Work–life balance:
PRESERVING YOUR SOUL

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FROM THE EDITORS

Are you sitting comfortably? Are you keen to read this or is it a chore or is it an example of procrastination (the answer for that dreadful quality project just might be hiding in this issue)? Is there anything else you feel you ought to be doing? Is the dinner ready?

Finding balance in our lives is not based on a formula as some helpful websites suggest (take the right amount of exercise, don't take work home, spend time with friends and you'll be right, mate). A sense of balance is an individual experience and how we achieve it will probably change throughout our lives.

There is a range of articles in this issue each of which may help you to experience balance in your life. For example, understanding the sources of distress and tension at work may relate to the ethical concerns you have about distribution of services and resources. The article by members of the Association's Ethics Board encourages readers to recognise the impact of ethical concerns and addressing them. Clinical tools such as the Quick Test of Language and Goal Attainment Scaling are evaluated; using effective clinical procedures can help us be confident in the work we are doing and increase the positive experiences and effectiveness we can have at work. Lindy McAllister describes the pioneering approach she has taken in her career in a paper originally presented for

the Elizabeth Usher Memorial Lecture at the Association Conference in 2006. The personal attributes she describes in herself such as her passion for development, her quest for challenge and novelty and her positive approach to risk taking all assist her to obtain satisfaction from life. We have three different views from people in a student role discussing the challenges and solutions they have found balancing study and "life".

We are thrilled to present an insight into speech pathology in Malaysia and look forward to learning more about speech pathology in our part of the world in the feature "Speech Pathology in the Asia-Pacific Region".

Also, hot off the press, we have a report and photographs from the extremely successful Speech Pathology Australia and NZSTA Conference: Reflecting Connections which was held in Auckland in May.

There are a number of other items of interest in this issue and we hope that you will take some time to reflect on how any or all of these ideas may help you to gain, retain or restore some work-life balance.

Louise Brown and Chyrisse Heine
Co-editors

FROM THE PRESIDENT

Work–life balance, preserving your soul – what an interesting theme, and so important to all of us. I suspect that many of us find it difficult to achieve though. Or does it depend on our definition of balance? Our profession seems to attract people who have a strong sense of responsibility (if we're going to do something, we like to do it right), a constitutional inability to say no (if we're asked to do something, we're likely to say yes), and an element of perfectionism (if we're going to do something, we want it to be the best we're capable of). I'm not suggesting that these are negative characteristics – far from it. They help us to do the best for our clients and for our profession. Our professional Association would not function without all those who say yes when asked to contribute – at local, state or national level. Many of the people who say yes to work for the association also say yes to many other types of involvement. The saying "if you want something done, ask a busy person" is often true.

Some of us may find that, at times, the work end of the balance is rather heavily weighted. This can occur for various reasons – perhaps there are increased demands in our workplace at particular times of the year, perhaps staff illness or attrition means that we need to take on additional responsibilities. And sometimes we say yes more often than we should! The potential consequences of tipping the balance too far in the direction of work are clear – stress, illness, burnout.

Are there possible consequences of erring on the "life" side of the balance? Perhaps that depends on personality, or the stage we are at in our lives. You may have a personality that is happiest at work – for you, too much "life" may not be satisfying, or you may see little difference between work and life. Your balance point will be different. For me, life stage was (and is) important – but the weighting has changed over the years. Life certainly needed to take precedence over work when my children were young – I chose to spend more time with them than at work. At this stage of my life, my children are grown, and I have much more time to devote to work. I still aim for a balance – notionally, I work only four days a week – but I do many things within my work life, and some volunteer work. I also aim to combine "work" and "life" whenever possible. Attending a conference may be work, but following it with a holiday provides the life balance! This issue of the *ACQ* may help you to reflect on your own work–life balance, and provide insight into how others have achieved this.

Let me finish with a lyric from a song which is now close to 30 years old, but which comes close to my personal philosophy. Perhaps it is your philosophy as well.

"It's better to burn out than it is to rust." – Neil Young 1979

Cori Williams

THINK BIG, ACT LOCALLY:

Responding to ethical dilemmas

Robyn Cross, Suze Leitão and Lindy McAllister

This article has been peer-reviewed

This paper asks speech pathologists to consider the impact of ethical dilemmas upon their own work–life balance. In raising awareness of the impact of workplace ethical dilemmas on individuals, this paper challenges speech pathologists to consider how systemic responses, in addition to individual action, may assist in developing and maintaining an equilibrium between work and life.

Keywords:
   dilemma,
   ethics,
   health care,
   service rationing

Robyn Cross   *Suze Leitão*   *Lindy McAllister*

Act local, act global

"What ought one to do?" is the fundamental question of ethics (St James Ethics Centre, 2008). The term "ethics" can be defined as "relating to morals, treating or moral questions" (Sykes, 1976, p. 355), or, as noted by Speake (1979, p. 112), as "a set of standards by which a particular group or community decides to regulate its behaviour – to distinguish what is legitimate or accepted in pursuit of their aims from what is not". The speech pathology profession within Australia, under the auspices of Speech Pathology Australia has long sought to practice ethically, currently guided by its *Code of Ethics* (2000). The Association's revised *Code of Ethics* was developed in 1999/2000 (Speech Pathology Australia, 2000), and its application to practice was supported by the development of an *Ethics Education Package* (2002). Based on the concept of aspirational ethics (what we aspire to do well) as opposed to prescriptive ethics (what we must do/not do), and written in plain English, the code of ethics is again due for review.

The Speech Pathology Australia *Code of Ethics* (2000) contains standards with the intent of identifying the values of the profession, providing a means by which people outside the profession may evaluate us. It also provides a basis for the decision-making of the Association's Ethics Board. At an individual level, the standards are also stated to "reinforce the principles on which to make ethical decisions" and "assist members of our Association adopt legitimate and professionally acceptable behaviour in their speech pathology practice" (Speech Pathology Australia, 2000).

A convergence of ideas, values and language becomes apparent when comparing the Speech Pathology Australia *Code of Ethics* (2000) with the codes of ethics of other professional and public service agencies in the western world (ASHA, 2003; AMA 2006). The existence of a code draws distinctions between the values of the organisation and/or profession, the legal obligations of an individual or employee and the personal values of a professional. While there is a clear distinction between these three domains, there is also great overlap and potential for conflict between them.

Conflict between these domains may lead to ethical distress, which the authors suggest can be one factor contributing to disrupted work–life balance and indeed to professional burnout. This paper provides two frameworks for thinking about ethics in the workplace, which may assist professionals to avoid or manage ethical distress. These frameworks are proactive workplace ethical thinking (at the individual or local level), and professional lobbying and advocacy (at the bigger picture or global level). We provide examples of successful lobbying and advocacy conducted by the professional association in recent years that have helped client groups access appropriate services and which may have lead to reduced ethical distress of speech pathologists who were unable to adequately balance conflicting ethical principles and duties in their workplaces.

McAllister (2006) identifies escalating pressure on professionals from increasingly complex workplaces, highlighting the need for ethical awareness and broad ranging ethical thinking. She highlights the strengths and limitations of a code of ethics in guiding contemporary practice, citing health service rationing as just one example of how increasingly frequent ethical questions or dilemmas can seem removed from current approaches to ethical decision-making. An example of health service rationing is seen in the frequent prioritisation of preschool children for therapy over school-aged children, even though school-aged children may clearly need our services, given the risk of residual communication impairments having lifelong impacts on educational, social, employment and mental health outcomes (Felsenfeld, Broen & McGue, 1994).

As an interesting aside, let's have a quick look at the word "dilemma"; it comes from the Greek *di* (equivalent to) *lemma* (an assumption or premise). In other words, a dilemma is a situation in which, when a person is faced with a choice of alternatives, neither of which seems adequate or both of which seem equally desirable. The situation about health service rationing highlighted above presents such a dilemma: if we prioritise school-aged children over preschool children, we may deny services to children who also require them and for whom "early intervention" might yield significant and long-lasting gains. If we prioritise preschool children over school-aged children, what effect may that have on the quality of life of those children who go into adult life with untreated communication impairments? We know that competence in early speaking and listening and the transition to literacy are seen as a crucial protective factor in ensuring later academic success, as well as positive self-esteem and long-term life chances (ICAN, 2006). Such a situation underlines the conflict between the ethical principles of beneficence, non-maleficence and fairness, and duties to clients as well as employers who set workplace policies (Speech Pathology Australia, 2000). The sense of unease, distress and conflict that arises within an individual when confronting a dilemma such as this can significantly impact on the balance between "work" and "life". Personal as well as

professional values will be challenged in such situations. The ability to draw on the principles within our *Code of Ethics* and to problem solve within its framework may assist in identifying and voicing our ethical concerns in the workplace setting, limiting the potential for any internal disquiet to impact on other parts of our lives.

Reviews by the Chair of the Ethics Board, Vice-President Communication and/or the Senior Advisor Professional Issues of the enquiries received by the Ethics Board of Speech Pathology Australia (informal summary reports to either National Council or Ethics Board, 2006–2008) reveal that this notion of "dilemma" is not just a theoretical concept. Members contact the Association seeking guidance, support and/or direction in responding to a range of issues, including:

- providing services to a group of clients demonstrating limited gains, while being aware that individuals who may benefit more from the service remain on the waiting list;
- ceasing services to clients when their quota of services has been fully utilised, yet who continue to make progress in intervention;
- managing a service within finite resources (staffing and/or financial) and having to determine who is prioritised above others for service;
- being required to work through an assessment waiting list at such speed that the assessment does not follow the evidence base and is superficial;
- knowing that a colleague is doing their planning and report writing at home because they are unable to manage the load at work, raising issues of client confidentiality, underresourcing at the workplace and workforce burnout.

In each of these examples, individuals may struggle with decision making, with limitations in how the *Code of Ethics* can support thinking about the ethical issues involved and the decision-making required. How can the key principles of professional ethics be upheld in these situations? McAllister (2006) suggests that the *Code of Ethics* and decision-making protocols cannot account for all possibilities. So, how do we as individuals develop an ability to address these dilemmas and in so doing, maintain equilibrium between work and life?

Local and systemic responses to ethical dilemmas

McAllister (2006) notes the need for clinicians to think and act ethically in their daily work life, not just when faced with specific ethical dilemmas. In other words, part of the answer lies in the proactive application/use of the code to shape our practice, rather than only drawing on it in times of dilemma or ethical emergency. Proactive ethical thinking may support professionals in maintaining balance between work and life, rather than trying to recapture balance once an ethical dilemma or emergency arises.

Further, using the example of health care rationing provided earlier in this paper, it is argued that, in addition to our individual level of response, we may also benefit as individuals and as a profession by stepping back from the immediate and "local" ethical dilemma facing us to gain a broader perspective. Recognising that individual clinicians lobbying their individual managers is unlikely to lead to change at the local level compels us to approach these issues from a larger or systems level which attempts to influence public policy through the provision of "evidence" and economic arguments.

Rationing of health services, while not a new issue, has had greater prominence in the last 20 years. The Honourable Justice Michael Kirby, in the inaugural Kirby Lecture on Health, Law and Ethics (1996) highlighted "the complex public policy questions raised by the attempts to apply ethical principles to the allocation of health care resources and, in particular, to adopt cost benefit analysis in the context of healthcare". Adding a further layer of complexity, there is recognition that "health care" can be an ill-defined term, which not only encompasses the physical aspects of health but extends to the social and economic determinants of health. The National Health and Medical Research Council (1993, p.1) identifies that "the allocation process involves different levels of decision-making ranging from the macro level of the governmental policy maker to the … micro patient/physician level. As a result, ethical considerations cannot be introduced into the allocation debate directly and unilaterally." Given the above, the reality for a health professional working in a clinical setting may be that while attempting to address the impact of health care rationing at the personal level through advocacy, debate and discussion (McAllister 2006), ongoing ethical dilemmas may arise because health care rationing extends beyond the "local" clinical level, and is entrenched within the broader health system.

What are our roles as clinicians then? Without doubt, there is a requirement for us to continue to advocate for change; but if only limited effect can be gained at the local level, should we be resigned to this? It is suggested that we might also meet our obligations under the *Code of Ethics* if we address such ethical dilemmas through broader, more "global" mechanisms.

Advocacy – from the macro to the micro

At the most "macro" level, as participants in a democratic system our ability to vote is demonstration of our ability to actively support (or inversely deny our support of) the stated policies of political parties in relation to social, economic and health care policies. Our individual contribution in providing expert opinion and advocacy to national and state committees and lobby groups allows input to public policy debate, review and development. Similarly, as members of our professional organisation, our lobbying and representation of the profession and how it may contribute to the provision of health care and education allows us to contribute to the shaping of public policy. The introduction of Medicare Plus is one example of how public policy has attempted to meet the dilemma of restricted community access to allied health services. Previously, access to services was limited to allied health services in the public sector, or the individual client had to pay for private providers. Following a change in government policy, Medicare Plus now allows general practitioners to refer clients requiring support for a chronic condition to registered private allied health professionals at a subsidised cost for up to five sessions. Another example of influencing public policy is the submission by Speech Pathology Australia to the National Inquiry into the Teaching of Literacy (Speech Pathology Australia, 2005), which resulted in increased awareness of the role of speech pathologists in this area. As a consequence, speech pathologists were listed as appropriate service providers to those in the community with literacy problems, and the Department of Education, Science and Training (DEST) asked the Association for input into policy development.

Continuing at the macro-level, research and/or continuous quality improvement undertaken by the profession adds to

the body of evidence to support further lobbying and debate on the value of health care services. This may include challenging the traditional scientific constructs of evidence, and ensuring that psycho-social and -economic factors are also considered. For example, data reported by Felsenfeld et al. (1994) refers to educational and occupational outcomes for adults identified in childhood as having speech impairment. Such data could be used by speech pathologists to lobby for provision of intervention services in childhood that are economically more cost effective than social welfare or work skills training later in life. Utilising this and other evidence, and presenting it against the framework of the profession's (and/or organisations') ethics could prove to be a powerful lobbying tool.

Our willingness as a profession to extend our education beyond the knowledge and skills required for provision of clinical services, to areas such as management, policy development and academia, further supports efforts to provide systemic responses to ethical dilemmas. The Speech Pathology Australia publication *ACQuiring Knowledge in Speech, Language & Hearing* regularly features speech pathologists who have continued to utilise their training and skills in arenas beyond that of the immediate clinician–client interface. In many cases, an impetus for pursuing change has been to allow individuals to further contribute, shape and/or drive development of initiatives in response to dilemmas arising from or frustrations experienced in clinical practice.

Raised public awareness through support of media campaigns promoting the profession and advocacy for relevant issues can build a momentum of political awareness. This was demonstrated by parent groups who successfully lobbied political parties during the recent federal election in relation to services for children with autism. The increase in Medicare funding for allied health services was similarly won through the influence of earlier lobbying campaigns.

Our ability to reflect and think critically about our own practice as clinicians, managers, researchers and academics assists us to be open to new ideas, welcome constructive challenge to our practice and trial new models and approaches. Many of the "grass roots" quality improvements that are implemented in the clinical setting contribute to the effectiveness of the services provided by clinicians and the outcomes for clients. And, at the most fundamental level, there is the everyday application of ethical thinking and action within the workplace. As argued by McAllister (2006), this requires personal courage.

From the big picture of national politics to the individual level, frameworks for thinking about ethics and a range of strategies that can assist us to proactively identify and respond to ethical dilemmas have been presented in this paper. These suggestions reflect the authors' views of how we may as individuals respond more "systemically" to ethical dilemmas in addition to responding at a "local" level in the workplace. These strategies will not provide a panacea for all ethical dilemmas that will be faced in the workplace. However, they may provide other means by which we can constructively and proactively address emerging or ongoing ethical dilemmas. In doing so, they may ultimately alleviate some internal conflicts about our practices that can impact on the work–life balance.

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Robyn Cross, Lindy McAllister and **Suze Leitão** are chair and senior members of the Speech Pathology Australia Ethics Board respectively. They all have a longstanding interest in ethics from a theoretical and applied perspective. This paper represents the first paper from the Ethics Board and aims to stimulate thinking and discussion among members of the profession.

Robyn is a senior manager within ACT Health, managing allied health at the Canberra Hospital and multi-disciplinary diabetes services across both hospital and community settings. Suze works part-time at Curtin University as a senior lecturer in human communication science and part-time in private practice as a clinician. Lindy is an associate professor at Charles Sturt University, half-time in the speech pathology program in School of Community Health and half-time as deputy director of the Education for Practice Institute.

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THE PREDICTIVE VALIDITY OF THE QUICK TEST OF LANGUAGE

Beth McIntosh

The Quick Test of Language (QT) was designed to identify 4–6-year-old children with receptive and expressive language difficulties. To evaluate the predictive validity of this language screening test, 52 children who had been part of the normative sample were retested two years after their initial preschool assessment. The QT was correlated with both expressive language and receptive vocabulary measures, with a low number of false negative and false positive cases. This result indicates that performance on the QT in the first term of preschool (4–5 years) predicts language ability in year 2 (6–7 years).

Keywords:
  language screening assessment,
  predictive validity

The Quick Test of Language (QT) comprises a picture stimulus booklet, instructions for administration of the test, scoring guidelines, score interpretation and a fully reproducible response sheet. There are a total of 30 stimulus questions, where 21 questions have a pictorial stimulus and 9 have no picture. The pictures are black-line drawings. The questions reflect Blank, Rose and Berlin's (1978) levels of language abstraction: matching perception (e.g., "What is this called?"), selective analysis of perception (e.g., "What do we do with it?"); reordering perception (e.g., "What will happen next?") and reasoning about perception ("What will happen if…?"). The order of questions has been randomised.

There were 130 children in the normative study with a mean age of 5 years 2 months (SD 6.1 months), within a range of 4 years to 6 years 3 months. Just over half the children (55%) attended a preschool in Ipswich, 28% attended a preschool in Brisbane and 18% attended a childcare centre in Brisbane. Girls constituted 49% of the sample and boys, 51%. Socioeconomic status (SES) was determined by information provided by the school principal or director of the childcare facility from census data.

Current study

For a study investigating the outcome of classroom-based intervention for communication skills (McIntosh, Crosbie, Holm, Dodd & Thomas, 2007), 100 children were assessed on the QT and two phonological awareness tasks. The children were at risk for communication difficulties because the school was located in a socioeconomically disadvantaged area (Clegg & Ginsborg, 2006). The language ability of 30 children, when they were first assessed in preschool, was indicative of poor performance according to the normative data of the QT. The school was approached to reassess all students who had participated in the intervention study.

Fifty-two (mean age 90.51 months; *SD* 3.75 months; range 85–100 months) of the 100 students were still attending the school and were in their second year of formal schooling. They were reassessed on two standardised language measures: the Formulated Sentences subtest of the Clinical Evaluation of Linguistic Fundamentals–4 (CELF–4) (Semel, Wiig, Secord & Tannan, 2006) and the Peabody Picture Vocabulary Test–3 (PPVT–3) (Dunn & Dunn, 1997) to determine whether those children who had performed poorly on the QT in preschool still had language difficulties.

Since the QT is based on Blank's approach to language assessment (both receptive and expressive abilities contribute to performance), it was important to establish whether the QT was relevant to the assessment of both expressive and receptive abilities. The PPVT–3 is a receptive vocabulary measure while the Formulated Sentences test assesses expressive sentence processing (and is statistically one of the most discriminating of the CELF–4 subtests). Both are currently used widely in clinical practice. These two measures were selected because they are quick to administer and assessment time was limited.

Seven final-year speech pathology students from the University of Queensland assessed the children under the supervision of two experienced paediatric clinicians in the first term of the school year. The testing of each child involved assessment of language, literacy and phonological awareness skills over two 30-minute sessions. Only the language measures are reported here.

Results

McIntosh and Liddy (2006) established the concurrent validity of the QT by assessing four children on the Preschool Language Assessment Instrument (Blank, Rose & Berlin, 1978) and seven on the Clinical Evaluation of Language Fundamentals – Preschool (Wiig, Secord & Semel, 1992). A Pearson correlation of .751 (p = .012) indicated that children scored similarly on the QT and the other assessments of language ability.

In this study, Pearson's r evaluated the relationship between children's QT performance when they were in preschool and their performance on the Formulated Sentences subtest of the CELF–4 two years later. There was a positive correlation (r $_{1,53}$ =.434, p = .001). Similarly, there was positive correlation using Pearon's r for the PPVT–3 (r $_{1,53}$ =.382, p < .01). Both correlations were significant, indicating that the QT has predictive validity.

To examine the QT's predictive validity in greater depth, those children who scored one standard deviation below the mean for their age on the QT in preschool were identified. Of those 52 children who were still at the school, 14 had performed poorly on the QT. Two years later, seven of these children performed below normal limits on Formulated Sentences subtest and five children performed poorly on the PPVT–3. Three of these children performed poorly on both assessments. The predictive ability of the QT was 90.4%. It is interesting to note, however, that those five children who performed poorly on the QT in preschool but were not identified as having a language difficulty in year 2, tended to

have standard scores at the bottom-end of the normal range (Formulated Sentences, 7–9; and PPVT–3, 88–96).

There were six children (11.5%) who performed within normal limits on the QT in preschool, but below the normal range on one of the language tests. Five children performed below the normal range on the Formulated Sentences subtest in year 2 although four of the five children were just below the normal range (with a standard score of 6). One child performed poorly on the PPVT–3, attaining a standard score of 80. Given the two years between assessments and differences in the nature of the QT compared to Formulated Sentences and the PPVT–3, a 88.5% predictive ability is acceptable.

Summary

The QT is a screening assessment for 4 and 5 year olds that has been developed for use as a referral tool for teachers who work with speech-language pathologists. Its purpose is to identify children in need of a speech pathology assessment for possible language difficulties. The predictive validity of the QT was examined by reassessing 52 children on Formulated Sentences (CELF–4) and the PPVT–3 two years later. The QT successfully predicted language performance for 80% of the children. These results indicate that the QT has very good sensitivity and specificity, in comparison to parent report on child language (Feldman et al., 2005). However, given the time restraints on the current study, further research into the implications of the QT results on a full language assessment may be needed.

Further information about how the Quick Test of Language can be obtained is available from Maureen Liddy, Speech-Language Pathologist, Stafford State School, Stafford Road, Stafford, Qld, 4053; phone: 07 3552 6306; email: mlidd2@eq.edu.au

Acknowledgements

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Beth McIntosh is an experienced paediatric speech-language pathologst who has just completed a three-year secondment from Education Queensland to the Perinatal Reasearch Centre with Professor Barbara Dodd. The Quick Test of Language was developed in collaboration with Maureen Liddy, speech-language pathologist Education Queensland. Beth is currently teaching year 1 in an Education Queensland school.

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PIONEERING IN PROFESSIONAL PRACTICE

Lindy McAllister

This paper is based on the Elizabeth Usher Memorial Address delivered at the national conference of Speech Pathology Australia in Fremantle, in May 2006. In this paper the author reflects on 30 years of pioneering speech pathology services in Australia and internationally, and speech pathology degree programs in Australia. The paper considers societal and systemic trends which are creating emerging frontiers for new pioneers in speech pathology practice. The paper asks readers to consider the qualities they possess that can lead them into pioneering new frontiers in professional practice.

This paper is based on the Elizabeth Usher Memorial Address presented at the Speech Pathology Australia national conference in May 2006. In that address I was asked to talk to some specific highlights of my 30-plus year career as a speech pathologist: to provide an overview of my work in Far North Queensland as a case study of pioneering in professional practice, to talk specifically about the pioneering work I undertook in establishing the first rural speech pathology course in Australia, and to discuss the interdisciplinary project I established in Vietnam as a way of encouraging speech pathologists to work in development. I was also asked to inspire speech pathologists to see the potential for pioneering in their own practice.

This paper underlines the fact that many of the frontiers we encounter in professional practice present themselves almost innocently or invisibly within the apparent ordinariness of everyday practice. It is if and how we perceive and respond to these seemingly ordinary events that will determine whether we see them as new frontiers to cross in professional practice. Few of us will cross new frontiers in terms of physically going where no one has gone before, although there are still many places in the world, and even still in Australia, which lack speech pathology services and where we could physically establish a new professional frontier. More likely, as with all health professionals, we will cross new frontiers in practice as we collectively respond to demographic, societal and technological changes which will shape what kinds of services we deliver, to whom and in what manner. These externally imposed frontiers will be considered in the final section of this paper.

The challenges of being the first speech therapist in Far North Queensland

When I think of pioneering in Australia I think of people like my great-grandmother, a girl fleeing the potato famines in Ireland, seeking a new life in colonial Australia. Susanna De Vries in her book on great Australian women notes "Colonial Australia was no place for a nervous woman" (2001, p. ix) and in 1976 Far North Queensland was no place for a nervous woman either. With one year of experience in the Queensland Education Department under my belt but brimming full of energy and optimism, I asked for a transfer to the vacant position for a speech therapist in Cairns in March 1976. The position had been served on a very part-time basis, for a year or so prior to my arrival, by a woman whose husband was a doctor at the hospital. Before her, a speech correctionist had been employed by the department to assist children with speech impairments. My predecessor had served only Cairns children by having them come to "the clinic". However, my brief was to establish a speech therapy service for all schools in the Cairns District. The district stretched from Innisfail in the south to Mossman in the north, and up onto the western edge of the Atherton Tablelands. Schools on Cape York received no services at all unless they rang in for advice. This Cairns District included numerous state schools, several special schools and a unit for children with hearing impairment. As I was the only speech therapist north of Townsville, I also was occasionally called up to the Cairns Base Hospital to see clients with dysphagia (a mystery to me as this was not covered in speech therapy degrees then), asked by the Department of Veterans' Affairs to work privately on Saturdays to see their clients, asked to provide consultative input into the then called Endeavour Foundation "subnormal association school", and asked frequently to talk to service clubs of all types. By the end of 1976, both the hospital and the Endeavour Foundation had created positions for speech therapists and I was left to focus on taming the schools of the wild north.

Looking north from the security of Brisbane in the days before the two-day train trip to Cairns, I wasn't nervous, but I should have been. I met my first of many frontiers of ignorance on my first day at work. My new boss, the District Guidance Officer, took me downtown to show me where to get the best sandwiches. On the way back to the office, we walked through the park along the waterfront. I still remember to my shame stopping dead in my tracks, staring at Aboriginal and Islander people sitting and chatting under the trees. In answer to my silly question "Where did they come from?", my boss told me they lived here. I had known Aboriginal children at school in Charleville (in remote southwestern Queensland), but in my years of high schooling and university in Brisbane I had never seen an Aboriginal person. The Queensland school curriculum had further reinforced my assumption that Indigenous Australians lived only in the arid zones. I wasn't even consciously aware that northern Australia had thriving Torres Strait Islander and Aboriginal cultures. And I certainly wasn't prepared for the fact that I might need to provide services for these people.

Nonetheless, I set out exploring my new frontier of "FNQ", as it was affectionately known to the locals. I would go on outreach trips to the Tablelands or Innisfail with guidance officers, for two to five days of assessments. It became clear to me within three months of arrival that the traditional one-to-one withdrawal model of service delivery that I had been prepared for during my undergraduate degree was not going to provide the coverage needed or meet the needs of teachers

and all the children who potentially required a service. It would have been easy to continue to do "the same old thing" because expectations of me were low. Had I stayed in "my clinic", I might have been simply fulfilling the first two of three prevailing views held by many teachers of the day: that speech therapists "spent term 1 assessing, term 2 doing "a bit of therapy", and term 3 getting pregnant and leaving". However, I seized the opportunity to do things differently, spent little time in the clinic, and almost serendipitously found myself pioneering new ways of providing services across large areas.

Through trial and error in the first year, I developed a plan for rotating through schools on a term basis, typically 2–3 schools each term. Schools would be responsible for identifying children of concern using a checklist I had developed. There was excellent support from the local schools for my work. At large seminars organised by the schools and conducted at the local teachers' resource centre, I regularly explained how to use the checklist to identify, refer and work with children with speech and language problems in the classroom. At the start of a school's target term, I would do screening assessments of all referred children, and use carbon paper to leave summary reports and suggested goals with the school on the same day. I would return in the next few weeks to run workshops on "how to help children with speech and language problems" in staff meeting times, and to meet with teachers about how we jointly could achieve these goals, preferably in the classroom. This might involve developing a program for the teacher, aide, parent or volunteer. If the teacher was willing, I would come into the classroom and co-teach an activity with in-built listening, and speech or language goals which would benefit the whole class as well as the target children. I would endeavour to see parents and explain their children's needs and programs, providing additional home practice where possible. Once programs were running, I could move onto the next school, returning to the previous school on a fixed intermittent schedule to check on progress, adapt programs and so on. A school could expect to see a lot of me one term, less the next, and only once or twice for "check ups" in the third term. I was always available to teachers and parents by phone on the day a week I spent in the office.

The approach to service delivery I developed was a combination of what we now refer to as block or cycle therapy, collaborative consultation and co-teaching. These initiatives were reported in more depth in McAllister (1985). I did also provide more extensive assessments and traditional one-to-one therapy for children who required this, for example those with severe speech impairments (e.g., post-cleft palate surgery, dyspraxia), and voice disorders. Children who stuttered I took to the Education Department clinic in Townsville during school holidays for an intensive program , and in later years I ran intensive group therapy with my new speech therapy colleague at the Cairns Base Hospital.

In conjunction with my boss, the District Guidance Officer, we tackled the issue of how to provide a service across the entire district. Using the models described above, we would seed services in the schools in larger country towns around Cairns. When a service was up and running, it would be withdrawn, citing distance, weather and road conditions as barriers to sustaining it. (Occasionally this was true – I once had two weeks "flood leave" when all roads out of my northern beach home were cut by floods.) The power of rural communities to influence government policy and spending was considerable in Queensland in the 1970s, and repre-sentations by schools and community members to relevant parliamentarians would lead to creation of a new speech therapy position. In just a few years, the service grew from one (me) to five speech therapists in the district.

One aspect of service delivery in FNQ that gave me particular pleasure was providing consultations over the School of the Air radio from the Flying Doctor base in Cairns. Teachers would occasionally ask me to "listen to this kid on the radio and tell me if he needs speech therapy". This was no easy task given the static on the radio but a short conversation with child and then parent could sometimes establish the need for a referral to the Bush Children's Health Scheme in Townsville for assessment and intensive therapy, or a visit to me next time they were in Cairns. Because I had grown up in "the bush", I had great sympathy for the isolation and distance faced by these families and would happily come into the clinic for an evening or weekend consultation if they happened to come to Cairns at short notice for other reasons. In recent years, this interest in equity of opportunity for access to services has motivated my research with Telstra into the use of low-tech telehealth, using the IT and computers already available in the homes of many remote Australian families (Wilson, McAllister, Atkinson & Sefton, 2006; McAllister, Wilson & Atkinson, 2008).

Another strategy for providing services to large numbers of children, teachers and schools was to involve as many speech therapy students as I could in my work. I asked the University of Queensland to send me students whenever they could, particularly in the school holidays. If students came in term time, they were exposed to the models of indirect service delivery I described above. They found this a great challenge as it was outside their experience to date. If the students came during school holidays, we would run intensive one-to-one and group therapy programs for children who needed direct therapy. The students served not only as many extra pairs of hands, but also as a lifeline for me to new ideas, resources, journals, and so on. In essence, they were my professional development program, and I remain gratefully in touch with many of them to this day.

I had a wonderful five years in Cairns, interrupted by a year at Western Michigan University to complete a Masters in

Speech Pathology, courtesy of a Rotary International Foundation Fellowship (one of the spin-offs of living in a small community is the opportunities that come your way). I learned many lessons from this early period of my career: the importance of a team (mine were guidance officers and remedial teachers); the value of a "good boss" and how this role could be filled by someone from another discipline; the need to do things differently, and (in the absence of "evidence" for such new approaches) to evaluate these innovations; and the need to hold fast to the courage of your convictions. I was responding to a locally contextualised need, using my creativity and common sense. Some of what I did was criticised as being "not what speech therapists do" (i.e, it was not a clinical, withdrawal model of service delivery). However, I was focused on meeting people's needs. What were common sense responses to those needs were later to be seen as pioneering work. We all have opportunities and capacities to be pioneers in our professional practice, because we are constantly encountering unmet needs in our purview which we are called upon to address in some way. Further, there is a great need to improve the way we do things. In the absence of an evidence base for much of what we do in caseload and service management (Roulestone, 1997) we should feel empowered to develop and evaluate any reasonable innovation in practice.

Lindy on the right, with other Education Department speech pathologists and a client on an intensive therapy block in Townsville, Qld, about 1976.

Establishing the first rural speech pathology course in Australia

My Masters degree opened doors to work in universities. It was a rarity to hold a postgraduate degree in the late 1970s and so when my husband wanted to move to Brisbane to study, the University of Queensland asked me to apply for a position with them. I had four rewarding years there as Clinical Coordinator, establishing, among other things, professional development programs for clinical educators, and developing an interest in adult learning and curriculum development which would later take me to a position at the University of Sydney and lead me into a PhD in clinical

education. These wonderful experiences in turn enabled me to obtain the position as the inaugural Head of Program for the new speech pathology degree to be developed by Charles Sturt University (CSU) in Albury, NSW, in 1998.

This new course was the first to be located outside a major metropolitan area and the first to have a distinct focus on preparing graduates for rural practice. Concerns for access and equity in higher education opportunities for rural students influenced course location and curriculum design. Investigations by CSU of the allied health workforce had suggested that educating rural students in rural areas would retain them in rural practice after graduation This was a major impetus for the establishment of the allied health courses in Albury, and the fact that some 75% of graduates choose rural or regional positions on completion of their courses vindicates CSU's decision-making.

The overarching goals developed by the teaching team were to prepare graduates who were not only competent as defined by our Competency-based Occupational Standards (CBOS) (Speech Pathology Australia, 2001) for current practice in both rural and urban contexts but would be competent for future practice in rapidly changing environments. Practice contexts for health professionals in the future will be significantly different to those in the present, due to changes in population demographics, information technologies, financial constraints, and community expectations for their health and social care. Reconfiguration of health services, policies and funding models is already leading to a shift in the focus of care from hospitals to community and domiciliary settings (Taylor, Foster & Fleming, 2008). Health promotion and education of clients on how to manage their own health are increasingly part of health professionals' roles, and in rural areas, issues of access and equity typically underpin service development in partnership with local communities (Taylor, Wilkinson & Cheers, 2008). Telehealth is opening up new modes of service delivery to meet the needs of rural and remote Australians, as well as urban Australians – (see for example Hill, Theodoros, Russell, Cahill, Ward, & Clarke, 2006).

With sound pedagogy and awareness of these trends in mind, the speech pathology staff at CSU set about developing a curriculum model that was closely linked to a social model of well-being as described by the *International Classification of Functioning Disability and Health* (ICF) (World Health Organization [WHO], 2001). Along with the range indicators in CBOS, the major curriculum threads of multiple literacies – including IT, rural health and Indigenous health, needs assessment of communities, development of partnerships, health promotion, agent training, community based practice, intercultural competence, and multidisciplinary teamwork – were woven through the course from the beginning. Exposure to more traditional medical models of practice occurred only in late third year and fourth year of the course once an alternative perspective and set of values for practice were well embedded. We have written about these curriculum innovations in several published papers which readers can access for more information (see for example McAllister, Wilson, Clark, McLeod, Beecham & Shanahan, 2004; McAllister, 2003). Another innovation is the sequence of multidisciplinary subjects and project work which begins in first year and runs through each year, with students in fourth year preparing a needs assessment and health promotion grant application for a small rural community (see Shanahan & McAllister, in press).

Locating a speech pathology course in a rural area posed major challenges around the provision of clinical placements. Albury is a small rural city of around 45,000 people, across

the Murray River from Wodonga, an even smaller rural city of about 35,000 people. Although both cities have small hospitals, community health and disability services, it was clear from the planning stages of the course that we could never source enough "traditional" clinical placements in the area. While this presented challenges, it allowed us to pioneer an alternative clinical education curriculum and placements, which would support the goals for the course. From the outset, we were clear that we did not want to pursue a model of having a large on-campus clinic. These often are uni-disciplinary in focus and employ a withdrawal model of service, yet we believed preparing graduates for rural practice required the development of skills for multidisciplinary work in community settings. Instead, we nurtured partnerships with health services, disability services and education departments across rural and regional NSW and Victoria which developed special programs and student units for us. For example, for several years, Wangaratta Health Service rotated our early year 3 students through their aged care, mental health, therapy in the home and rehabilitation teams to conduct projects under the supervision of a range of health professionals. Students' goals were to learn about rural health services broadly and about team roles. They did not deliver speech therapy; that came later in their course. A range of partnerships with community agencies and charities provide every student with many opportunities to develop skills for community-based practice. Our four student units in more conventional health settings offer full-time year-round clinical education for the large majority of our students.

In addition, we have been particularly successful in working with the NSW Department of Education to provide speech pathology services in all schools in the Albury region (Beecham, Winkworth, Clark, Shanahan, Denton, McAllister, & Wilson, 2006). The department pays for the purchase of supervision from the local community health centre and we provide students and resources to enable curriculum adaptation, on-the-job teacher education and cooperative classroom-based delivery of speech therapy services to hundreds of children and scores of schools. Our students are getting high quality learning experiences and the school children and teachers are getting a service they would not otherwise have, as the NSW Department of Education does not employ speech pathologists and the local health services cannot meet all their needs.

We do send our students all round Australia (and indeed the world) on placements in fourth year, many of them to rural and remote settings. We pioneered the use of information technologies in the form of on-line chat to support students on placements and facilitate peer support for widely dispersed students (McLeod, Barbara, Wilson & McAllister, 2002; McLeod & Barbara, 2005). With advances in interactive information technologies, we hope to be able to provide even more timely support across distance in the future.

Consistent with the philosophies that guide our program, we go into the community as much as possible, but we also bring the community to us. For many years now, students have been the beneficiaries of two unique teaching programs: parents as tutors and clients as tutors (Beecham et al., 2006). The first program has received funding support from the Albury City Council and various disability agencies to enable several parents to teach small groups of our students about living with and managing children with disabilities, and the impact of disability on the child, family, and wider community. In the client as tutors program, adults with a range of acquired and congenital disabilities work with students to provide feedback on their communication and interviewing skills, and

understanding of the impact of disability on activity and participation in the clients' lives.

Writing about these innovations so many years after their development makes it sound clean and easy, which it certainly was not. A curriculum that downplayed clinical and medical models of practice and left much of what was thought of by many as "the real clinical placements" (i.e., those in hospitals and community health centres) until late third year and fourth year was vigorously critiqued by other universities and clinicians in the field. Clinical educators could not believe that students in early fourth year might not yet have been on a hospital placement. We gathered courage and our reply was always "don't judge them by what they can do at the start of the year; look at what they can do at the end of the course". The course accreditation system of Speech Pathology Australia, with its focus on outputs (are they competent at the end of the course?) not on inputs, had given us the freedom to pioneer a new curriculum and we had seized the opportunity. The critique we received strengthened our determination to rigorously evaluate what we were doing. Feedback from the employers of our new graduates, some of whom have won much sought-after new graduate positions in the biggest hospitals in Australia, as well as in rural settings, is very positive. Employers tell us our graduates are confident and self-directed, good team players, know how to set up a service and understand the realities of rural health and rural service delivery. They are viewed as well prepared for both urban and rural practice, in medical and non-medical settings. We feel "the proof is in the pudding", as it were. The pioneers who developed this course (myself, Libby Clark, Sharynne McLeod, Linda Wilson, Ian Thompson and Lucie Shanahan, with our fieldwork administration officer Andrea Zanin) were thrilled to have our collective pioneering efforts acknowledged by receiving the Vice-Chancellor's Award for Teaching Excellence in 2002.

Our team getting their Vice Chancellor's Teaching Excellence Award 2002.

Establishing a multidisciplinary fieldwork program in Vietnam

The most challenging of our curriculum goals to achieve was the development of intercultural competence in our students. Albury and the surrounding communities are essentially mono-cultural. Although some 30 languages are spoken in local homes as a result of postwar migration, English now prevails, and we have relatively few recent migrant groups in the area. We needed to look further afield for intercultural placements for our students. Most of these are obtained in Sydney, Melbourne and the Northern Territory. However, I saw an opportunity to meld a personal interest (international

development) with professional ones – preparing students for multidisciplinary teamwork, practice with people with complex disabilities, and intercultural competence. I was keen to develop an international placement in a developing country. Eight months of backpacking in Africa in 1987 had shown me the enormity of need of people with disabilities in developing countries. Some experience with remote support of students from the University of Sydney doing volunteer work in an early intervention program in Nepal had shown me the transformative power of such experiences for students' personal and professional identities and capacities (see the series of Postcards from "Sally" in McAllister, Lincoln, McLeod & Maloney, 1997).

Vietnam was a logical country to develop a partnership with, given the strong links arising from the Vietnam war, postwar reconstruction input from Australia, trade links and migration. Australia has a significant older Vietnamese migrant population who might potentially benefit from having cohorts of allied health students familiar with Vietnamese language and culture. Because of our multidisciplinary teaching program at Charles Sturt University, it was important that any international program was multidisciplinary in nature. In 1999 I visited Vietnam (at my expense) and continued networking with agencies in Vietnam through 2000. In 2001 we were invited to work with two groups: Phu My Orphanage for some 300 children with physical disabilities in Ho Chi Minh City (HCMC, also known as Saigon), and a new deaf school in Ba Ria in Vung Tau Province south of HCMC. Establishing and managing international placements is challenging and we have continued to reflect on, refine and evaluate our programs in conjunction with our partners in Vietnam. We have learned many lessons along the way (McAllister, Whiteford & O'Connor, 2007) and as a result currently concentrate our work in HCMC where we can ensure better resources and support for student learning and well-being, and for our partners.

Each year, up to 15 final-year occupational therapy, physiotherapy and speech pathology students, with rotating fieldwork educators from these disciplines, spend six weeks at the orphanage. One goal of the program is to educate and train Vietnamese staff in the orphanage (Vietnamese trained physiotherapists, paediatricians, teachers and carers) about optimising feeding, communication, play, mobility and other activities of daily living with children with physical and intellectual impairments. The aim is not to "treat" or provide direct therapy to individual children, except when modelling skills and supporting capacity development for Phu My staff. The second goal pertains to student learning. Students are expected to develop intercultural competence and a basic knowledge of Vietnamese language, history and culture. Students need to target learning goals pertaining to skills in training and working with interpreters; training and educating others (Vietnamese staff, other volunteers at the orphanage, CSU students from other disciplines); working with children with physical and intellectual impairments; managing student team dynamics and group processes; and working in resource-poor environments. Over the years we have fine tuned a three-stage learning program for students which develops knowledge and skills before departure, in-country and on return, to ensure that learning is generalised to Australian contexts. We have described our program in more depth and the research and evaluation outcomes in several publications (McAllister & Whiteford, in press; McAllister, Whiteford, Hill & Thomas, 2006; Whiteford & McAllister, 2006).

Because we have chosen to work in an orphanage – a closed system – we have been rightly criticised for not taking a broader perspective on addressing disability in Vietnam. In the last few years, as our cultural competence, knowledge and networks have grown, we have begun to move outside into the community to influence perceptions and programs for people with disabilities. We have supported the orphanage paediatrician to spend six months in Australia to learn about current approaches to early intervention and family-centred practice. He has now established a community-based program to train and support parents to keep their children with disabilities at home, rather than surrender them to the orphanage. We have provided needs assessment and staff training in HCMC for that initiative. We have also encouraged a new non-government organisation in Hoi An to develop community-based approaches to their work, and adopt a social model of disability. Hospitals and universities have also come to us for input on the development of research and curriculum development in communication disorders. The impact of this program on student learning (and on learning in the wider professional community) was recognised in a 2007 team award, a Citation for Outstanding Contributions to Student Learning, from the Carrick Institute for Learning and Teaching in Higher Education.

In establishing this program I was also keen to stimulate wider interest and opportunities in our profession for participating in development work. The growing number of inquiries I receive about our Vietnam program and other possibilities for international volunteering encouraged me to work with other interested speech pathologists to establish a Member Network – Speech Pathologists Working with Developing Communities, within Speech Pathology Australia. It is my hope that members of this network will eventually be able to provide mentoring and resource support to each other in all stages of international volunteering – pre-departure, in-country and on return. The lessons learned from international intercultural work can enrich our practice in Australia in many ways.

So far, I have focused on three areas of my own career which have been recognised by others as pioneering. I hope I have made the point that rarely in these endeavours did I have a perception of myself as being engaged in pioneering work. I was following my passions or responding to the needs of people in creative, commonsense ways. I was lucky enough to be able to pioneer on new frontiers of practice opening up in Far North Queensland, in rural health professional education, and in Vietnam.

New frontiers for pioneering work in speech pathology

What frontiers in professional practice do you want to establish? Or perhaps the question would better be phrased as "What frontiers will you need to cross because they have been established by others?" Not all frontiers are geographical frontiers. In this section of this paper I want to consider just a few of the numerous trends in society and in the systems we work in which are setting new frontiers in professional practice.

Frontiers emerging from societal changes

Of all the new frontiers emerging from the societal trends we are experiencing, I want to identify three which loom large for consideration by speech pathologists. These are not necessarily recently emerging frontiers but they still demand responses from us. First, Australia is one of the most multicultural societies in the world, yet our responses to this are often inadequate. For example, when I consider the work being done by my colleagues in Malaysia, a multilingual,

multicultural nation, I can see we have much we could learn from them. They are developing (not adapting) culturally appropriate assessments (e.g., Rogayah, 2006) and wrestling with the issues of choice of language for therapy (Chuan & Rogayah, 2008). Second, we know that our population is ageing and that ageing often brings communication and swallowing problems. Concurrently, there is a movement of health and social service funding to keep people out of hospitals and at home as long as possible. Where is our professional response to the training of staff who might assist elders to maintain good communication or adapt to changes in their hearing, communication and swallowing abilities?

Third, societies around the world are grappling with how to provide services to people with high needs for support through social welfare and social support agencies. People outside the mainstream of society frequently have communication impairments. For example, a significant number of juveniles in detention have speech and language problems (Bryan, 2004) as do females in prison (Olson Wagner, Gray & Potter, 1983). Without Australian figures we can only extrapolate from data from the USA which suggests that as many as 76% of unemployed people have communication problems (Ruben, 2000). The cost of communication problems in educational, social, economic and mental health outcomes requires a response from speech pathologists, yet we are generally absent from policy-making forums and agencies providing services for these marginalised groups.

Frontiers emerging from systemic changes

There are numerous trends at the level of the systems in which we work, which are and will continue to impact on our work. Concerted responses are required from us as individuals and as a profession as we stand on these frontiers looking to an uncertain future. I want to identify two of these trends in particular. First, like all western economies, Australia faces a looming health workforce crisis, and not just in rural areas (Australian Government Productivity Commission, 2005). Not only do we have an ageing population requiring and expecting a high level of health care, we have an ageing health workforce (Australian Government Productivity Commission, 2005). As these health professionals retire in the next decade, they will not be replaced at the same rate. Projections are that in the decades ahead, fewer people will join the Australian health workforce in a decade than currently do so in one year. One response in the medical and nursing workforces has been to recruit staff from developing countries, but western societies cannot morally continue to strip health professionals from such countries, already critically short of health staff. What then might be pioneering responses from our profession to the inevitable workforce shortage in speech pathology? We have already begun to look at the idea of new categories of health workers to whom we could delegate aspects of our work and to re-examine our scope of practice. But the issues involved make us nervous: what ought to be delegated versus retained as a core role for speech pathologists? Why? What level of education should be required for workers we delegate to? Who will monitor education and quality of their work in the absence of registration or credentialing bodies? Who will supervise these delegates? How? And how often?

The second major frontier I want to touch on is common across developed societies. Over the last decade, high-end video-teleconference suites have been rolled out for use in Australian health departments. Recent developments in interactive information technologies means that video-cameras which allow videoconferencing through home computers and mobile video-phones are becoming affordable to average people and therefore increasingly common. The addition of a video component as well as audio to Voice Over Internet Protocols (VOIP) such as Skype makes video-tele-conferencing across vast distance even easier and cheaper. The potential now exists for telehealth consultations in clients' homes using technologies they already have to hand (see for example Dunkley, Pattie, McAllister & Wilson, 2006). These developments will extend further the already excellent pioneering developments being undertaken by Theodoros and colleagues in the use of specially developed software and portable units to enable telehealth delivery of speech pathology services into homes (Hill, et al., 2006).

While the roll out of video-teleconference suites has made inroads into the provision of mental health, radiographic and medical services to rural Australians in particular, few speech pathologists have crossed this frontier and the use of video-teleconferencing for speech pathology consultations reportedly remains low in most states. Research conducted by CSU (Dunkley, et al., 2006) into access to IT and attitudes to using IT for the delivery of speech pathology services by telehealth showed a marked gap between potential consumers and rural speech pathologists in rural NSW and Victoria. Rural families had far more access to IT and used it for more purposes than did speech pathologists, and were more positive to its use for tele-speech pathology than were the speech pathologists. Further, speech pathologists seriously underestimated the access to IT and receptivity of rural families to telehealth, and this together with their poorer workplace access, and lack of training to use IT may offer explanations for the low rate of participation by speech pathologists in telehealth services. There is enormous potential for pioneering the use of tele-speech pathology into domiciliary settings, but also enormous legal and ethical issues to resolve as well.

Conclusion

In this paper, I have highlighted three aspects of my career where I was fortunate enough to be engaged in what is now seen as pioneering work. I believe we can all be pioneers in our professional practice. What does it take to be a pioneer? When I look back on the last 33 years I ask "what was it about me that lead to this work?" I can identify a desire to see different parts of the country as one factor, but as I said earlier fewer and fewer frontiers will be defined by geography. A quest for novelty and challenge, the capacity to see opportunities not obstacles, a risk-taking disposition, passion, pragmatism, flexibility, creativity, stamina, perseverance in the face of opposition, a commitment to service – probably all these things have influenced my approach to my work, just as they influence my approach to life broadly. But these personal qualities are shared by many people. I encourage you to ask yourselves:

- What are the frontiers in my workplace?
- What passions, skills, experiences and commitment can I bring to the frontier?

We need to recognise a new frontier as it emerges on the horizon. I believe it is better to go forward to meet those new frontiers rather than wait for them to come to us, when our opportunities for response might be constrained or dictated by others.

> Pioneers are ordinary people like us: who see needs, challenges and opportunities, and pursue them; who want to do things differently!

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WEEKEND SPEECH PATHOLOGY SERVICES

Wendy M. Archer and Anne E. Vertigan

Wendy Archer   **Anne Vertigan**

Early speech pathology intervention offered to patients with acute dysphagia aims to minimise risk of aspiration and dehydration. Further, early administration of medications may result in earlier medical stabilisation, improved patient outcomes and shorter hospitalisation. However, access to speech pathology management of dysphagia can be problematic on weekends. A weekend speech pathology service commenced in 2001 at the John Hunter Hospital Newcastle, Australia. This service is described and data pertaining to referrals and service provision is presented. The high success of this service is demonstrated over a six-year period. This paper may provide other acute hospitals with information and recommendations to consider when planning a weekend service.

Keywords:
    speech pathology,
    Dysphagia,
    weekend service

No single clinical sign or symptom can predict the risk for developing aspiration pneumonia but speech pathologists can accurately identify patients with possible dysphagia (Chan, Phoon & Yeoh, 2004). Bedside examinations in the stroke population have 80 percent sensitivity (Eisenberg & Kamerow, 1999). Early intervention optimises recovery from stroke and even if swallowing problems are not clinically apparent, a speech pathologist should be consulted to avoid aspiration pneumonia and malnutrition (Eisenberg & Kamerow). Dysphagia can lead to dehydration, aspiration pneumonia and malnutrition, as well as depression and deterioration in quality of life (Chan et al., 2004). Therefore early management of dysphagia is important. If the patient is unable to eat adequate amounts to maintain a healthy weight, then malnutrition may occur which can weaken the immune system resulting in susceptibility to illness (Eisenberg & Kamerow). The evidence for early speech pathology intervention with people with possible dysphagia provides support for extending speech pathology service provision to include weekends.

Tomolo (2006) reported a four-month pilot study on a newly established weekend speech pathology service at the Royal Melbourne Hospital (RMH), Victoria. This study reported workload statistics and perceptions of speech pathologists, nursing and medical staff regarding weekend speech pathology services. Findings included improved quality of care and minimisation of patient risk. The RMH pilot study documented a reduced number of nasogastric tubes inserted, reduced nil by mouth status, and the prevention of unsafe oral feeding following implementation of a weekend service. Tomolo also highlighted a paucity of evidence regarding benefits of weekend allied health services, specifically no published articles related to weekend speech pathology services. Thus, although intuitively, weekend speech pathology services appear to be worthwhile, there is a limited objective evidence base to them. The aim of the current paper is to contribute to the evidence base regarding weekend speech pathology services by describing the weekend speech pathology service at John Hunter Hospital (JHH) and presenting data pertaining to this service provision through a retrospective data audit. This paper could be a useful reference for other services planning to establish a weekend speech pathology service.

Method

Setting

A weekend speech pathology service was established at JHH Newcastle, New South Wales (NSW) in November 2001. The JHH is the principle referral centre, teaching hospital and a community hospital for Newcastle and Lake Macquarie, NSW, Australia. It is the only trauma centre in NSW outside Sydney and has the busiest emergency department in the state (Hunter New England Health, 2005).

John Hunter Hospital contains 550 beds with specialities including anaesthesia and intensive care, emergency medicine, respiratory medicine, cardiology, cardiac surgery, neurology, neurosurgery, head and neck surgery, endocrinology, kidney transplants, nephrology and gastroenterology. The speech pathology department employs 5.5 full-time equivalent (FTE) clinicians to service a diverse inpatient and outpatient adult caseload. The department has trained specialists in areas including dysphagia, modified barium swallow, laryngectomy, tracheostomy, voice and progressive neurological diseases. The aim of the weekend service was to reduce the length of time patients were kept nil by mouth or maintained on modified diets over the weekend period. Speech pathologists within the department felt reluctant to upgrade patient diets on Fridays due to concerns regarding aspiration risk with no speech pathology review over the weekend. It was also a concern that patients who were nil by mouth were less likely to receive their medications and nutrition over the weekend period.

Referrals to weekend service

Weekend speech pathology services are provided from 9 a.m. to 1 p.m. on both Saturday and Sunday. New referrals to the weekend service can be made electronically via page or verbally between 9 a.m. and 12.30 p.m. on Saturday and Sunday. Referrals received after 12.30 p.m. may be held over until the next working day unless time permits. Referrals received after 4 p.m. on Friday may also be referred to the weekend service. Current inpatients on the speech pathology caseload are referred to the weekend service by 4 p.m. each Friday by their treating speech pathologist. The treating speech pathologist completes a weekend referral form (Appendix A) including suggested services required and attaches the patient's database form (Appendix B).

Staffing

A grade 1 speech pathologist was recruited permanently in November 2001 to commence the weekend service to provide four hours service on both Saturday and Sunday. The speech pathologist is typically rostered to work additional part-time

hours during the week in the department to prevent isolation and allow inclusion in department activities and training (for a total of 0.2 FTE). New graduate clinicians have generally been recruited to the position. The senior speech pathologists within the department provide telephone supervision to the weekend speech pathologist on a rostered basis. The weekend speech pathologist is required to contact the supervising speech pathologist via mobile phone to discuss issues pertaining to prioritisation, critical decision-making and service delivery. The supervising speech pathologist is paid an on-call allowance.

Scope of service provision

The weekend service is provided to inpatients with swallowing, speech and/or language difficulties. Weekend speech pathology services are not provided to patients with tracheostomies or laryngectomies due to difficulties recruiting speech pathologists with competencies in these specialised areas and the time requirements. Patients referred to the weekend service are prioritised according to the schedule set out in table 1. Examples of high priority include new admissions with acute dysphagia or patients who have deteriorated over night. Examples of lower priority include new admissions with acute onset of communication disorders or patients who have improved over night and require review for potential to upgrade their diet. The supervising senior speech pathologist participates in patient prioritisation with the weekend speech pathologist (table 1).

Table 1. Current prioritisation criteria	
Priority	**Description**
1	New admissions to the hospital with acute dysphagia
2	Patients who have deteriorated over night
3	Patients who are nil by mouth without stable enteral feeding
4	Patients at nutritional or dehydration risk due to dysphagia
5	Patients commenced on an oral diet that requires review to ensure safety
6	Patients with fluid consistency upgraded on Friday who require review to ensure safety
7	Patients with food consistency upgraded on Friday who require review to ensure safety
8	Patients requiring a direct swallowing therapy program
9	Patients requiring education regarding dysphagia management prior to discharge
10	New admissions to the hospital with acute onset of communication disorders
11	Patients who improve overnight and could be reviewed with respect to an upgrade

Inpatients on the current speech pathology caseload who have not been referred to the weekend service by their treating speech pathologist may be subsequently referred to the weekend service by medical, nursing, allied health staff or family and are prioritised according to the prioritisation schedule. The weekend speech pathologist discusses these re-referrals with the supervising clinician prior to seeing the patient. The supervising speech pathologists conduct regular audits of referrals to monitor consistency and appropriateness of referrals across the department.

Data audit

Data pertaining to the weekend caseload has been collected since November 2001. This data includes occasions of service (OOS) provided, OOS required but not provided, new referrals, weekend diet upgrades, weekend diet downgrades, number of patients who commenced oral diet or enteral feeding on the weekend, and number of diet changes recommended on Fridays.

Data was analysed retrospectively for the initial 10 weeks of the weekend speech pathology service in 2002 and in three subsequent 6-month periods from April 2003 to September 2003, October 2003 to March 2004 and September 2005 to February 2006. The initial 10-week data collected was extrapolated to provide a 6-month sample consistent with the other time periods recorded.

Table 2. Numbers of occasions of service (OOS) and new referrals recorded for selected time periods between November 2001 and February 2006				
	Nov 2001 – May 2002[a]	Apr 2003 – Sept 2003	Oct 2003 – March 2004	Sept 2005 – Feb 2006
OOS	270	305	276	235
New referrals	12	72	51	46

[a] Data for November 2001 to May 2002 was extrapolated from actual data from November 2001 to February 2002.

Results

Numbers of occasions of service and new referrals recorded between November 2001 and February 2006 are reported in table 2. In the period November 2001 to February 2002, 95% of the OOS were for dysphagia with 5% for speech or language difficulties. Four of the six new referrals to the weekend service commenced enteral feeding on the day of review, thus minimising hydration or nutritional complications as a consequence of their nil by mouth status. During this period 16 patients had their diet consistencies upgraded. A further 14 patients had their diet consistencies downgraded, thereby reducing the risk of aspiration. There was an average of 11 OOS per weekend during each data collection period with no significant increase over time. The number of new referrals increased from 12 in the initial data collection period to 46 in the finale data collection period.

Discussion

The JHH weekend speech pathology service has successfully provided management of dysphagia, speech and language difficulties to an adult inpatient population within the acute setting for almost six years. This weekend service reduces the number of new referrals received on Mondays and enables clinicians to implement dysphagia management changes on Friday knowing that the patient can be monitored over the weekend. Prior to initiating the weekend service, potential diet upgrade decisions on Friday were often delayed until the following Monday to enable monitoring. This delay could prolong hospitalisation and affect progress in meeting speech pathology, medical and discharge goals. Senior supervision over the weekend is necessary to minimise pressure of time management and increased caseload demands. The ability to refer to the weekend service anecdotally contributes to reduced weekday workload stress among speech pathologists and increased patient satisfaction. The service also manages patients who are suitable for

upgrades over the weekend while without a speech pathology service they would be required to wait for weekday review to progress. Anecdotally there is the perception among the medical staff that providing a weekend service minimises hydration and/or nutritional complications, as a consequence of their nil by mouth status. This early intervention enables medication to be administered orally or via nasogastric tube, which contributes to stabilising or improving patient medical status. This approach poses potential for improved medical outcomes, thereby reducing length of hospitalisation.

Models of weekend service delivery

Although both JHH and RMH provide a 4-hour service on Saturday and Sunday, there appear to be some differences in the weekend service delivery models between the JHH and the RMH programs. The first difference relates to staffing. RMH recruit weekend speech pathologists with a minimum of six months acute experience. In contrast JHH has not been able to routinely recruit speech pathologists with experience and has employed new graduate speech pathologists with senior supportive phone contact. With JHH located in regional NSW it is not always possible to attract speech pathologists to the area with postgraduate experience. The second difference relates to the caseload served. Laryngectomy and tracheostomy caseloads are serviced at RMH on weekends. In contrast these caseloads are not serviced on weekends at JHH due to difficulty recruiting speech pathologists with training in these specialised areas. Despite these differences it appears that both the JHH and RMH models offer a successful weekend speech pathology service.

Future directions

Future studies could focus on the impact of weekend service speech pathology on length of hospitalisation, and measure other factors such as patient and carer/family views as recipients of weekend services. Further data analysis could examine the number of low priority patients recommended for weekend review who were held over to Monday due to time constraints. Anecdotal evidence suggesting reduced workload stress among our department speech pathologists as a consequence of the weekend service could be formally assessed.

Conclusion

This retrospective database audit demonstrates high utilisation of the weekend speech pathology service supporting its long-term need to continue. Increasing the evidence base to support weekend services may benchmark speech pathology as a seven-day profession in acute care.

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Appendix A. Weekend speech pathology service referral

Date: _____

COMPLETED BY THE PATIENT'S USUAL SPEECH PATHOLOGIST:
The patient's database must be attached to this referral, with the patient admitted onto AHMIS prior to referral where possible. Place in the weekend folder by 4 p.m. on Friday.

Patient Name:	
Ward:	
Case Load:	
Medical Diagnosis:	
Speech Pathology diagnosis/diagnoses	1 . 2 . 3.
Patient's current diet:	
Date of most recent contact:	

Appendix A.Weekend speech pathology service referral continued

Outcome of most recent speech pathology contact:	
Request weekend service intervention:	Initial assessment – swallowing
	Initial assessment – communication
	Review current diet
	Educate patient/family re swallowing management
	Direct swallowing therapy (please specify)
	Communication therapy (please specify)
	Check patient's medical chart/check with nursing staff
	Other (please specify)
	_____
	_____
Frequency of service requested:	Saturday
	Sunday

Estimated priority ranking (by patient's usual SP):

COMPLETED BY SUPERVISING SPEECH PATHOLOGIST:

Patient prioritisation (before new referrals are received): _____

SATURDAY	SUNDAY
Weekend service provided:	Weekend service provided:
Initial dysphagia assessment	Initial dysphagia assessment
Initial communication assessment	Initial communication assessment
Swallowing review	Swallowing review
Swallowing therapy	Swallowing therapy
Communication therapy	Communication therapy
Education regarding swallowing management	Education regarding swallowing management
Discussion with nursing or medical team/checking of patient's notes	Discussion with nursing or medical team/checking of patients notes
Other (please specify)	Other (please specify)
_____	_____
_____	_____
The outcome of this service was:	The outcome of this service was:
Diet continued: no change to patient's current management plan	Diet continued: no change to patient's current management plan
Patient commenced oral feeding:	Patient commenced oral feeding: Diet:
Enteral feeding was commenced	Enteral feeding was commenced
Patient was not admitted to hospital over the weekend due to intervention	Patient was not admitted to hospital over the weekend due to intervention
Diet downgraded:	Diet downgraded:
Diet: _____	Diet upgraded:
Diet upgraded:	Patient unable to be seen due to:
Diet: _____	_____

SATURDAY	SUNDAY
Patient unable to be seen due to:	On Monday this patient:
_____	Needs a swallowing review Needs initial swallowing assessment Needs communication assessment Needs education regarding:
Other relevant information:	
_____	_____
_____	Needs liaison with:
_____	_____
_____	Other (please specify)
	_____

COMPLETED BY THE PATIENT'S USUAL SPEECH PATHOLOGIST:

Feedback from service provided on Monday:

Swallowing

Patient placed NBM
Patient commenced oral feeding
Diet was upgraded
Diet was downgraded
Patient reviewed with no change to diet

Change to patient's recommendations:

Improvement/deterioration in medical condition (give details):

Commenced/continued swallowing therapy (give details):

Other relevant information (eg: feeding strategies, carers/family issues, compliance, progress discharge planning)

Communication

Assessment conducted	aphasia	dysarthria	dyspraxia	voice
Assessment type:	informal	formal (give details)		

Therapy – focusing on:

Other relevant information: (eg: information provided to family/carers, handouts given, exercises given, etc)

SPEECH PATHOLOGY PLAN:

_____

Appendix B. Speech pathology patient database

MRN: _____	DOB: ____/ ____/ _____
Surname: _____	First Name: _____
Street: _____	Suburb:_____ Postcode: _____
(Insert medical record sticker)	

Telephone: NOK: _____

Medical Officer: LMO: _____

Speech Pathologist: DVA No: _____Wt ❏   Gold ❏

Date Referred: ____/____/____ (by _____)   Reason for Referral: _____

Date 1st seen: ____/____/____ ICD – 10 Completed ❏

Therapy Diagnosis: _____

Medical Diagnosis: _____

CLINICAL INFORMATION:

Date Discharged: ____/____/____   Discharge Destination: _____

USING GOAL ATTAINMENT SCALING AS AN OUTCOME MEASURE FOR PROMPT THERAPY

Natalie Marx

PROMPT is a form of therapy used by speech pathologists around the world. While there is much anecdotal evidence to support its use, there is minimal research based evidence available. In this article Goal Attainment Scaling is suggested as an outcome measure to be used consistently for PROMPT therapy as a means to build an evidence base. A sample case is used to demonstrate the application of this idea in a clinical setting.

Keywords:
> evidence based practice,
> Goal Attainment Scaling,
> outcome measures,
> PROMPT

With the ever-increasing emphasis on evidence based practice in health care, and thus in the field of speech pathology, there is an ongoing need for evidence to support what we do in practice. For many therapeutic techniques carried out in our clinics, there is little or no research-based evidence regarding efficacy or outcomes, yet clinical judgement supports their continued use. Clinical demands often cannot wait for researchers to produce necessary evidence and therefore at times practice leaps ahead and guides the research process. One way of directing this process is to use outcome measures in clinical practice. Through a clinical case example, this article looks at evaluating outcomes of PROMPT therapy and aims to offer a suggestion for future clinically based research through the consistent use of Goal Attainment Scaling as an outcome measure.

What is PROMPT?

Prompts for Restructuring Oral Motor Phonetic Targets (PROMPT) was created by speech pathologist Deborah Hayden in the 1970s and 1980s. It is said to be a "philosophy", an "approach", a "system" and a "technique" (PROMPT Institute [TPI], 2007). It combines a practical system of manual cues or prompts to help children and adults with speech difficulties to produce speech sounds in a wholistic and functional approach to therapy (TPI, 2007). PROMPT is founded on theories from the physical-sensory, cognitive, social-emotional and behavioural domains, including, for example, the relationship between speech development and neuromuscular development (Kent, 1981), brain plasticity in response to tactile input (Kaas, 1991), stages in cognitive development (Piaget, 1964) and the development of language within a social context (Vygotsky, 1978).

The PROMPT Institute currently runs training workshops internationally for speech pathologists, and produces materials for assessment, planning and therapy using the PROMPT technique (TPI, 2007). For a detailed description of the PROMPT technique the reader is referred to TPI (2007) and Square (1999).

Evidence base for PROMPT

There is much anecdotal evidence supporting the efficacy of PROMPT; however, there is very little in the way of a researched evidence base for this practice (e.g., Bose, Square, Schlosser & Van Lieshout, 2001; Freed, Marshall & Frazier, 1997; Bose, van Lieshourt & Square, 2000). In a single subject multiple baseline design Bose et al. (2001) demonstrated promising results in using PROMPT to promote speech movements for the production of simple sentence structures in an adult patient with Broca's aphasia. However, with a single case it is difficult to separate the effects of extraneous variables (such as client motivation and response to therapy technique) from the effects of therapy on the results. Furthermore, improvement was seen in therapy involving only linguistically simple utterances and not more complex utterances. The impact of individual idiosyncracies of the subject may lead to misleading results. A larger sample size is needed before these findings can be generalised to a wider group. Freed, Marshall and Frazier (1997) demonstrated improvements in production of a core vocabulary, using PROMPT with an adult who had suffered a left cerebrovascular accident. The results of this study are weakened, however, by the fact that treatment did not follow the PROMPT motor speech treatment hierarchy, an essential component of the approach (Bose et al., 2001) and the core vocabulary selected did not provide consistent practice of particular motor movements identified as areas of weakness (Bose et al., 2001), thus therapy lacked coherence and continuity. Additionally, this study had a weak "pre-test – post-test" experimental design with a single subject, further tempering the strength of the results.

While this small-scale preliminary evidence showed promise, the methodological flaws cannot be overlooked. These studies are also limited to adults, and cannot therefore be generalised to children without consideration of factors such as neurological differences between developmental and acquired speech disorders. Evidence in support of PROMPT for the paediatric population remains unpublished to date, yet several studies have reportedly yielded positive outcomes (e.g., Chumpelik & Sherman, 1980, as cited in TPI, 2007; Chumpelik & Sherman, 1983, as cited in TPI, 2007; Houghton, 2004, as cited in TPI, 2007). Clearly, more and stronger evidence is needed to investigate whether PROMPT therapy is in fact as effective as it claims to be. The introduction of a consistent outcome measure to this field of therapy is needed in order to build a bank of evidence to support the widespread use of this therapy, and to enable development and improvement in its application. Goal Attainment Scaling is one such outcome measure which appears well suited to this task.

Goal Attainment Scaling

Goal Attainment Scaling (GAS) is an outcome measure developed for use in the fields of medicine, psychology, education, rehabilitation and social work (Smith, 1994). It is an individualised system based around the evaluation of clearly set goals (Smith, 1994). Progress toward each goal is measured using an operationally defined five-point rating scale from –2 ("much less than expected") to +2 ("much more than expected") (Cardillo, 1994, p. 49). Each point on the scale represents predicted or possible levels of outcome relating to the particular goal. The rating scale must be set before

commencement of work towards the goals, and a specific timeframe must be set for independent evaluation of progress, or rating, using the pre-set scale (Cardillo & Choate, 1994). The follow-up rater collates a "summary score" which is used to find a corresponding T-score (Cardillo, 1994). GAS has been found to have high inter-rater reliability (Stolee, Rockwood, Fox & Streiner, 1992) while reliability over time and between scales has not yet been shown (Caslyn & Davidson, 1978; Cardillo & Smith, 1994). The validity of GAS as an outcome measure has been criticised (e.g., Caslyn & Davidson, 1978); however, a number studies (e.g., Goodyear & Bitter; 1974; Williams & Stieg, 1987) found GAS to be a valid and reliable outcome measure in the rehabilitation setting (Hurn, Kneebone & Cropley, 2006). A review of research in this area has shown that while GAS has flaws in terms of a "general measure of outcome", it is a strong measure of "treatment-induced change" (Smith & Cardillo, 1994, p. 272). It is recommended that it be used in conjunction with other standardised forms of assessment for pre and post testing (Smith & Cardillo, 1994; Malec, 1999). GAS has been found to measure "clinically important change" (Rockwood, Stolee & Fox; 1993, Rockwood, Joyce & Stolee; 1997), including small changes which may not be detected in standardised assessments (Rockwood, Stolee & Fox; 1993; Malec 1999).

PROMPT uses a structured format for a "System Analysis Observation" based on the stages of the Motor Speech Hierarchy (TPI, 2007) which forms the basis of assessment, and leads into the development of three main goals for therapy (TPI, 2007). GAS can be seen as a natural extension of this, allowing for systematic evaluation of the outcomes of these goals.

Clinical case

Subject

The client involved in this project, DB, was a 4-year-old boy. He was initially seen by a non-PROMPT trained therapist, and was found to be suitable for a trial of PROMPT therapy. He was then referred to a PROMPT trained therapist for on-going therapy. The potential of GAS as an outcome measure for PROMPT therapy arose and was seen as an opportunity to explore the tool for this purpose. Much of the background information reported here was gleaned retrospectively from reports and progress notes from the initial therapist; therefore sufficient baseline measures desirable for the present study are lacking.

An initial assessment of DB's speech and language skills prior to commencement of PROMPT therapy indicated severe speech and language difficulties. His hearing was found to be within the normal range and gross and fine motor skills (except oromotor skills) were developing normally. He used mainly vowel sounds when speaking and was unable to be fully understood in social situations. DB had an expressive vocabulary of 4–10 recognisable words (e.g., Mum and "gar" for "car"), using four different consonant sounds (/g/, /h/, /m/, and /j/). He was unable to complete a formal articulation assessment due to his limited vocabulary. DB did not use any grammatical markers, and his mean length of utterance was 1–2 words. He also showed significant delays in receptive language including difficulty understanding questions and grammatical markers, and difficulty following multi-step directions. Social communication difficulties were also noted, including difficulty initiating communication (including non-

Table 1: Goal attainment follow-up guide; DB's therapy goals				
Level of attainment	**Goal 1** **DB will count from 1-5 without PROMPT**	**Goal 2** **DB will pronounce words with changing jaw gradient (4-1)**	**Goal 3** **DB will produce CV words with rounded vowels**	**Goal 4** **DB will produce alveolar consonants in the initial position of CV words**
Much less than expected **−2**	DB will need surface PROMPTs to produce an approximation[1] of each number.	DB will need parameter PROMPT for jaw gradient on all target words	DB will produce 50% of target words with surface PROMPT.	DB will elevate his tongue to the alveolar ridge for /n/ with PROMPT <50%.
Somewhat less than expected **−1**	DB will produce one number without surface PROMPTs, yet will need PROMPT for other numbers.	DB will need parameter PROMPT for 80-90% of target words.	DB will produce 70% of target words with surface PROMPT.	DB will elevate his tongue to the alveolar ridge for /n/ /t/ and /d/ with PROMPT <50%.
Expected level of outcome **0**	DB will produce two numbers without surface PROMPTs. (may need visual/auditory cues)	DB will need parameter PROMPT for 60-70% of target words. (may need visual/auditory cues)	DB will produce 70% of target words with verbal cue to round lips.	DB will achieve correct tongue placement for alveolar sounds[2] on 50% of attempts with PROMPT.
Somewhat more than expected **+1**	DB will produce three numbers without surface PROMPTs. (may need visual/auditory cues)	DB will need parameter PROMPT for 50% of target words. (may need visual/auditory cues)	DB will produce 90% of target words with verbal cue to round lips.	DB will produce alveolar sounds in isolation with PROMPT
Much more than expected **+2**	DB will produce all numbers without surface PROMPTs.	DB will need parameter PROMPT for less than 50% of target words.	DB will produce 70% of target words without verbal cue or PROMPT.	DB will produce alveolar sounds at the beginning of CV words with PROMPT.

1 Expected pronunciation of numbers: one- 'ooah', two- 'oo', three- 'ee', four- 'for', five- 'fah' or 'fy' (as in 'my').
2 Tongue placement without production of sound (ie. no airflow) acceptable.

verbal) and making appropriate eye contact. He has attended regular therapy using the PROMPT technique over a period of one and a half years. The GAS procedure was introduced in the latter months of this period of therapy.

Procedure

Four therapy goals were selected based on assessment results (primarily the PROMPT System Analysis Observation). It was planned to review these goals after a period of 10 weeks. Possible outcomes for each goal were defined on a 5-point scale as can be seen in table 1.

DB attended 4 half-hour therapy sessions, conducted by a PROMPT trained therapist, over 10 weeks. In the eleventh week a second PROMPT trained therapist conducted a review session to evaluate the goals set, using the 5-point scale. Individual therapy was conducted in a private speech pathology clinic with the client's mother present.

The primary therapist read chapters 1 and 3 of Kiresuk, Smith and Cardillo (1994) as a guideline for the use of GAS. The second therapist (follow-up rater) was informed of GAS follow-up procedures through informal discussion as Kiresuk et al. (1994) recommend that all parties involved in rating be familiar with GAS procedures.

GAS scores were calculated based on the follow-up clinician's ratings. A t-score was obtained from the Summary Score Conversion Key (Kiresuk et al., 1994, p. 275).

Table 2 Core word lists – selected in conjunction with DB's parent		
Word list for goal 2	Word list for goal 3	Sound/word list for goal 4
Tiana driving jumping hiding climbing	shoe blue moo moon book spoon (final consonant deletion and cluster reduction acceptable)	/n/ /t/ /d/ /s/ knee ta (thank you) tea two da (dad) do see

In the interest of exploring the feasibility of using GAS in a clinical setting, the duration of setting and scaling goals, follow-up evaluation of goals, scoring outcomes and calculating the summary score were timed. This was compared to the time usually taken to set goals for clients in this particular clinical setting.

Results

For goal 1 DB reached a level "somewhat more than expected" (+1). He was able to produce three numbers without surface PROMPTs. For goals 2 and 3 DB reached the expected level of outcome (0). He required a parameter PROMPT for 60–70% of target words from the goal 2 word list and he was able to produce 70% of target words from the goal 3 word list with a verbal cue for lip rounding. The follow-up rater noted that for goal 3 DB produced 50% of the target words without cues or PROMPT.

The sum of DB's scaled scores was equal to –1, the average scale score was –0.25 and his T-score was 46.37.

It was found that setting goals and scales post-assessment took 20 minutes, while the time usually taken to set goals post-assessment ranged from 10 to 15 minutes. Follow-up

evaluation with DB took 30 minutes, which is equivalent to a regular therapy session in this setting. Scoring the outcomes using the scale provided took 15 minutes and calculating the summary score took 10 minutes.

Discussion

The prediction that the client would reach the "expected level of outcome", specified as 0 on the scale, was reached or exceeded for three of the four goals set, with the fourth goal reaching an outcome "much less than expected". The aim of this project was to evaluate the outcomes of PROMPT therapy in one subject, using GAS. GAS allowed the measurement of change in the client, in relation to the specified goals. It can be seen from the follow-up ratings that the client made progress toward three of the set goals. The t-score is 0.25 "points" below the mean, indicating overall improvement; however, one must be cautious in interpreting this score. First, one cannot disregard the fact that extraneous variables were not controlled, and therefore change cannot be attributed confidently to the therapy provided. Second, despite research in support of the construct validity of GAS, one must question whether the improvement shown is a measure of the therapist's ability to set realistic goals. This second point raises the issue of interpreting the scores provided by GAS.

It could be said that by making goals small and achievable enough, progress is more likely. Thus, GAS could be a measure of how skilled the professional is at setting goals. However, it is important not to lose sight of the fact that it is a measure of whether progress is being made with a particular client, regardless of the size of the steps. Long-term goals as well as short-term goals could be set and evaluated within different timeframes, to gauge overall improvement. The extent of the progress made should not detract from the fact that it is progress and improvement towards the specific individualised goals set. GAS has been used effectively to evaluate programs (Malec, 1999), and the nature of the data provided has been shown to be useful in team discussions (Malec, 1999), for example, in making changes to goals, expected outcomes or methods employed to reach particular goals. Kiresuk and Sherman (1968) recommend sharing the role of goal-setting across a team as a means of reducing bias in goal-setting.

It should also be noted that DB missed two therapy sessions in the period set for GAS, which potentially alters "expected" outcomes. A further drawback to this study is the fact that formal assessment was not carried out alongside the GAS procedure. This would have enabled both a comparison between outcome measures and an opportunity to evaluate GAS outcomes. Future studies should include such an assessment component for comparison.

In this small-scale project, it was found that GAS presented as a feasible outcome measure to implement in the clinic in terms of time. Setting the "scale" with possible outcomes took only 5–10 minutes longer than the usual process of goal-setting employed in the clinic. The review session was equivalent in length to a regular review session conducted in the clinic, and time taken to collate notes from the review and rate the client's performance on the scale provided was equivalent to the usual time taken to collate data from a review session with a similar client. Calculating the summary score was also a relatively quick procedure given that tables were provided. This could be compared to the time taken to look up a standard score in a test manual. Overall, it can be seen that GAS does not require significant additional time as compared to regular clinical procedures, and could therefore

easily be incorporated into standard clinic procedures. Potentially, the most difficult aspect to arrange is the availability of an independent follow-up rater with appropriate skills; however this did not pose an issue in this instance. The use of video-taping could help to overcome this issue, yet this would raise the need for further research to evaluate alternative methods of follow-up (Caslyn & Davidson, 1978)

As discussed in the introduction, there is limited evidence outside of anecdotal evidence supporting the use of PROMPT. While GAS does not provide a detailed method for evaluating the PROMPT technique or specific aspects of efficacy, it can be seen as one way of paving the road towards building an evidence base in this area. By introducing the use of a consistent outcome measure, a pool of outcome data would be available for further research. From this base, researchers could branch into evaluations of such areas of efficacy and formal comparisons with other treatment methods. GAS could be seen as a cobblestone in the road towards that end.

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OUTSIDE THE SQUARE

The voice as a behavioural probe of emotional/neurophysiological disorders

Adam Vogel

Speech pathologists commonly use the voice as a marker of the clinical disease state. In the case of Parkinson's disease, for example, imprecise consonant and vowel production combined with changes in pitch variability often leads to a diagnosis of dysarthria. Moreover, changes in these speech characteristics tell us something about the progression of the disease. In a similar way, the voice has demonstrated its potential as a marker of central nervous

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system functioning in several populations not considered part of our core business. The influence of depression, anxiety or fatigue on an individual's functioning is difficult to quantitatively capture using existing psychometric assessments, as examination relies on a combination of subjective clinician/patient report and neuropsychological assessments. As neuropsychological tests have provided equivocal results in central nervous system disorders that contain intrinsic emotional changes, the voice has been considered as an objective and non-invasive alternative.

It is clear that the voice has strong face validity as a qualitative marker of neurophysiological functioning. Patients with depression can be recognised by their reduced rate of speech and diminished pitch variation. A similar vocal pattern manifests in populations undergoing extended periods of sustained wakefulness. These observable clinical disturbances in motor functioning combine with cognitive and emotional disturbances to provide the assessor with a psychopathological profile that reflects changes in the central nervous system. Aside from instrumental investigations, the majority of clinical evaluations continue to rely on subjective patient/clinician report to determine the type and level of impairment. Perceptual or listener-based analysis of vocal changes related to emotion and physicality are important in the diagnosis and evaluation of pathological conditions. However, perceptual measurements are subjective, and have inherently poor intra- and inter-rater reliability. Having quantitative information about changes in the voice acoustic profile of a patient or participant can contribute to the accuracy of current subjective assessment protocols.

Although the rationale for using the voice as a marker of clinical change has been established, capturing these changes on a large scale is challenging. Historically, voice studies have involved small sample sizes and idiosyncratic voice acquisition hardware/software configurations that lack utility and are labour intensive. This process has intrinsically higher costs related to personnel and equipment requirements. Furthermore, commercially available software and hardware designed to collect and analyse data can be cumbersome and complicated, often requiring extensive user expertise, which can further drain the financial resources of a clinical trial or study.

In this context, easy to use voice recording procedures and automated analysis needs to be developed and validated. The application of fully automated, fast and accurate voice acoustic regimes has the potential to extend voice assessment beyond speech pathology to a wider clinical and commercial audience. For example, the voice could be used as a marker of clinical change in pharmaceutical trials for depression, or, as it has in the past, as an indicator disease state in a pathological population. This stream of research offers a number of opportunities not previously available to speech pathologists through unique collaborations with big business and through
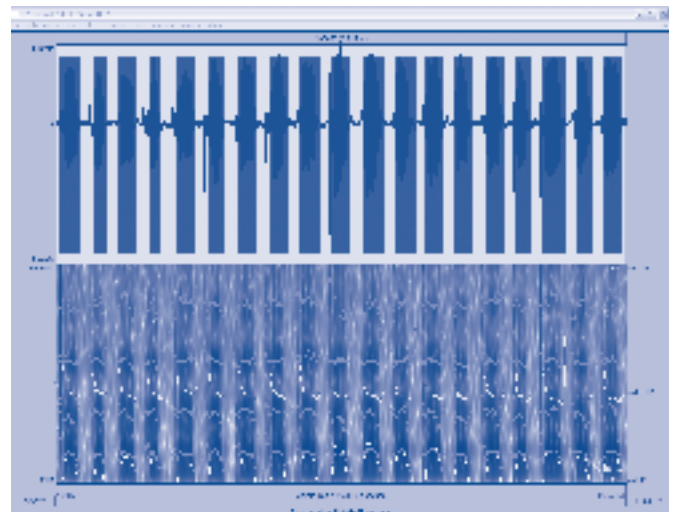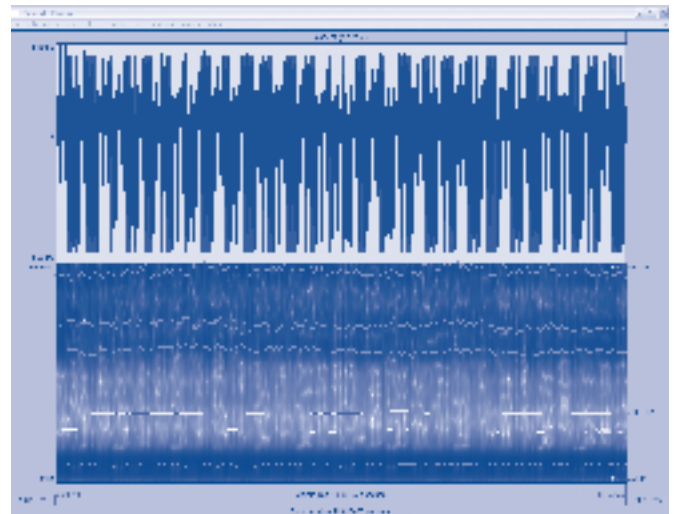
the exploration of populations not typically under the care of our profession.

Within this framework, careful analysis of the voice can be considered a behavioural probe of emotional/neurophysiological disorders, with potentially greater sensitivity than existing neuropsychological approaches.

Adam Vogel completed a BA (Psychology) in 2000 and Masters of Speech Pathology Studies in 2003 at the University of Queensland. He spent the first few years after graduation working in London within the Neuro-disability Service at Great Ormond Street Hospital. Since returning to Australia, Adam has been working as a speech pathologist and researcher in the Friedreich Ataxia Clinic at the Monash Medical Centre and as a clinical scientist for CogState Limited. He is currently completing a PhD at the Centre for Neuroscience, University of Melbourne.

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OUTSIDE/INSIDE THE SQUARE

Balancing work and family while doing a PhD, or, the two-dimensional woman

Libby Smith

Libby Smith completed a BA/BSc (Neuroscience/Linguistics) in 2001 at the University of Melbourne and an MA (Neurolinguistics) at the Rijks-Universiteit Groningen in the Netherlands in 2003. Since then she has worked for the Murdoch Children's Research Institute in the Childhood Communication Research Unit, based at the Royal Children's Hospital. She is currently enrolled in a PhD in the Department of Paediatrics at the University of Melbourne.

In June 2006, three months before my first baby was due, I stopped working in my job as a research assistant in the Speech Pathology Department at the Royal Children's Hospital in Melbourne, and started my PhD. I had the opportunity to be involved in an exciting project investigating the neurobiological basis of stuttering in children using functional magnetic resonance imaging (a brain imaging technique). I had always planned to do a PhD at some stage in my life, and this opportunity was too good to pass up. Several people asked me if I was crazy to begin a PhD while about to have a baby, and one older colleague said to me, "Who do you think you are? Superwoman!?". Superwoman I am not, and I had more than a few doubts about my decision.

I decided to take 6 months off to spend at home with my son and then return to study part-time. I thought it would be easy to go back to my office two days a week. I felt very lucky that my husband could care for our son one day, and my mother the other. After 6 months at home, I was ready for some more cerebral stimulation and adult company, and looking forward to a little time out from my son (who was a demanding little fellow, as many babies are). I was also looking forward to receiving my scholarship again, albeit at half-pay, as surviving on my partner's income alone was quite a challenge. However, things didn't go according to plan. I found it very difficult to concentrate on my work after being up two or three times in the night to feed or settle my baby. I spent many hours staring blankly at the computer screen trying not to fall asleep – in fact, I remember falling asleep on my keyboard at least once. At home, things weren't going well either. Neither my husband nor my mother could manage to coax my son to take any milk from a bottle – it was mummy or nothing! This was very stressful for everyone. In the end, I would come home at lunch-time, or one of them would bring him in to work (fortunately our home is only 15 minutes away) so I could feed him, and I would start late and come home early for the other feeds, trying to make up the hours during the evening.

The first four months back at work were a struggle, and not very productive. I remember thinking that thank goodness I had the flexibility of studying, as opposed to a job, where in most cases it would not be possible to come in late and leave early, or take a morning off after a particularly sleepless night. If things had become any more difficult, I could have suspended my candidature and taken some more leave without putting anyone out or causing any problems. Having this as an option was reassuring, even though I was able to overcome the difficulties in the end.

Eventually we all got the hang of it and things started to go more smoothly. The main challenge after that was trying to get the study momentum going. I found studying part-time resulted in very slow progress; because so much time elapsed between one study day and the next, I had almost forgotten what I was thinking about last time. I felt that I needed to immerse myself in the ideas and theories of my field in order to be able to clearly develop my own ideas and questions. This was difficult while studying part time.

In February this year, after a year of part-time study, I decided to enroll full-time. I now spend four days a week in my office and I am usually able to make that time very productive. After being on waiting lists for nearly two years, my son was lucky to be offered a childcare place in the crèche at the hospital one day a week. Meanwhile my partner has been able to rearrange his work hours so with help from my mother and his mother, they are able to care for my son three days a week at home.

This balance is working very well for our family. I do miss my son while I am away from him, but I am happy at work, and feeling very productive and stimulated. I have written my literature review, finalised my methodology and submitted the ethics application for my project. I am really looking forward to recruiting participants and beginning my data collection. At home, I try to make sure the time I spend with my son is as high quality as possible. I am so pleased to see him when I get home that I have lots of enthusiasm for chats, games and cuddles. If he is sick, I can stay at home without too much worry, because whatever I am working on can usually wait. I don't work late, because I like to get home in time for a trip to the park or a few games before dinner. The downside is that when I have a deadline approaching, I am back on the computer as soon as he is tucked up in bed, working into the night. But no matter how stressful the deadline, on the three days a week that I am at home, I have a real break from my project. The demands of a young child are real and immediate, and require something of a mental shift. I become absorbed in his world, where cuddles, food, nappy changes, exploring, talking and playing are all that counts. This time-out prevents my PhD from becoming all-consuming, and really helps me to clear my head and relieve built up stress.

As I see it, I have two babies, my son, and my PhD project. I am a very devoted mother, and these two babies take up almost all of my time and energy. I have heard it said before that life for a working mother can become two dimensional – those dimensions being work and motherhood. I would agree – there is little time left over for special time with my partner, leisure activities, hobbies, or even cleaning the house! But a little bit of flexibility goes a long way when you have young children. While there have been a few bumps in the road, combining study with a baby has given me the opportunity to achieve my personal goals while providing enough flexibility for me to meet the needs of my little one and accommodate the unpredictable nature of motherhood.

Speech Pathology in the Asia-Pacific Region

Speech-language pathology in Malaysia

Shobha Sharma

Brief history of the country

Malaysia (total land mass of 329,847 sq km) comprises Peninsula Malaysia and East Malaysia and consists of thirteen states and three federal territories. Kuala Lumpur in Peninsula Malaysia is the capital, while Putrajaya, located some 50 km from the Kuala Lumpur, is the seat of the federal government and functions as the administrative capital of the country. The Malay Peninsula was a trading point for merchants of the East and West from the 16th to the 18th centuries. During the late 18th and 19th centuries, Great Britain established colonies and protectorates in the area of current Malaysia. In 1948, the British-ruled territories on the Malay Peninsula formed the Federation of Malaya, which became independent in 1957. Malaysia was formed in 1963 when the former British colonies of Singapore and the East Malaysian states of Sabah and Sarawak on the northern coast of Borneo joined the federation. Malaysia has been successful in diversifying its economy from dependence on exports of raw materials, to expansion in manufacturing, services, and tourism (Andaya & Andaya, 1982).

Population demographics

According to the Demographic Statistics Unit of the Statistics Department of Malaysia (June 2007), the multicultural and multilingual population of Malaysia stands at 27.17 million. The Malays (Bumiputera) form the majority of the population (50.68%) while there are sizeable Chinese (23.19%) and Indian (6.92%) communities as well. Other Bumiputeras (natives), expatriates and non-citizen residents make up the other 18.92%. Population distribution is uneven between the Peninsula and East Malaysia with approximately 20 million residents concentrated in the Peninsula.

Religions and languages

Islam is the official religion in Malaysia with approximately 61% of the population practicing it actively although it must be stated that religious freedom and tolerance is widely observed. Buddhism is practiced by 19.2% of the population, 9.1% practice Christianity and 6.5% practice Hinduism; the remaining 5% of the population practice various other religions including Sikhism, Jainism, Taoism and Shamanism (generally practiced in East Malaysia) (Population and Housing Census 2007).

Bahasa Malaysia is the official language; English, Mandarin, various Chinese dialects (Cantonese, Hokkien, Hakka), Tamil, Hindi and Urdu are also widely spoken. Although Bahasa Malaysia remains the formal and official language for the government, English continues to be the language of business and is a compulsory second language in all educational institutions up to secondary level. The language(s) of higher education in Malaysia, including in the speech-language therapy (SLT) degrees, is generally a combination of English and Bahasa Malaysia, and students have the option of answering exam questions in either language.

Education

Schooling begins between the ages of 4 and 6, in nurseries and kindergartens which are mainly privately run. The curricula vary, leading to vast differences in the fundamental knowledge and skills gained. Formal primary education begins at the age of 7 and continues until the age of 12. Children may attend either government-operated or government-funded primary schools – the national schools or the national-type schools. National schools use Bahasa Malaysia as the medium of instruction for all subjects taught, while national-type schools use either Tamil or Mandarin as the medium for instruction. Upon completion of the six years of primary education, students attend secondary school for an additional five years, at the end of which students sit for the Malaysian Certificate of Education examination which is equivalent to the British "O" Level exams. Based on the results achieved, students who wish to enter the Malaysian public universities do a further 1.5 years before taking the Malaysian Higher School Certificate. Students wishing to pursue their further education overseas also have the option of enrolling in the numerous private colleges after secondary education.

Special education

According to statistics from the Social Welfare Department of Malaysia (SWDM) (December 2007), a total of 211,467 individuals are registered with the SWDM. Of this number, 19,267 are visually impaired, 30,842 are hearing impaired, 70,716 are physically impaired, 82,446 have some form of learning disability and 1,391 have cerebral palsy. A further 6,805 individuals are registered as disabled but are not able to be classified under any of the earlier mentioned categories due to the existence of more than one disability. The figures, however, may underestimate the disabled population in Malaysia. The World Health Organization estimates that approximately 1% of the population in a country has some form of disability, and Malaysia does not mandate the registration of individuals with disabilities.

Presently, children with special needs are mainly being served in special education schools. As more special education programs are introduced in Malaysian schools, more children with disabilities enrol in both primary and secondary mainstream schools to gain access to education. Special education teachers face annually increasing enrolments of children from diverse backgrounds, but many teachers do not feel adequately prepared for these challenges.

The concept of inclusive education was only introduced in Malaysia in 1995 and is still in its infancy. Inclusive education is regarded as functional integration of students with disabilities with their non-disabled peers. Students are placed initially in special education classrooms and transferred to inclusive classrooms if they are able to adapt academically and socially with their peers. The placement decision is made by the school principal on recommendation of the special education co-ordinator. In practice only two or three students

are placed in inclusive classrooms at one time. The majority of students in inclusive classrooms have visual or hearing disabilities, and are being trained for technical and vocational skills in vocational schools throughout the country. Starting only in 2000, five schools have been selected for the implementation of the inclusive program and to date no empirical data is available to evaluate its success.

Health care

Health services, including speech therapy, are offered by both government and private facilities. Despite mandatory country service of doctors and recruitment of overseas-trained staff, there is still a severe medical workforce shortage, especially of highly trained specialists and allied health care professionals. This means certain medical care and rehabilitation services are available only in large cities. Efforts to bring facilities to the rural areas of Malaysia have been hampered by lack of interest from health care professionals in setting up clinics in such underdeveloped areas.

Speech-language therapy

History

Speech-language pathology (SLP) services are reported to have been introduced to Malaysia in the 1960s through British and American volunteer organisations. SLPs were educated in universities in the USA, United Kingdom, Australia and India. By the mid-1980s–early 1990s, a handful of SLPs returning to Malaysia after completing their education overseas formed the Malaysian Association of Speech-Language & Hearing (MASH) to represent the cause of SLPs and audiologists in the country. MASH became a registered body in 1994. Membership to MASH is through proof of professional qualifications in either audiology or speech sciences/pathology/therapy. Current figures suggest that there are only 39 registered SLPs in the association, as registration is not compulsory before being able to practise. Presently approximately 110 of the 150 SLPs in the country are graduates of the National University of Malaysia (Universiti Kebangsaan Malaysia, UKM) that offers the speech sciences program as a four-year honours degree.

Although the term "speech-language pathologist" is the formally recognised designation, the terms "speech therapist" and "speech-language therapist" continue to be used without differentiation across the country. The scope of practice includes assessment, diagnosis and rehabilitation of speech, communication and swallowing disorders. Many SLPs work in private settings that include private hospitals, private speech clinics and private centres that cater for the rehabilitation of specific disorders such as Down syndrome, autism, stroke and so on.

The first SLT course in Malaysia was established in UKM's Department of Audiology and Speech Sciences under the Faculty of Allied Health Sciences in 1994 and has had ten cohorts of students graduate from either the audiology or speech sciences program. Working very closely with established universities in Australia, United Kingdom, USA and Hong Kong, UKM receives annually a stream of visiting professors who impart knowledge and enhance research in the areas of audiology and speech sciences for students, faculty and clinicians alike. Students in the speech sciences program take eight semesters of coursework, which includes normal and disordered language development, components of linguistics, articulation disorders, voice disorders, stuttering, swallowing and feeding disorders, and some basics in audiology. In addition, students are required to complete 300–350 supervised clinical clock hours of hands-on rehabilitation of patients and clients with the various disorders of speech, language and swallowing.

The Science University of Malaysia (Universiti Sains Malaysia, USM) started a program in speech pathology in the 2004/05 academic year and offers the Bachelor of Health Science (Speech Pathology). The first cohort of nine students is expected to graduate in the 2009/2010 academic year. The International Islamic University (IIU) is planning to have their first intake of students for the speech program in the 2009/2010 academic year.

Services

Owing to the steady number of graduates from the speech sciences program of UKM, speech pathology services are beginning to become more visible across the country. Each major government hospital in 10 of the 13 state capitals in Malaysia has at least one SLP providing assessment and rehabilitation services. However, based on the USA's projected recommendation of 1 SLP for each 2000 people (US Department of Labor), Malaysia clearly faces a severe shortage of SLPs, which means that extremely heavy caseloads will persist for some time. The average SLP's caseload consists of paediatric clients and patients who have language delays/disorders (including autism, Down syndrome, intellectual impairment and the like), hearing impairment, articulation disorders, cleft of lip and/or palate, feeding disorders and learning disabilities. Adult caseloads of the SLPs would comprise patients with laryngectomies, stroke, traumatic brain injuries, dysphagia and voice disorders. Services in government settings are free of charge for patients who attend government schools, are government pensioners or are registered with the Social Welfare Department as a person with a disability. All others pay only a minimal fee of 5–10 Malaysian ringgit for the same services (A$1 = MYR 3). In private hospitals and centres, the costs services vary dramatically. Many individuals initially seek the services of private practitioners, but frequently report financial strain after a few sessions and eventually may seek assistance from government facilities.

Barriers to service provision

Therapy and speech rehabilitation sessions are generally conducted on a one-to-one basis in the primary language used in the individual's environment. Being a multilingual and multicultural country, clinicians face a daily problem of not speaking the language of the patient seeking therapy. In such circumstances, clinicians use the parents or caregivers as translators and work through them for the rehabilitation of the patient (Matsuda, 1989). Additionally, the clinician faces the challenge of being culturally sensitive and appropriate without offending the patient and/or the family (Cheng, 1989).

Professionals from other disciplines such as psychologists, audiologists, occupational therapists and physiotherapists are consulted when necessary but rarely is there implementation of combined clinical consultation or service. This can be quite frustrating as input from various professionals is often required for proper decision-making. The SLP is thus required to be sensitive and aware of the various issues that may arise for the patient outside of speech and communication.

Services of the SLP continue to be available only in the state capitals of Malaysia and only in the major government hospitals, with outlying areas being devoid of SLP services. Caseloads are high due to the shortage of SLPs but most patients referred for the services are given an appointment at

least for an assessment session. Follow-up sessions, however, may be one to three months later, depending on the severity of the disorder or the availability of a session slot. This results in frustration, reduced levels of motivation from the patient and family as well as poorer success rates/prognosis.

Lack of opportunities for continuing education in specific and specialised areas such as dysphagia and voice disorders also leads to some SLPs choosing to work mainly with paediatric language disorders. As a result, populations of patients requiring medical speech pathology are left out, and do not receive the services of the SLP.

Speech pathology in Malaysia is in its infancy and continues to face frequent changes. Continuous upgrading of services and the knowledge base is required in consultation with more established universities, hospitals and research facilities. It is hoped that the profession of speech pathology matures to provide maximal benefits to the patients in the very near future through awareness programs for both professionals and the public, so they are more aware of the importance and value of the speech pathology services.

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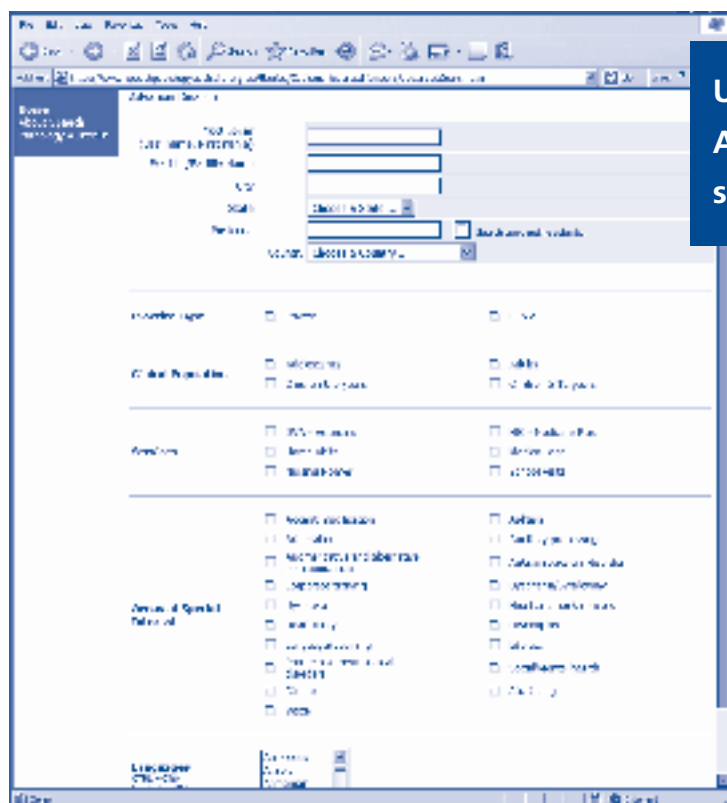*Jalan Raja Muda Abdul Aziz*
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STUDENTS WRITE…

Juggling family, study and life!

Jessie Smith

Reflecting back on my student days…

Vegemite fingerprints decorate the sliding glass door and the sideboard is beginning to resemble a haunted house. In this come all the joys of juggling two small children and studying full-time. The demands of family life and work are always a difficult one but with compromise it can be done. Just ask our family! In between my second and third year of studying Bachelor of Health Science (Speech Pathology) at Charles Sturt University our family became three.

Balancing a small baby and university was challenging, yet fun. We managed to incorporate study, work and child-rearing as well as having a social life. I think that compromises and imagination play huge parts … reading speech pathology text books is always much more stimulating then Hairy Maclary!

Three months after I completed my degree, we had our second son. This became more of a challenge and my husband and I decided that I would be a stay-at-home mum for a little while. I give credit to those who can dedicate themselves their lives solely to the little people around them – this to me is a far harder job then balancing work and family life. When my son was 3 months old, I began working in a counselling role. My speech pathology skills were invaluable as I used my communication skills in diverse ways. On-site childcare centres work wonders!

Six months after completing my degree I begun working privately in three local private and public schools. It was amazing to finally use my speech pathology degree in a traditional way. My working two days a week was fantastic for our family. I had two jobs: two days a week as a professional, contributing in the community, and the other, by far, the most important job I have, looking after our beautiful sons.

Fast forward to 2008, one year after completing my degree I decided to further my study and become a teacher. I called two weeks before commencing the course and enrolled to complete my Graduate Diploma of Education. The positives of the course were the career advancement; flexible teaching hours, etc., but of course, positives always entail negatives.

The main one was that the course is full time, 9–4 every day.

However, our philosophy this year is to consider the long-term gains for our family. The boys go to my wonderful personal nanny (aka my mother-in-law) and have adapted really well. It is me of course who misses them the most.

Being a busy parent is challenging, with highs and lows. The biggest difficulty for our family to spend quality time, rather then simply "time" together.

Yes, the house isn't as spotless as it was; yes, the clothes go un-ironed but the boys are hilarious, outgoing and wonderful people, and this indicates to me that we're managing work and home life perfectly … well almost!

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STUDENTS WRITE…

Finding your feet: A perspective on placements in education as a student clinician

Sarah Gordon

My first clinical placement as a speech pathology student in a west Brisbane primary school was one of the last placements I thought I would be suited to, let alone enjoy. From the moment I knew that my passion was to study speech pathology, I have been resolute that my speciality as a graduate speech pathologist would be in the adult acquired neurological disorders ward of a private inner-city hospital. One can imagine my disillusionment, then, when I found out that my first "real" clinical placement was to be in a paediatric language and literacy clinic at a state primary school. However, not only did I successfully complete the primary school placement, but I am currently working in a private Brisbane high school clinic, and have enjoyed both placements beyond what I could have imagined.

Upon reflection, when I pictured what it might be like on the first day of my primary school placement, I envisaged standing up the front of a classroom and having whiteboard markers thrown at me from all directions. This was not, fortunately, what happened. I was not as confident when I discovered that my next clinical placement was to be at a high school, fearing that more than whiteboard markers may be coming my way. However, I have only had one whiteboard marker flicked at me to date, and have gained experiences that have been incredibly valuable. While I have faced many challenges during my placements in paediatric practice, I have also experienced numerous highlights which I value immensely. I would like to share my experience of working in paediatric language and literacy from the perspective of a student clinician.

Sarah Gordon

One of the major challenges I have been presented with has been in understanding the behaviour of children and adolescents. My expectations were not unrealistic when I started both the primary and high school placements – I expected that the behaviour of these students would be unpredictable at times and that I would be required to enforce certain "behaviour management" strategies to keep my clinic in order. However, implementing those strategies was considerably more difficult in reality than in theory. Several times during my primary school placement, particularly during group therapy sessions, managing bad behaviour was daunting and unsuccessful. Although the other student clinicians and I were familiar with how to manage behaviour, it was difficult to practise. I feel that this difficulty may have been due to the ages of the student clinicians. Most of us had finished high school within the last five years, and I sensed that our clients knew that we were novices in their classroom jungle! Individual sessions could be equally difficult, and I have faced this with students across the spectrum. Many a session has been spent asking for heads to come off the desk and chairs to be sat on (not swung on!). Many efforts have been made to encourage the shy students and rein in the chatterboxes, and many days have seen blank faces looking at me like I had three heads. However, I have come a few steps closer to understanding children's behaviour by having been immersed in it, and towards the end of my clinical placements, I have felt more capable of running my sessions on my terms.

Working with adolescents has been an experience which has fostered and enhanced my clinical skills, but has also provided many moments of uncertainty, both professionally and personally. My experience working as a speech pathology student with senior school students has reminded me how difficult high school can be for many teenagers. As was the case when I worked in a primary school, my age seemed to be perceived by my high-school clients. This time, however, it usually proved to be a positive factor in developing and maintaining rapport – the students felt that they could relate to me well because I was closer to their age. This positive rapport was difficult to maintain at times, when moods fluctuated and enthusiasm for coming to therapy waned. Furthermore, on several occasions, I was the subject of personal disclosures by my students of certain sensitive issues. There have been times when being such a young trainee speech pathologist has been quite intimidating, from the perspective of gaining respect from students and learning to identify as a competent professional in an environment in which you are unfamiliar. As a student clinician in a high-school environment, I am still learning to juggle the fine line between confidentiality and responsibility, and have learned a great deal by watching the remarkable work of the learning support staff at the schools in which I have been fortunate enough to work. I believe that practising as a speech pathologist, in particular in a high school, requires refined skills to cope with not only the speech and language issues surrounding the clients, but also the vast emotional, psychological and behavioural concerns that may coexist.

From a purely professional perspective, my experience of devising and implementing assessment and intervention for language and literacy disorders has been largely enjoyable and entertaining! Administering standardised assessments has been difficult at times if a student was unenthusiastic about participating, and I found scoring of such assessments required practice and experience. I have implemented structured programs with room to individualise therapy, and have spent many hours colouring in butterflies and castles, learning about Pokémon characters, and trying to understand the intricacies of scoring sports with which I am utterly unfamiliar. As a student clinician, I have found that both primary and high-school students can be thoroughly engaged in therapy if one can find the right trigger. However, finding the trigger is the difficult part, and I have reflected on many therapy sessions feeling as though I had bored my students to death and really ought to find a new profession. It is difficult not to feel personally responsible for a therapy session that did not go to plan. However, as my clinical educators have highlighted to me, there are many personal and motivational factors that paediatric clients bring to a session that are equally likely, if not more likely, to derail it than a lack of ability by a competent student clinician.

Working as a speech pathology student in a school environment has been extremely challenging and has developed my clinical skills immensely in terms of my professional identity, my assessment and diagnostic skills, my ability to relate to my clients while maintaining control of a session, and my improvisation skills as the needs of my clients (and my best laid plans) change! While being a student clinician in a paediatric educational setting is a demanding and complex task, I have discovered that it is a role best embraced with a positive outlook, a willingness to learn new and exciting things, and a set of brightly coloured whiteboard markers just in case.

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WEBWORDS 30

Work–life balance and authentic interests

Caroline Bowen

"The right time is ANY time that one is still so lucky as to have." – Henry James

When it comes to novelists, late starters are an awesome breed. Take Annie Proulx (1935–) of *"Brokeback Mountain"* fame, who at the age of 58 was the first woman to win the prestigious PEN/Faulkner book award for her debut novel, *Postcards*, having spent part of her early career writing "how to" books. This was no flash in the pan for Proulx, and the very next year she won a Pulitzer Prize and the National Book Award for *The Shipping News*. Other literary late starters include provocative columnist and broadcaster Norman Lebrecht (1948–) who received the Whitbread First Book Award for *The Song of Names* at 54, and Booker Prize winner Penelope Fitzgerald (1916–2000) who wrote her first novel at nearly 60. Most famously, Mary Wesley (1912–2002) found fame as a first-time novelist at 70. How did Proulx and Wesley approach issues of work–life balance, in lives filled with marriages, motherhood, early financial struggle and regular day jobs?

Describing the writing process, Proulx revealed, "I find it satisfying and intellectually stimulating to work with the intensity, brevity, balance and word play of the short story", possibly conjuring an image of a privileged life in which opportunities to write any time, for however long, and un-interruptedly were a given. But Proulx who has had three husbands and three sons must have worked hard to attain and maintain the discipline, time management skills and boundaries required to address family responsibilities and to achieve creative space. Maybe she honed her intense writing practices to fit with her domestic and employment situations, or perhaps she is one of those extraordinary older women who have the apparently effortless knack of fitting everything in. Wesley, who turned 19 the year Proulx was born, expressed firm views about work, and about courage, ageing and retirement. In an interview shortly before her death, she snapped, "I have no patience with people who grow old at 60 just because they are entitled to a bus pass. Sixty should be the time to start something new, not put your feet up." Like the unretiring Australian ex-prime minister John Howard (1939–), Wesley had much to say about women and family life too, and would probably have weighed in fearlessly to any discussion around the vicissitudes of work–life balance.

"Women's courage is rather different from men's. The fact that women have to bring up children and look after husbands makes them braver at facing long-term issues, such as illness. Men are more immediately courageous. Lots of people are brave in battle." – Mary Wesley

Barbecue stopper

As an issue, work–life balance divides social and economic conservatives, impinging upon family values, work choices, and men's and women's role in society. Speaking at the Aston Electorate Dinner in Melbourne on 16 July 2002, Howard described the battle many people have to keep work pressures at bay as topic of conversation that could bring a barbecue to a standstill.

"And nothing is more important than the debate that goes on in the community. I call it a barbecue stopper, about the balance between work and family. I find that if you really want to get a conversation going, particularly amongst younger people, you'll start talking about the competing challenges of work and family." – John Howard

Until British sociologist **Catherine Hakim**[1] persuaded the former PM that not all women were the same, he held staunchly, and irritatingly for many men and women, to the view that the gold standard for a functional family was a two-parent arrangement with mother at home, father at work, and children protected from the ghastliness of childcare centres. Hakim turned this around when she explained that there were at least three types of woman ("home-centred", "work-centred" and "adaptive"), and that social policy should acknowledge each, and not expect all women to find happiness at home bringing up children and looking after husbands, as Mary Wesley put it. When Don Edgar of the RMIT Centre for Workplace Change looked into the situation for his book, **The War Over Work**[2], he found that 70% of women *had* to be adaptive out of economic necessity, doing the family-work/paid-work balancing act.

Simplicity

Struggling with competing deadlines, shifting priorities and constant interruptions it was becoming difficult to write coherently on this journey from Proulx, via Lebrecht, Fitzgerald, Wesley, Howard, Hakim and Edgar, and lately to Sogyal Rinpoche. I was almost *waiting* for the next distraction when Claudia from a couple of streets away sidled into my office.

"I've been knocking for ages. You're not busy are you, Caroline?"

"A bit, I'm writing my column."

"But you said you would listen to my talk," she glowered, sixteen going on four. "Mum's minding Peter and she says she can't entertain him and listen to me."

I directed attentive eyes in her direction, composed my best you-now-have-my-undivided-attention face and hoped not to forget how I had intended, seconds before, to integrate the Rinpoche quotation into my piece. It was not worth asking whether it *had* to be now. It had to be now. She cleared her throat importantly, surveyed an imaginary audience somewhere beyond the window, smiled graciously and declaimed, "According to the UK-based Work Foundation, '**work–life balance**[3] is about people having a measure of control over when, where and how they work. It is achieved when an individual's right to a fulfilled life inside and outside paid work is accepted and respected as the norm, to the mutual benefit of the individual, business and society.' What do you think?"

My mind was still on Rinpoche. "It fits perfectly with what I'm writing. Look." She scanned the spiritual master's words.

"Our task is to strike a balance, to find a middle way, to learn not to overstretch ourselves with extraneous activities and

preoccupations, but to simplify our lives more and more. The key to finding a happy balance in modern lives is simplicity."
– Sogyal Rinpoche

"That's that Tibetan guy?"

"It is. He teaches Rigpa Buddhism."

"Rigpa?"

"Rigpa is a Tibetan word that implies 'intelligence' or 'awareness', and, at a deeper level, 'the innermost nature of the mind'. Rigpa aims to present the Buddhist tradition of Tibet in a way that is both completely authentic, and as relevant as possible to the lives and needs of modern men and women."

"Cool." she chirruped. "I like that simplicity idea."

"You don't think it's a simplistic idea?"

"No, I think it's interesting..."

I maintained the attentive visage, even though the word "interesting" had triggered a memory of wise Eleanor Roosevelt. Should Eleanor follow Sogyal? I tracked the idea through as she read me the rest of her talk, and made us both a cup of tea.

Minding Peter

When she had finished extolling the virtues of combining work with further study, flexitime, me-time and job sharing, providing examples of family-friendly work places and wondrously accommodating employers (were they fictional?) of parents with young children she was ready to chat.

"Isn't your mum normally at work today?"

"She took a day off without pay because of Peter."

"Really?"

"Well, Sal had to go to work and Vince is in PNG for another week, and Peter could not go to school because he was playing with this kid who's got impetigo."

"He's not sick then?"

"No, but his teacher reckons he's probably infectious and she doesn't want the whole of Year 1 catching it."

"What's happening tomorrow?"

"Sal says she's taking a day's annual leave to stay home with him because anyway their new ginormous plasma is being delivered and the warehouse could not give her a definite time…"

"And the next day?"

"He'll just have to go to school because mum's coming to my talk and Sal has to be in court. See, she can't justify taking two days off with her career and everything to think of. Not when she's got exams coming up and she's going on maternity leave in 10 weeks time."

"So your mum's actually missing two day's pay. That's quite a good example of what happens when work–life balance comes unstuck, don't you think?"

She looked a little offended. "You sound like dad now – he's always getting dramatic about the high cost of earning a living. But it normally all works perfectly … it's only when something comes up, or someone gets sick that it's **mission impossible**[4]. Sal's a really good manager. Vince says she's got everything organised down to the last detail."

"Who'll collect Peter after after-school-care?"

"Mum and Sal were wondering if you would."

Her mobile rang. "Yeah. Cool. At my mum's friend's house … I've been here hours. When? No, I can't tonight. Mum's got uni and dad's working late and I have to mind my nephew until my sister picks him up. Hang on. I'll ask Caroline if she can come over and look after him."

She shot me a glance and saw the answer on my face. "No, she can't. Maybe some other time. See ya."

She stood up. "Thanks for the tea, um, I didn't mean to put you on the spot about minding Peter. You wouldn't mind listening to it again, would you?"

Good advice

By the time she had gone, following a second and third practice of her speech and more cups of tea, it was dark and the Sogyal Rinpoche idea had gone too. But I did remember the Eleanor Roosevelt quote.

"One thing life has taught me: if you are interested, you never have to look for new interests. They come to you. When you are genuinely interested in one thing, it will always lead to something else." – Eleanor Roosevelt

It was stored away in my head with other snippets of solicited and unsolicited good advice for life and work, sometimes delivered shyly, diffidently or serendipitously as throwaway lines from people whose judgment I trusted. Whether dropped casually into a conversation or thoughtfully explained, most were remembered because they were well-timed. "Have fun along the way; the years go by quickly," someone had said. "Persist, persevere, try hard and never give up," said another. "Hold despair in contempt – keep going." "Learn to say 'no'. As time passes, and you prove yourself, many more people will ask you to do many more things. Remaining active and involved is vital – but know that each time you say 'yes' to something you may be effectively saying 'no' to another opportunity to enjoy using your time and skills." "Look after yourself; pace yourself – avoid burnout – don't take it all, *or yourself*, too seriously." "Collaborate with people because you enjoy working with them, rather than because of a shared interest in a topic." "Set realistic goals and expectations for yourself and for the people you serve." "Avoid toxic relationships." "Time your deadlines so that all your projects don't finish at once. Have several projects at various stages of progress." "Study, work, mentor, teach and write in areas you are passionate about, and give yourself time to think." "Value today." "Listen." "Share."

Roosevelt's observation is the one that has helped the most. Recognising whether the opportunities, openings, challenges and invitations that arise hold the promise of abiding interest is an ability that can be fostered. It comes down to asking questions like, "Am I flattered to be asked, or am I really enthusiastic about this chance?" "Am I tempted to do this just because it might look good on the CV, or is it something that will whet my curiosity and keep me motivated?" Continually "refreshing" our careers, following interests and developing new ones, keeps us excited about the tasks at hand. By not focusing too much on the extrinsic rewards, and appreciating and nurturing the intrinsic incentives of interest, motivation and challenge that work has to offer we may come close to achieving balance.

Links

1. http://www.lse.ac.uk/people/c.hakim@lse.ac.uk/experts.htm
2. http://www.theage.com.au/news/Reviews/The-War-Over-Work/2005/05/27/1117129898877.html
3. http://www.employersforwork-lifebalance.org.uk/work/definition.htm
4. http://www.theage.com.au/news/business/work-and-home-balance--its-mission-impossible/2007/02/16/1171405443406.html

Webwords 30 is at http://speech-language-therapy.com/webwords30.htm with live links to featured resources.

CLINICAL INSIGHTS

Erica Dixon

It seems life as a speech pathologist in the educational setting is very different depending on the region in which you are located. In Student Services of the Highlands Network, Grampians Region, Department of Education and Early Childhood Development in Victoria, we feel privileged to be part of a highly dynamic and innovative multi-disciplinary team of speech pathologists, psychologists, social workers, and visiting teachers (visual impairment, hearing impairment, physical disability, mental health and autism spectrum). The unique drive for entrepreneurship and innovation and co-location of the Student Services team, as well as the service methods has attracted state-wide interest.

In 2005, our service delivery model altered from a cluster model to a centralised system, allowing Student Services staff to be all based in the same office. Since this change we have noticed very valuable professional dialogue both between and within disciplines. This model also means that we are able to have weekly Student Services meetings and speech pathology team meetings which all contribute to team cohesiveness. Our team is managed, supported and inspired by a full time coordinator of student services.

Our service is based in Ballarat in Regional Victoria, but we service a relatively large geographical area (from Inverleigh to Yandoit, to Bacchus Marsh, to Waubra, to Trentham). The distances involved mean that we have to work "smarter" to provide support to our clients, families, schools and school communities.

The types and amount of support that we are able to offer our stakeholders (students, teachers, principals, school communities and families) is vast and highly responsive. Our high level of responsiveness is mostly attributable to our "Consultation and Intake Phoneline". This phone system allows school personnel to contact a member of Student Services from 8:30 a.m. until 4:30 p.m. each school day to discuss options for support for students. Possible referrals to our team are discussed and, where appropriate referral to other more suitable community organisations or professionals is recommended. Schools in our network have reported that they are delighted with the unprecedented support that the phoneline offers them. It has greatly enhanced our relationships with schools and built our skills as individual professionals. The process has also broadened our knowledge of the greater services that our Student Services team provides. The intake system has allowed us to determine the exact number of referrals that we receive. Each referral has greater detail than before this process which allows for an effective triage process. All of this means better service for our clients.

Our caseload consists of children aged from grade prep through to year 12. We predominantly work with children with articulation, fluency and language difficulties. These broad categories are made up of students with cleft palate, hearing impairment, and childhood apraxia of speech, severe language disorder, intellectual disability, autism and other syndromes.

Our team usually offers one-on-one therapy in blocks of 5 weeks (i.e., once a week for 5 weeks) followed by a "break". We have found that this schedule is a much more effective manner of service delivery than our previous fortnightly or monthly service. Subjectively, we have observed that clients can make gains in consolidation during the "break" from direct therapy. This approach has allowed us to provide more frequent and consistent service and increased our discharge rates. This type of service delivery has also increased our sense of job satisfaction and has allowed clients to experience success and the time they need to consolidate their skills.

The changes to funding structures and the increasing demands on our service, as well as the flow-on effects of pressures on Early Intervention services has encouraged our team to seek out and further develop and implement a new oral language program. And this has led to two members of the team to take on a network-funded research project on collaborative approaches to language in the classroom and their own study into the effectiveness of this collaborative approach.

The very nature of communication cannot occur in isolation and the education setting is no exception. The collaborative approach is something that is vital to us and we could not work in schools without the excellent support we get from the teachers, integration aides and other school staff in our schools. The willingness of teachers to provide support for the therapy of their students is always welcome. The enthusiasm that integration aides have when they participate in therapy sessions is also invaluable. This team approach that we take to our students when we work with teachers and integration aides is a vital ingredient in our successful outcomes.

The spirit of collaboration has also lead to the speech pathology team offering a vast array of professional development programs for teachers and aides. We offer early years, middle years and secondary training, as well as cued articulation. School personnel are provided with training and ongoing support to implement the oral language program in their schools. MAKATON and other specific topics for individual schools are also available on request.

Our work environment is changing and the need for work–life-balance is an important concern for us as much as any other setting. The "new" Victorian government Department of Education and Early Childhood Development is in the process of developing new structures and potentially expanding our clinical caseload. The aim is for seamless service delivery from birth to 24 years. Whatever the final outcomes, we see endless opportunities for dynamic thinking on the horizon.

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TOP 10 APHASIA RESOURCES AND REFERENCES

Samantha Siyambalapitiya and the third-year speech pathology students,
James Cook University, Queensland

This latest Top 10 is a set of resources and references with a twist: these references were selected by speech pathology students, some of whom have not yet seen people with aphasia on their student placements. The third-year speech pathology students at James Cook University have been learning about aphasia this semester and were recently asked to seek out a resource or reference that they thought would be helpful in the management of aphasia. This is the list of some of the resources and references that they selected, along with their reasons for choosing them.

1 *Aphasia Info website: http://www. strokesupport.com/info/aphasia/default.asp*

This website is designed for patients with aphasia and their family and friends. It includes information about: what aphasia is, tips for communicating at home, support groups; and access to a free newsletter and aphasia/stroke survivor stories.

The website is easily accessible from an 'aphasia' google search. This is a very realistic way of how patients, family and friends would search for aphasia information. The information was basic and easy to understand and there were many extra links if more information was needed. The 'survivor stories' provide hope for the readers and might be a great motivation for language therapy. Helpful tips on how to communicate with a person with aphasia are also included. Overall, this site a great first step to finding information on aphasia.

2 *Penpals for people with aphasia: http://www.aphasiahelp.org/penpals/*

This website is particularly relevant for those patients exhibiting deficits with reading and/or writing; however, other sections of the website are an excellent educational tool for all people affected by aphasia. The aphasia-friendly site connects people with aphasia from around the globe through a network entitled 'aphasia penpals'. This website is useful and interesting. It allows the person with aphasia to participate in real-life activities and by incorporating this resource into management, the clinician can provide more holistic speech pathology interventions.

3 *Whitworth, A., Perkins, L., Lesser, R. (1997).* **Conversation analysis profile for people with aphasia (CAPPA).** *London: Whurr.*

The *Conversation analysis profile for people with aphasia* (CAPPA) is an assessment tool, based on conversational analysis methodology. It involves a two-part, structured interview with the person with aphasia and their main conversational partner, and a recorded 10-minute sample of conversation in the home environment. The CAPPA examines the relationship between what actually occurs within a conversational exchange, such as opportunities for interaction, repair strategies and so on, and the person with aphasia and their communicative partner's perception of these events. The CAPPA is a useful tool to assist clinicians in improving their clients' functional communication. It identifies conversational strengths and weaknesses in real, everyday, interactional communicative exchanges, which may be used in the development of a functionally relevant and individually tailored intervention.

4 *Cruice, M., Worrall, L., & Hickson, L. (2006). Perspectives of quality of life by people with aphasia and their family: Suggestions for daily living.* **Topics in Stroke Rehabilitation, 13*(1)*, 14–24.**

This qualitative study sought the perspectives of four older individuals with stroke and aphasia regarding what brings them quality in their daily lives. The article includes transcript excerpts from interviews carried out with both the people with aphasia as well as their carer/partner/child. Recurring themes from the people with aphasia included having positive relationships with others, being content with living arrangements, having independence, and participating in meaningful activities. This article is useful for managing aphasia because it highlights the idea that the clinician must gain an understanding of the patient's priorities and goals, as well as the patient's lived experience and individual perspective on stroke and aphasia, in order to plan a meaningful intervention program with a view to obtaining satisfying outcomes.

5 *Pulvermuller, F., Neininger, B., Elbert, T., Mohr, B., Rockstroh, B., Koebbel, P., & Taub, E. (2001). Constraint-induced therapy of chronic aphasia after stroke.* **Stroke, 32: 1621–1626.**

Constraint-induced aphasia therapy is based on similar principles to constraint-induced therapy for the rehabilitation of movement of the extremities in physiotherapy. This approach uses the principles of massed practice (30 hours of training in 2 weeks) and constraint induction (constraints are used to force the patient to perform actions they usually avoid). Constraints include material difficulty, rules and shaping, reinforcement contingencies and behavioural relevance (focuses on actions relevant to everyday life). This approach can be used with patients with chronic aphasia, which is particularly interesting considering that, in many cases of aphasia, there may be little further improvement in the chronic stage.

6 *Cherney, L.R., Halper, A.S., Holland, A.L., & Cole, R. (2008). Computerized script training for aphasia: Preliminary results.* **American Journal of Speech-Language Pathology, 17***(1), 19–34.*

Computerised script training for aphasia discusses the use of computer software for training conversational speech in individuals with chronic aphasia. Individualised scripts are developed for each patient and recorded on the software for them to practise at home. Baseline and post-treatment scripts are audiotaped, transcribed and compared to target scripts for content, grammatical productivity and rate of production of script-related words. The client is required to meet weekly with the speech pathologist to monitor practice and progress. From this study, participants noted four main areas of improvement, including increased verbal communication, improvement in other modalities and situations, communication changes noticed by others, and increased confidence. I particularly liked this approach to therapy as it provides another mode of service delivery, especially for those clients who enjoy and/or find it easier to use computers.

7 *Booth. S., Swabey. D. (1999). Group training in communication skills for carers of adults with aphasia.* **International Journal of Language and Communication Disorders, 34***(3), 291–309.*

Group training in communication skills for carers of adults with aphasia uses the CAPPA (see item 3) and collaborative repair scores to provide carers of people with aphasia with individualised feedback regarding their communication. This feedback is used to improve communication skills and quality of conversation for both the carer and the adult with aphasia. The study presented convincing results in support of this approach in addition to highlighting the importance of involving partners of those with aphasia in the therapy process.

8 *Levin, T., Scott, B. M., Borders, B., Hart, K., Lee, J., & Decanini, A. (2007). Aphasia Talks: Photography as a means of communication, self-expression, and empowerment in persons with aphasia.* **Topics in Stroke Rehabilitation, 14***(1), 72–84.*

This article describes a 5-week course, 'Aphasia Talks', involving five people with aphasia and facilitated by students from a postgraduate design school who were aiming to explore design solutions for stroke survivors. One two- to three-hour class was held each week for 5 weeks with an individual exit interview at the completion of the course. In the first session, participants were introduced to the class structure and provided with a camera and accessories, as well as a wallet-sized card asking permission to take someone's photograph. Over the next three weeks, participants were asked to take 40–50 pictures based on the themes of past, present and future. Of the photos taken, four or five were selected to discuss with the group. Each participant had the chance to stand up in front of the group and present their photos, with a speech pathologist present for each discussion. In the final class, participants discussed the class overall. Exit interviews found that all participants

would take the class again and that they were able to form strong connections with others through greater self-expression. All participants said they would continue taking photos for communication. This approach is different, interesting and a great group therapy idea. It would be useful for working on functional communication and targeting the participation level of the World Health Organization's International Classification of Functioning, Disability and Health (ICF).

9 *Hoen, B., Thelander, M., & Worsley, J. (1997). Improvement in psychological well-being of people with aphasia and their families: Evaluation of a community-based programme.* **Aphasiology, 11***(7), 681–691.*

The therapy approach described in this study consists of two group therapy sessions run simultaneously, one for the client with aphasia and one for their primary caregiver. The group for caregivers provided information, coping strategies and an opportunity to express concerns and emotional difficulties. The group for aphasia clients worked towards changing the clients' approach to new or challenging situations, their attitude towards their diagnosis, the way they deal with emotional difficulties, and providing strategies to maximise communication. Results from the study indicated that both the client and the caregiver experienced an improvement in well-being (measured using an assessment for well-being/quality of life). Qualitative data demonstrated that participants reacted positively to the program. This group therapy approach is useful in that it addresses both interactional and transactional elements to maximise a client's ability to interact and communicate with others. Additionally, the inclusion of a simultaneously run support program for the client's caregiver allows for maintaining healthy home relationships. This approach would be useful for the management of aphasia because changes in lifestyle and self-identity can impact on an individual's motivation for therapy and participation in life. Improving a client's well-being can have positive ramifications across all other levels of the ICF.

10 *Aphasia Beyond Words – Helping stroke survivors with aphasia improve communication; http://ww2.heartandstroke. ca/Images/English/Aphasia_Eng_r3.pdf*

This printable resource gives information about the cause of aphasia and its implications for an individual, and provides functional strategies to facilitate or maximise communication with an individual diagnosed with aphasia. This resource provides strategies to support communication at both the acute and the community-care stage of recovery, and is therefore a valuable resource that can be used during different stages of the recovery process depending on the client and their family's needs.

Third-year speech pathology students

Phillipa Warner	Maree Andrews	Angela Kent
Alison McGann	Jessica Sharpe	Renee Gardner
Elizabeth Hayward	Morgan Dale	Philippa Smith
Danielle St Ledger		

BOOK REVIEWS

Connect – the communication disability network. (2007). *Having a stroke, being a parent.* **London: Connect Press (located at: 16–18 Marshalsea Road, London); ISBN 978 1 906315 01 6; spiral bound, 48 pages; £9.00.**

Deborah Hersh

This guide is part of the Connect Ideas Series and results from a collaboration between Connect – the communication disability network (a UK charity working collaboratively with people with aphasia to address the issues they face) and the Stroke Modernisation Initiative based in Lambeth and Southwark in London. It was funded by the Guy's and St Thomas' Charity. The guide is for parents who have aphasia following stroke, as well as for their families, and it includes a DVD containing six personal accounts of coping with parenting with aphasia. My overall impression from reading this guide and watching the DVD is how useful, practical and positive it is. The accounts are very moving and sensitively produced. They show how, in addition to coping with the life-changing impact of aphasia and stroke, parents have to find ways to continue parenting, maintaining relationships with their children, supporting their development and being actively involved in their lives.

The guide is clearly presented, with key words emboldened, pictures and bullet points. It is full of quotes, advice and tips from parents with aphasia. The guide has six chapters, preceded by a reminder section of the different stages of childhood and what parents have to deal with at each stage from babies to teenagers. The first chapter is about the acute, hospital period and looks at how best to reassure and explain what has happened to children, how to make them feel comfortable with hospital visits, the importance of enlisting help, keeping routines going and coping with the "realisation that their Mum or Dad is not invincible" (p. 16). Chapter 2 is about feelings and attitudes on coming home. It focuses on sadness, anger, fear, guilt and embarrassment reported not only by those with the aphasia but by partners and children. Some quotes are very powerful, like that of the children who kept checking if their Mum was all right because of their fear that she would have another stroke, or the guilt from the parent with aphasia that the children had missed out on their childhood and been forced to "grow up too quickly" (p. 24). Chapter 3 addresses changes in roles and relationships, for example, in family dynamics, in maintaining involvement in children's routines, and in coping with discipline issues. Chapter 4 is full of practical ideas for coping at home and getting support, including asking for help, getting organised, and communicating with the child's school. Chapter 5 is a summary of the positive changes reported by parents following stroke and aphasia. They included a better work–life balance, spending more time with the children, and noticing their children becoming more independent and considerate. The final chapter contains relevant contact information for (mainly UK) agencies and websites, and lists a few useful books for families on aphasia, stroke and caring. This is a great example of collaboration and of learning from the experiences of people generous enough to share their stories and advice. I would recommend it highly as a resource that should be made available, not only to parents with aphasia, but also their partners and children.

Swinburn, K., Parr, S., & Pound, C. (2007). *Including people with communication disability in stroke research and consultation: a guide for researchers and service providers.* **London: Connect Press (located at: 16–18 Marshalsea Road, London); ISBN 978 0 953 6042 8 9; spiral bound, 107 pages; £20.00.**

Deborah Hersh

This guide in the Connect Ideas Series is very clearly written and contains practical ideas and suggestions for involving people with aphasia, and indeed, for people with communication disability more broadly, in research and consultation.

In chapter 1, the authors point out that user involvement in stroke research is becoming a *requirement* of research policy, funding and ethics approval, and not simply an optional extra. They encourage this involvement, not only in relation to giving information, but also in terms of people with communication disability acting as advisors, consultants, steering group members and co-researchers. Chapter 2 explains the different causes and characteristics of communication disability. It draws on Aura Kagan's work at the Aphasia Institute in Toronto by dividing communication into getting messages in and messages out and offers suggestions about how to promote supported conversation. Although such support is time consuming, the authors argue that, with clear preparation, researchers can access the 30% of communication impaired people post-stroke who would otherwise be excluded from studies. Chapter 3 considers recruitment and sampling, making information accessible, consent procedures, and administration. It illustrates each point by offering artefacts in the appendix, examples from a range of previous research projects which have used adapted materials to be accessible to people with aphasia. These artefacts are very useful indeed, for example, in demonstrating the clarity of a well-produced information sheet or in showing the contrast between a standard and adapted consent form. Chapter 4 gives information for successful interviewing with a person with aphasia, including tips about how to deal with the more common difficulties such as communication breakdown, moving away from the topic or being spoken for by a relative. Chapter 5 discusses, in very practical terms, how to arrange, facilitate and minute successful meetings and focus groups. In chapter 6, the authors consider how research findings can be disseminated and evaluated in an accessible way. Not only is this important for those who have participated, but it also forces researchers to be very clear about their findings. The final chapter contains summaries of research projects associated with Connect which have involved people with aphasia. It also lists a few useful contacts and a bibliography.

This guide is written to be useful to researchers and service providers who have no speech pathology background, but I would equally recommend it to speech pathologists and students doing research and consultancy with people with aphasia and communication disability. It encourages reflection and is full of good ideas based on years of experience of many people involved with Connect. This guide should help people with communication disability share their experiences and suggestions, and ultimately should encourage more inclusive and rich research and consultation.

This book describes an aural rehabilitation program suitable for use with older adults with hearing impairment. The book is divided into a number of sections including an introduction, six modules (containing session content and handouts) and appendices.

The six-page introduction describes the research leading to the writing-up of this program, the features of the program, how sessions should be conducted, key communication activities and outcomes of previous research.

The six modules describe the 6 x 2hr sessions recommended for this program. Each module consists of a brief description of the objectives, materials required and an outline of the session. For example, one of the objectives in module 3 is "to identify component skills necessary for better communication around the house" (p. 37). The session outline for this module includes "introductions" and provides participants with an outline of the agenda, examples of communications situations around the house, how and where to practise communication skills, and finally, it discusses individual home situations. Three handouts are provided at the conclusion of this session.

The appendices contain the ACE recruitment flyer, feedback from previous participants and three outcome measures (a modified version of the Client Oriented Scale of Improvement, the International Outcome Inventory-Alternative Interventions (IOI-AI) and IOI-AI for significant others).

Overall, this program is presented in a neat spiral-bound book, and contains photocopiable sheets and a short but useful reference list. The program reflects a strong evidence base (trialled on 178 subjects in a controlled study, previously reported on in numerous references provided at the back of the book), although the inclusion of case study examples would give clinicians guidance regarding application of the program. The handouts are presented in a small font, which might pose difficulties for those adults with visual loss. Clinicians would need to adjust the print size so it is suitable to individual client's needs.

The ACE program is easy to administer and does not require much preparation. It can be conducted by a variety of professionals and appears to be especially useful for SLPs working with clients with hearing loss in either the community or nursing homes. The ACE program is definitely a worthwhile resource to add to one's collection.

Acknowledgement

REFLECTING CONNECTIONS

Antipodean knowledge sharing

Alison Russell and Trish Bradd

Alison Russell, Trish Bradd, Clare McCann, Catherine Epps and Felicity Bright.

Keynote presenter Dr Pamela Snow

After 12 years Speech Pathology Australia and NZSTA rekindled old friendships and came together to share their experience, practice and ideas at the '2008 Reflecting Connections Conference' in Auckland. It was a pleasure planning the Conference with the capable support of our NZ colleagues, Felicity Bright (Co-convenor), Clare McCann (Scientific Program Coordinator) and Catherine Epps (committee member), and the fabulous support of the student helpers during the week.

Dr Pamela Snow's opening keynote presentation about child abuse challenged the audience to consider how speech pathologists can play a crucial role in positioning oral language competence as a social justice and public health issues across the lifespan. Her workshop and second plenary explored the relationship between maltreatment of children, oral language competence and mental health, all key social determinants of health and educational outcomes. Her presentations sparked considerable discussion about how the profession needs to broaden its perspective to include advocacy for children, the consideration of mental health in our practice, and our role in influencing public health policy.

Associate Professor Margaret Maclagan from Christchurch University gave an interactive presentation as the Inaugural Grace Gane Memorial Lecture (NZSTA) which had us contemplating trans Tasman linguistic similarities and differences.

Associate Professor Alison Ferguson

Associate Professor Alison Ferguson presented the Betty Usher Memorial Lecture on the Discourse of Speech-Language Pathology and challenged us to critically reflect on the discourse of speech pathology.

There were a number of opportunities for people to get together and share ideas with special interest group and member network lunches a particular highlight.

The CPC was delighted to have the support of the conference sponsors and the exhibitors who made a particular effort to bring their displays to New Zealand.

The Gala dinner proved to be a social highlight with an impressive range of "bling" on display, not to mention

Associate Professor Margaret Maclagan with Stella Ward.

dancing which was up to the usual high standard! Despite some dysphonia the next day, delegates turned out in full force for the action packed final day.

The Adelaide Conference was launched at the Gala dinner with delegates decked out with glow bracelets. We passed the baton to the Adelaide CPC and look forward to seeing you all in Adelaide in May 2009.

Gala Dinner dancing

2008 REFLECTING CONNECTIONS CONFERENCE

Patricia Bradd - Fellowship Award

Patricia McCabe - Recognition of Service Award

Loraine Fordham - Recognition of Service Award

We thank Sue Horton the VPO Councillor who retired from Council as of the AGM

Speech Pathology Australia launches their new Corporate Identity

Speech Pathology Australia Councillors

Natalie Ellston, Caroline Huze, Jade Cartwright and Beth King enjoy a drink at the Conference Dinner

Thank you to our hard working volunteers

The Conference Dinner 'bling' winner Michelle Watt

Gail Mulcair, CEO and Debbie Gower, 2008 Conference Manager

Speech Pathology Australia exhibition stand

Nestlé Nutrition exhibition stand

The Powhiri Ceremony at the Welcome Drinks

ACQ NOTES TO AUTHORS

*A**CQuiring Knowledge in Speech, Language and Hearing* is a major publication of Speech Pathology Australia and provides a professional forum for members of the Association. Material may include articles on research, specific professional topics and issues of value to the practising clinician, comments and reports from the President and others, general information on trends and developments, letters to the Editor and information on resources. Each issue of *ACQ* aims to contain a range of material that appeals to a broad membership base.

ACQ is published three times each year, in March, July and November.

Issue	Copy deadline (peer review)	Copy deadline (non-peer review)	Theme*
November 2008	9 May 2008	11 July 2008	Intervention – why does it work and how do we know?
March 2009	21 August 2008	16 October 2008	TBA
July 2009	2 January 2009	5 March 2009	TBA
* articles on other topics are also welcome			

General

Material submitted must be your original work. Any direct quotations or material used from other sources must be credited in full. If copyright clearance is required to use material included in your article, please supply evidence that this has been obtained.

With rare exceptions, we do not publish material that has already been published.

Articles will be checked by a copy editor to ensure consistent presentation and standard of English.

Length

Articles should not usually exceed 2500 words (including tables and references). This is equivalent to approximately 11 double-spaced pages. Longer articles may be accepted, at the discretion of the editors.

Format

The article should be submitted electronically via email (as an attachment). One hard copy and a copy on disk (preferably in Microsoft Word) is required if the article contains symbols (e.g., phonetic font).

The title page should contain the title of the article, the author's name, profession, employer, contact phone number and correspondence address, as well as a maximum of five key words or phrases for indexing.

The format must be double spaced with 2.5 cm margins, in a serif face (such as Times or Courier), each page numbered sequentially.

CDs must be clearly marked with file name, author's name and program used, including version number and whether PC or Macintosh (e.g., MS Word 2000 IBM). Each table or figure must be in a separate file on the disk. Do not incorporate figures or tables within the text of the article. Formatting must be kept to a minimum. Do not use tabs, bold or other highlighting of the text. References must appear at the end of the article. The first line of each paragraph should be indented. Do not right justify the text. Use one space after punctuation, including full stops. Double quotes should be used.

Peer review

Articles submitted to the *ACQ* may undergo a peer review process if: (a) requested by the author(s), or (b) requested by the editor.

If peer review is requested, the article will be sent to two reviewers. The authors will be provided with information from the review process and will be invited to revise and resubmit their work if this is indicated. The sentence "This article was peer reviewed" will appear after the title for all peer reviewed articles.

Style

Clear and concise writing is best. Use short sentences and paragraphs and plain English.

Reproduce any quotations exactly as they appear in the original and provide the page number(s) for the pages you have quoted from.

References, which should be kept to a minimum, should follow the American Psychological Association (APA) (2001) style.

The title should be kept as short as possible.

Headings should be short. Within the article a maximum of two levels of headings should be used. For first level headings use all capitals, centred with one line space above and one line space below. For second level headings use a capital letter for the first letter of the first word only, centred with one line space above and one line space below.

Tables and figures

If there are to be tables or figures within your article, these should be printed on separate sheets with a clear indication of where they are to appear in the article. All tables and figures should be numbered. Figures should be presented as camera-ready art. Each table or figure must be in a separate file on the disk. Do not incorporate tables or figures within the text of the article. Digital images should be sent as uncompressed TIF or EPS files.

Abstract

Please include an abstract of approximately 100 words describing your article.

Biographical information

Please include approximately 15 words about yourself and a clear photograph of yourself. This can be a casual or formal shot. A good quality print or slide is acceptable. These should be labelled with your name on a sticky label on the back. To avoid impressions damaging the back of the photo, write on the label before it is attached to the photo. Digital photos should be uncompressed TIF or EPS files.

Article submission form

If your article is accepted for publication, it will only be published if the "Article Submission Form" and "Copyright Warranty and Assignment" are completed and signed (please contact National Office for these forms) or go to **http://www.speechpathologyaustralia.org.au/acqnotes.html**

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