in the process from visual recognition to phonetic realisation.

The speech and language therapist employs a range of cueing techniques to provide the client with additional information to assist in the immediate facilitation of word retrieval. Typically this involves either providing a description of the target - semantic cueing - or prompting with the initial sound - phonemic cueing. Numerous studies have investigated the effectiveness of various types of cues as they differentially facilitate naming in different types of aphasia.

Stimley and Noll (1991) argue that examination of the changes in the frequency of error types people with aphasia produce in response to semantic and phonemic cueing 'has the potential of providing a better understanding of the naming process, its impairment and the effects of cues'. They established that semantic cueing elicited different types of errors from those produced following phonemic cueing.

Semantic cueing was associated with an increase in error categories such as semantic paraphasia and decrease in phonemic paraphasias and unrelated words. Stimley and Noll also found subjects produced more non-specific responses following semantic cueing. Their examination of the types of error produced following phonemic cueing showed there was a significant increase in phonemic paraphasias and a corresponding decline in semantic paraphasias.

Questions

Our investigation sought answers to the questions

(i) what patterns of error responses, and modifications or shifts under cueing conditions, do normal elderly and fluent aphasic speakers produce?

(ii) how does this information inform clinical practice?

We analysed the types of picture naming error responses of normal elderly and fluent aphasic subjects produced:

a) uncued

b) following semantic cueing

and c) following phonemic cueing.

Three subject groups were included in this investigation (Table 1).

Table 1 Subjects details

Group	Number	Male	Female	Range	Mean age
NOR	10	1	9	61-95	71.9
ANO	10	7	3	61-82	68.3
WER	9	7	2	61-86	72.1

1. **NOR**: a group of normal elderly people, sought from a sheltered housing complex in central Scotland and tested by the second author
2. **ANO**: people with mild / anomic aphasia
3. **WER**: people with moderate-severe / Wernicke's aphasia.

The people from the two groups with fluent aphasia were subjects in a previous investigation (Armstrong, 1993), in which selection criteria are described.

Testing

The subjects were given the Armstrong Naming Test (1996). If a subject failed to name a picture correctly, a semantic cue was given first, either the function, location or a description of the item. If the subject still failed to name the item correctly, a phonemic cue was given, the initial (C)(C)V of the target. Testing was discontinued after five consecutive failures to name despite cues. During testing, transcription of responses was made and the sessions were audio-recorded to obtain a permanent record of these responses.

For scoring purposes the following responses were considered:

i) uncued picture naming responses (correct or incorrect)

ii) correct responses produced following semantic cueing and phonemic cueing

iii) error responses following semantic and phonemic cueing.

Errors were assigned a type (Table 2) using a classification system based on the methodology of Stimley and Noll (1991). Additional error categories, adapted from Armstrong (1993), were introduced to account for the types of naming errors reported in the literature as being commonly produced by normal elderly subjects in picture naming tests.

Table 2 Error classification system

Specific error types	Broad classification
Phonemic paraphasias Neologisms Phonemically flawed semantic paraphasias Phonemically and semantically related paraphasias	Phonemically-based errors
Semantic paraphasias Circumlocution	Semantically-related errors
Non-specific errors Inadequate responses	Non-specific errors
Tip-of-the-tongue type errors	Tip-of-the-tongue type errors
Did not know responses	Did not know responses
Unrelated word errors	Unrelated errors
Visual misperceptual errors	Visual misperceptual errors

Attempts at picture naming

The three groups were clearly differentiated by their mean test scores. As a result of different numbers of unattempted pictures, different total attempts at naming emerged. For NOR, ANO and WER, a total of 500, 318 and 138 attempts at naming were made. Of these, correct responses were made on 94 per cent, 64 per cent and 21 per cent of the attempts respectively.

Cueing Responsiveness

NOR responded better to semantic cueing than phonemic cueing. However, because of the high number of correct responses, the numbers involved are very small; 30 cues in total were given, The reverse pattern was observed for the aphasic groups. Fifty per cent of the phonemic cues given to ANO resulted in correct naming, compared to only seven per cent of the semantic cues given. However, WER derived very little benefit from either form of cueing (85 per cent failure rate), with phonemic cueing having a slight advantage over semantic cueing.

Error Analysis

Incorrect responses produced prior to and following cue administration provided the opportunity to examine whether semantic and phonemic cueing influenced the types and proportions of errors produced. WER have been excluded from the following analysis because of the relatively small number of pictures they attempted.

Effect of semantic cueing on naming errors

Of the 14 incorrect responses produced by NOR following semantic cueing, 13 were produced by two subjects aged 85 and 95 years. The types of errors produced by NOR prior to and following semantic cueing (Table 3) showed the same pattern of error type distribution predominated, mainly semantically-based errors.

Table 3 Number and type of incorrect responses produced by NOR and ANO (as percentages in brackets)

	NOR	ANO	NOR	ANO	NOR	ANO
Error categories	Uncued	Uncued	Following semantic cue	Following semantic cue	Following phonemic cue	Following phonemic cue
Phonemically based errors	0	59 (33)	0	16 (11.3)	0	45 (60)
Semantically-related errors	20 (66.7)	57 (32)	11 (78.6)	28 (20)	3 (43)	9 (11.8)
Non-specific errors	0	32 (18)	0	69 (49)	0	8 (10.5)
Tip-of-the-tongue	0	11 (6)	2 (14.3)	25 (18)	2 (28.5)	7 (9.21)
Did not know	1 (3.3)	4 (2)	1 (7.1)	2 (1.4)	2 (28.5)	4 (5.27)
Unrelated errors	0	8 (5)	0	2 (0.7)	0	3 (4)
Visual misperceptions	9 (30)	6 (3)	0	0	0	0
Total naming errors	30	177	14	142	7	76

Prior to cue administration, ANO produced errors in all error categories with semantically-related, phonemically-based and non-specific errors accounting for 83 per cent of the total errors made (Table 3).

Following semantic cueing, a different pattern of responses is evident. There was a decrease in phonologically-related, semantically-related and unrelated word errors and an increase in the proportion of non-specific and tip-of-the-tongue errors, where the subject indicated recognition of the target word but was unable to retrieve its name. Often s/he would describe the target using gesture, or give some relevant physical detail. Accompanying comments such as "I know what it is but I can't get it" or "It's on the tip of my tongue", combined with shakes of the head, are typical of this error type. As with NOR, no visual misperceptual errors were produced following incorrect response to semantic cueing, presumably as semantic cueing facilitated the correct recognition of these previously misperceived items.

Effect of phonemic cueing on naming errors

Examination of the distribution of the types of errors produced by NOR following phonemic cueing (Table 3) indicated a decrease in the proportion of semantically-related errors and an increase in 'did not know' responses and tip-of-the-tongue responses. A significant correlation was found between the types of error responses produced after semantic and after phonemic cueing.

For ANO, under the phonemic condition, there appeared to be an increase in the category of phonemically-related errors, a decrease in the categories of semantically-related and non-specific errors, and a reduction in the number of tip-of-the-tongue responses. No difference was observed in the proportions of unrelated errors and did not know responses. For ANO, there was no significant correlation between types of errors produced after semantic cueing and following phonemic cueing.

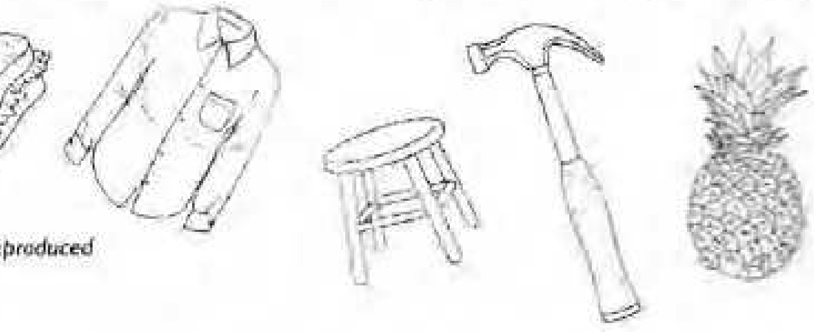
Clinical implications

This investigation utilised small samples of group data from healthy elderly people and people with fluent aphasia as the basis for a detailed quantitative and qualitative analysis of picture naming errors made prior to and following semantic and phonemic cueing. (WER were excluded from the main analysis because of the paucity of data they provided.)

It has provided some useful implications for the clinical use of cueing in the facilitation of naming in aphasia. In terms of semantic cueing, this strategy seems to inhibit visual perceptual misinterpretation and responses which are not related to the target. If clients respond to the cue in a non-specific manner (eg. "oh yes" or "yes, but what's it called?"), it is unlikely that repeated presentation of the same or a similar cue or will provide the additional information the client requires for successful naming. The effect of semantic cueing, in picture naming at least, may lie more in facilitating picture recognition, that is, the early processes involved, than word finding per se.

The argument for the use of phonemic cues - despite recognition that the effect of phonemic cueing on overall naming performance is not long-lasting - is strengthened in that this type of cue facilitates not only correct naming but also a closer phonemic approximation to the target response. While the target may not be accurately produced, it will often be more recognisable to the listener.

Furthermore, this investigation has reinforced the contribution that error analysis makes to permitting identification of the level at which the process of naming has been disrupted; scoring



Excerpts from Armstrong Naming Test, reproduced courtesy of Whurr Publishers.

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responses as correct/wrong only means much information is lost. More accurate diagnosis of the level at which errors are being made and of which types of cue facilitate naming in an individual client will allow therapists to devise more accurate therapeutic aims and to target their therapy more exactly (case example in figure 1).

Measuring effectiveness

Speech and language therapists now have to devote considerable time to evaluating whether their treatment is effective. This study has provided further evidence of the benefit of cueing and helps to demonstrate how naming performance may be positively influenced by cueing either in the production of a correct response or a still incorrect but closer-to-target response. Effective treatment may be measured more easily by evaluating changes in types of errors or modifications in naming errors made by clients with aphasia under different cueing conditions rather than by using scores on naming tests alone as an index of improvement, since these are often too crude to demonstrate clinical change.

References

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Stimley, M.A. and Noll, J.D. (1991) The Effects of Semantic and Phonemic Prestimulation Cues on Picture Naming in Aphasia. *Brain and Language* 41, 496-509.

At the time of this study, Linda Armstrong was a lecturer and Michelle Brogan a final year student at the Department of Speech and Language Sciences, Queen Margaret College, Edinburgh, EH12 8TS.

Figure 1 - Case example

Client HP, with anomic aphasia, attempted to name 45 of the pictures. She managed to name only 12 correctly without cues, which seems to indicate a severe picture naming difficulty. However, when her cued performance is examined, a much more positive account is evident and indications for management of naming difficulties are made possible.

	Uncued	*Following semantic cue*	*Following phonemic cue*
Correct responses	12	1	12
Error responses	33	32	20
Error type:-			
Phonemically-based	15	6	15
Semantically-based	3	6	15
Non-specific	7	18	3
Tip-of-the-tongue	4	0	1
Did not know	1	1	1
Unrelated	3	1	0
Visual misperception	0	0	0

It is clear that semantic cueing did not help HP; indeed, response to this strategy - along with her lack of visual misperceptions - served to show her difficulty did not lie in recognising the picture. The increase in non-specific responses, eg. "yes, but what's it called?", or repetition of the semantic cue and reduction in phonemic errors, mirror the findings of Stimley and Noll (1991). After phonemic cue, the pattern reverts, with the number of phonemic errors increasing again (75 per cent of total errors made after phonemic cue). Superficially then, it seems that, although phonemic cueing produced another 12 correct responses, there remained almost half of the pictures (20) still incorrectly named.

Closer examination of these however revealed that most incorrect responses were now very close to target, with only one or two of the target phonemes wrongly selected or sequenced (and so probably intelligible for everyday conversation). For example, for picture 1 (pencil), her final response was ⟨pentick⟩, compared with her initial response of ⟨slip⟩. Importantly too, she was aware of her errors, as shown by multiple attempts, but awareness did not often result in self-correction.

Some implications for therapeutic intervention can be proposed:

- ***semantic cues do not seem to be helpful***
- ***discourage HP from making multiple word finding attempts - try encouraging her to "think it out" before making a response***
- ***use phonemic cues in treatment, with the long-term aim of HP using self-cueing***
- ***advise carers to accept almost correct attempts at word retrieval in conversation.***

Questions & Answers

Do right / wrong scoring systems in naming assessments have limitations?	It is difficult to draw up individual treatment plans without knowing accurately where errors are being made and how different cues help.
What may be the main effect of semantic cueing in picture naming?	Semantic cueing seems to help visual recognition, an early level of the picture naming process.
How can error evaluation contribute to measuring treatment effectiveness?	Changes in a client's naming errors and response to cues over time can indicate progress which may not be shown by test scores.

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INFORMATION FOR CONTRIBUTORS

Writing for Speech & Language Therapy in Practice

Every magazine and journal has a specific and consistent style on which its readers depend. This feature addresses common queries from potential contributors to Speech & Language Therapy in Practice.

This magazine has a general readership within the speech and language therapy profession and aims to bridge the gap between theory and practice. A certain amount of technical knowledge can therefore be assumed. Every attempt should be made to provide a practical focus and examples.

Writing an article

Articles are received in one of three ways.

1. The editor approaches potential authors with an idea.
2. Therapists contact the editor to discuss a possible article.
3. Unsolicited articles are received by the editor.

(Please note that the editor has to reserve the right, for whatever reason, not to publish articles received.)

Checklist

1. Articles must be typed. If it is at all possible to send your article on disk, please do so, preferably one suitable for a PC. Disks will be returned.
2. One copy should be sent to Avril Nicoll. Always keep a copy yourself in case of loss and to compare with the edited version.
3. Photographs and illustrations are very useful for breaking up text and bringing it to life and should be included if possible. Photographs will be returned.
4. Length for general features is usually up to 2500 words but this is flexible.
5. Statistical information should be kept to a minimum and put in tables, and the practical implications of it summarised in the text.
6. Provide full references in alphabetical order. (Examples of required content and preferred layout are overleaf.)
7. Please try to meet deadlines if at all possible. It allows time for the editor to request further information and for you to put this together. If you know you are going to be unable to meet a deadline, please let the editor know as soon as you can.
8. Articles submitted to Speech & Language Therapy in Practice must not be simultaneously submitted to any other publication without the editor being advised. Please also inform the editor if you have submitted articles on the same subject from different angles to other publications.
9. Provide your full working title as you would like it to appear and ensure you send details of your home / work addresses and phone numbers, fax number and e-mail if applicable.

Regular features

Focus on ...

A speech and language therapy department describes its philosophy and structure and gives up to eight examples (around 250 words each) of projects or developments. Accompanying photographs and diagrams are welcome. Total length is usually up to 2500 words. Key points are listed by the editor.

How I...

Provides a personal response by three therapists to a given case or everyday problem or task. Written in the first person, authors are encouraged to explain their thinking processes and options available to them and to give specific examples so readers can share in their experience. Length is usually around 900 words. A photograph and employer's logo are requested. Practical points are listed by the editor.

My top resources

(starts Autumn 1997)

A personal account by a speech and language therapist. A brief job summary is followed by descriptions in up to 100 words each of why ten commercially available or home-made resources are indispensable in everyday practice.

Reviews

Reviews should

- be concise - 250 words up to 450 maximum
- be relatively jargon-free
- contain an overview of the item, not a list of contents
- be a personal response - how the item or parts of it changed your thinking and informed your practice, or failed to do this
- contain information about who would find the item useful and why. Please bear in mind the fact that readers may well use your comments to decide whether or not to buy an item. You should not feel therefore that you have to be positive about the item if you have not found it helpful.

The editing process

Articles are edited and returned for your approval. You may be asked to provide extra information which the editor feels would clarify what you have written and / or add practical value.

The aim is not to change the meaning or personal style of writing. Headings and sub-headings will be added and practical points highlighted by the editor.

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More specific information

Examples are drawn from recent issues of *Human Communciation.*

References

References should be provided in alphabetical order, with content and layout as follows:

Aitkens, S. and Buultjens, M. (1992) Vision for doing. Moray House: Edinburgh.
Best, A. (1986) Implications of visual impairments in: Ellis, D. (ed.) Sensory Impairments in Mentally Handicapped People. Croom Helm: London.
Park, K. (1995) Using objects of reference: a review of the literature. *European Journal of Special Needs Education*, 10 (1).
Ware, J. (ed.) (1994) Educating Children with Profound and Multiple Learning Difficulties. David Fulton: London.

(Selected references from Hendrickson and McLinden, Vol. 6 (2).)

Case examples

Whatever you are writing about - an assessment, a therapy approach, liaison - try to use case examples when possible to show how this worked for an individual client. These will probably be short and needn't include background detail.

While it can mislead to use cases for whom only partial information is provided, two examples may show how carer questionnaire responses and test results can be used together when planning advice or intervention (Figure 2).

Some of ER's test results and carer responses have been described. They indicate that the day carer recognises some degree of comprehension difficulty while the home carer thinks ER's difficulties lie in expressing a response rather than in understanding. The ABCD score indicates her difficulty with longer more complex instructions so in this instance, both carers could be advised to use shorter sentences when asking ER to carry out particular daily activities based on verbal instructions. With reading comprehension, it appears from test performance that, although ER is still able to understand single words, her ability to understand sentences has deteriorated severely. Her carers could be informed it is unlikely that she reads the newspaper but she may well be able to understand some headlines and if she appears interested in this activity, it could be encouraged.

Figure 2 - ER: Practical implications (Armstrong & Borthwick, Vol. 6 (2))

Questionnaires and checklists

If you mention a questionnaire or checklist that you use, include a copy or at least a couple of examples of questions / points. This has two advantages: a) the reader knows exactly what you mean b) the reader can make use of something which has already been tried in practice rather than having to start from scratch.

To provide us with further information about their lexical processing skills we devised a picture naming task of more complex multisyllabic words (Figure 1). We selected frequently occurring words of 2, 3 and 4 syllables which could be easily represented in pictures. (Clark & Makin, Summer Supplement, June 1996)

MULTISYLLABIC WORDS:
PICTURE FINDING
NAME: Date:
TARGET RESPONSE
1. CALCULATOR 4
2. PYJAMAS 3
3. JIGSAW 2
4. PRISONER 3
5. DETECTIVE 3...
50. PROPELLER 3

Figure 1

Resources

If you mention any commercially available resources, make it easy for readers to access them by listing the manufacturer / supplier, telephone number and cost.

Dysarthria clinical advice leaflet, Royal College of Speech & Language Therapists, 7 Bath Place, Rivington Street, London EC2A 3DR (£12.50 per pack of 50). (Hewerdine, Summer 1997)

Departmental resources

If you mention resources from your own department, could you make copies available to readers? If so, give an address, cost and information about cheques.

Therapists in South Tees have developed a range of advice and information leaflets about their service. They would have to be adapted for use in other areas, for example by changing the logo, but are photocopiable and available as a set at a cost of £10.00 payable to South Tees Community and Mental Health NHS Trust from The South Tees Speech & Language Therapy Service, 157 Southfield Road, Middlesborough, Cleveland. (Fraser, Vol. 5 (2))

Diagrams

Diagrams which summarise therapeutic procedure are a useful reference.

It became obvious during data collection that a preliminary study to determine a more realistic standard should have been carried out before starting (Figure 2). (Novice. Vol. 5 (4))

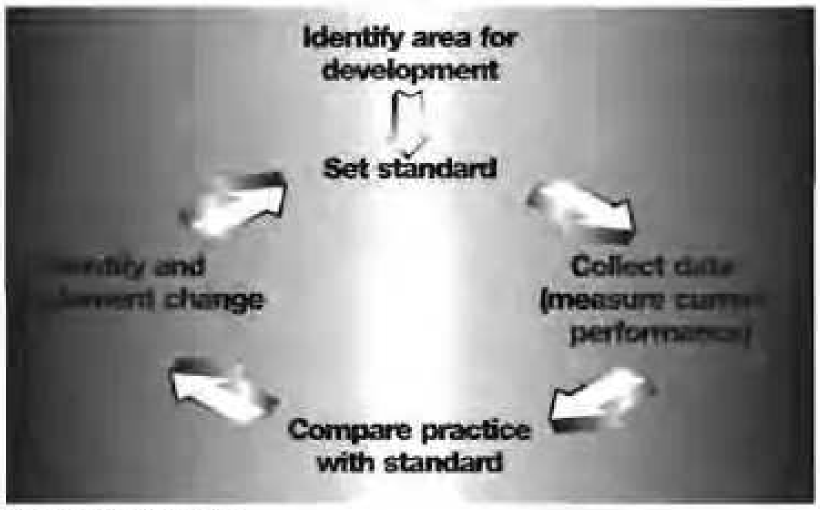

Figure 2. Audit Cycle

Voluntary organisations

Give details of voluntary organisations where appropriate.

The Gender Trust is available to help anybody who feels trapped in the wrong body (gender dysphoric). They offer literature, information on available counselling, a contact system for support and a helping hand fund for people on welfare.

The Gender Trust
BM Mermaids (under 18s)
or BM Gentrust (over 18s)
London WC1N 3XX
tel. 01305 269222 before 10pm. (Clark, Vol. 6 (1))

Doing things differently

Don't be afraid to say what you would like to have done under ideal conditions or feel you could do differently if you were in a similar situation again.

To draw full conclusions about the progression of VC's condition, it might have been helpful to initiate assessment for clinical depression, to establish whether this could have influenced the downturn in motivation. It would also have been useful to have assessed communication more rigorously using the same items throughout and to have had further psychological assessment to establish whether some mental functions remained unimpaired. However, VC's motivation was such that she declined further assessment and we felt we had enough information to advise family and staff. (Walmsley & Evans, Vol. 5 (3))

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EVENTS

The Michael Palin Centre for Stammering Children - Courses for therapists

4 & 5 June
The Communication Skills Approach to the Management of Stuttering in Adolescence
Assessment and treatment. Adaptable for use in individual as well as group therapy.
Time: 9.30-4.30 Fee: £90 (£80 SIG members)

10 September
Managing early childhood dysfluency for generalist therapists
New procedure for identification of children at various levels of risk and appropriate remediation strategies.
Time: 9.30-4.30 Fee: £45 (£40 SIG members)

7 & 8 October
Non-intensive therapy for 7 - 14 year olds
Therapy addressing the differing needs of individual families. Fee: £90 (£80 SIG members)

A week with the team
Programme arranged to suit individual requirements.
Fee: £200

Observation of intensive therapy courses
Two weeks in the Summer holidays.
Fee: £300

In-service training on dysfluency
By arrangement.
Details: Diana De Grunwald.
The Michael Palin Centre for Stammering Children, Finsbury Health Centre, Pine Street, London EC1R 0JH, tel. 0171 530 4238.

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16 June
Signalong conference
Communicating Choices
Looking at an approach based on individual need. Workshops on implementation of signs and symbols. Using and developing symbols. Enabling end-user involvement. Simple sex!
Keynote speakers: Mick Archer, Editor 'Special Children' and Dr Jane Shields, Speech & Language Therapist, Storm House School
Venue: Medway Arts Centre, Chatham
Time: 9.30 - 4.30
Fee: £45 (£30 for parents and family members of people with learning disabilities)
Details: The SIGNALONG Group, Communication & Language Centre, All Saints Hospital, Magpie Hall Road, Chatham, Kent ME4 5NG, tel. 01634 819915.

AFASIC

2 July
AFASIC conference - Exclusively Inclusive
Explores important factors in successful inclusion of pupils with speech and language impairment. Looks at the whole school approach, accessing literature and how to marry speech and language therapy with classroom approaches.
Speakers: Mel Ainscow, Julie Dockerill, David Cropp, Nicola Grove, Sally Newman and Chris Dyer
Venue: The Institute of Education, 20 Bedford Way, London Fee: £25 (parent member) £58 (professional member), £75 (non-member)

14 June **Dyspraxia (South)**
20 September **Dyspraxia (North)**
Tutors: Lesley Spence, speech and language therapist and Rhona Perry, specialist language teacher
Fee: £20 (members) £25 (non-members)

20 June
Severe receptive language in the classroom
Tutors: Jacqui Harrison and Rhona Perry, specialist language teachers Fee: £65

26 September
Professional partnerships
Teacher / therapist, language unit / mainstream school on shared site, language unit / mainstream schools off site - collaborative model of working. Tutors: Virginia Martin, teacher, Lesley Spence, speech and language therapist Fee: £65

10 October
Functional language in the classroom
Tutor: Maggie Johnson, speech and language therapist
Fee: £74 + £6 for manual

14 November
Understanding the emotional and behavioural problems of language impaired children
Tutors: Alison Wintgens and Andy Alborough, speech and language therapists Fee: £65
Details of all AFASIC courses: Carol Lingwood, 29 Hove Park Villas, Hove BN3 6HH, tel. 01273 381009.

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25 - 27 September
Nottingham Paediatric Cochlear Implant Programme Foundation Course
Guest speaker: Professor Quentin Summerfield, MRC Inst. Of Hearing Research
Fee: £250 (residential) £150 (non-residential)
Details: Maureen Ross, tel. 01159 485560; for registration forms tel. 01158 856545.

ACE Centre

24 September
Scanning Software for Experienced Switch Users
Hands-on experience with programs such as Clicker, Switch Access to Windows and HotSpots.

27 October
Alternative Access - How do we Assess?
For teachers, parents and professionals.

29 October
An AAC Overview - High and Low Technology
Includes sign and symbol systems, speech output devices and available applications.

1 December
From 'Cause and Effect' to 'Scan and Select'
The progression of the switch user.

25 June / 3 December
Planning a Communication System
Selecting vocabulary, high and low tech devices, integrated approach.
Fee for all courses: £50
Details: Mick Donegan.
The ACE Centre, Waynflete Road, Oxford, OX3 8DD tel. 01865 63508.

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4 October
Moor House School Golden Jubilee Conference
Topics include research and development, the CHAT project, attention deficit hyperactivity disorder and relating speech and language therapy to the curriculum.
Venue: The Royal Geographic Society, Kensington
Fee: £50
Details: 01883 712271

AD/HD An Intensive Training Day for Teachers, Psychologists and Health Professionals

9 June The Queen's University of Belfast
23 June University of Exeter
3 July University College of Ripon & York St. John, York
4 September University of Stirling
6 October Birmingham
7 November University of Manchester
Speaker: Jenny Lyon, Chartered educational psychologist
Fee: £117.50
Details: Jill Fry, Course Bookings Manager, International Psychology Services, tel. 01273 832181

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