



Speech-Language & Audiology Canada
Orthophonie et Audiologie Canada
Communicating care | La communication à cœur

SAC Position Paper on

The Role of Speech-Language Pathologists with Respect to Augmentative and Alternative Communication (AAC)

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A position paper represents the direction SAC has taken on a particular topic or provides guidelines for particular areas of practice. These positions are time-bound, representing the thinking at a particular point in time.

Position

It is the position of Speech-Language and Audiology Canada (SAC) that all speech-language pathologists (S-LPs), regardless of their work settings, should have basic knowledge of the augmentative and alternative communication (AAC) tools and strategies that can support the expressive and receptive communication needs of their clients. All S-LPs should be prepared to apply their knowledge of AAC strategies in the course of assessment and intervention. S-LPs also have a responsibility to refer to specialized AAC services where required.

Recognizing that some AAC interventions involve complex technology and require access to specialists, SAC advocates for ready access across Canada to specialized, interprofessional AAC services in order to ensure that all clients, regardless of the complexity of their needs, are well served.

Rationale

Communication is essential to participation in life, including meaningful social, learning and vocational activities across one's lifespan. AAC tools and strategies can play an important role in enabling individuals with limited or no speech to live independent, dignified lives, commensurate with their abilities and desires.

Because individuals who require augmentative and alternative communication represent a highly diverse but low incidence population (Beukelman & Mirenda, 2012a), AAC is a domain of speech-language pathology that may be relatively unfamiliar to many S-LPs. Students in speech-language pathology frequently receive minimal education or training in AAC (Hurtig, 2013). Consequently, many S-LPs report discomfort or a lack of confidence when assessing an individual who requires AAC (Marvin, Montano, Fusco, & Gould, 2003; Dietz, Quach, Lund, & McKelvey, 2012).

Generalist S-LPs may find themselves increasingly involved in AAC interventions due to a number of converging factors. First, national and international efforts to make society more inclusive continue to gain speed. The United Nations Convention on the Rights of Persons with Disabilities recognizes the importance of ensuring accessibility to effective means of communication, including AAC. Accessibility legislation now exists in Canada that specifically addresses communication needs. For example, the 2005 Accessibility for Ontarians with Disabilities Act has mandated accessibility standards, applicable to both public and private organizations, to ensure all residents have equal access to information, regardless of disability. In Manitoba, similar legislation, the Accessibility for Manitobans Act, came into force in 2013.

Attempts to address organizational and other barriers to full participation have come alongside changes in legislation. For example, Communication Disabilities Access Canada (www.cdacanada.com), a national non-profit organization that promotes human rights and accessibility for individuals with communication disabilities, has, in response to documented needs (Collier, Blackstone, & Taylor, 2012), developed a number of initiatives that support businesses and organizations in becoming more accessible to individuals with communication disabilities, including access to essential services such as legal and justice services.

Additionally, in health-care settings, there is growing recognition that effective communication between the provider and recipient of care is critical to patient safety and quality care. One recent study found that hospital inpatients with a communication disorder are three times more likely to experience a preventable adverse medical event than those without, resulting in extended hospital stays, readmissions and other negative sequelae (Bartlett, Blais, & Tamblyn, 2008). The Joint Commission, the largest US hospital accreditation organization, now considers effective patient-provider communication, including access to AAC systems at all points along the continuum of care, as a criterion for accreditation (Joint Commission, 2010).

Concurrently, the adoption of relatively affordable mainstream consumer technology, such as tablets and smartphones, for use as speech generating devices (SGDs) has transformed the field of AAC. Until very recently, the cost of an SGD was prohibitive for many families. Now, individuals who use AAC, along with their families, can often afford to purchase a tablet and communication software independently. This has led to an increase in the number of individuals with access to high-tech AAC systems (Niemeijer, Gosnell Caron, Marden, & Shaham, 2012). It also presents a challenge to S-LPs: they no longer play a gatekeeping role in determining who might access funding for an SGD to the same degree as they did in the past. While this can be seen as empowering for families, it also increases the risk that technology will be selected in the absence of appropriate assessment or intervention planning. Regardless of the technology options available, or their cost, the importance of careful clinical decision-making cannot be overstated.

With growing demand and recognition of the role that AAC can play in supporting greater life participation, there comes a new urgency in providing guidance to all S-LPs regarding their roles in AAC interventions.

Background

AAC interventions are appropriate for individuals who are without functional speech either permanently (Millar, Light, & Schlosser, 2006) or temporarily (Hurtig & Downey, 2009).

AAC tools and strategies can help ensure that an individual can communicate successfully while receiving therapy aimed at restoring natural speech (Weissling & Prentice, 2010).

For individuals whose communication needs cannot be met through speech alone, there are many potential benefits to employing AAC tools and strategies including: an increase in the amount and complexity of language that can be produced relative to unaided speech; access to more effective methods for acquiring and demonstrating knowledge; greater social acceptance and inclusion; heightened self-esteem and motivation; an expansion or maintenance of viable communication partners and environments (Beukelman, Garrett, & Yorkston, 2007); stronger interpersonal relationships; increased productivity; and access to a greater range of vocational and academic opportunities. These outcomes ultimately translate into an enhanced quality of life.

AAC interventions are often most successful when delivered in an interprofessional manner. This is especially true in the case of clients who present with physical, sensory and/or cognitive disabilities in addition to any speech or language impairments. S-LPs should have a basic knowledge of the roles and responsibilities of other professionals as they pertain to clients who require AAC, including but not limited to occupational and physical therapists, psychologists, teachers and rehabilitation engineers.

AAC systems should be developed in consultation with the client, family members, caregivers and other stakeholders in order to ensure that the system will meet the client's communication needs and abilities and be functional in the client's typical environments.

Although no standardized tests can directly identify the type of AAC system an individual requires, AAC interventions can and should be delivered with the same rigour that is applied to other areas of clinical practice. The goal of an assessment is to identify a client's strengths and abilities and to develop a strategy for building on those strengths. Depending on the client, an assessment may include evaluation of a client's current abilities and needs in areas including language, literacy, mobility, physical access, hearing and vision (Beukelman & Mirenda, 2012b). An assessment should also consider a client's current and future language development and communication needs and goals across environments and communication partners. It is clear that the areas examined during a complex AAC assessment transcend the boundaries of any single discipline. For that reason, an interprofessional approach to assessment and intervention is critical to achieving positive client outcomes.

Assessments are typically guided by frameworks such as SETT (Zabala, 2005), the Communication Matrix (Rowland, 2012), the Participation model (Beukelman & Mirenda, 2012c, p. 109) and Social Networks theory (Blackstone & Hunt Berg, 2003a; Blackstone & Hunt Berg, 2003b).

In determining the most appropriate interventions for a client, AAC specialists frequently attempt to situate a client on the continuum of communicative independence (Dowden, 1999). The continuum ranges from emerging communicators (i.e., those who communicate about the 'here and now' using means such as gesture or facial expression) to independent communicators (those who are able to communicate on any topic with any partner). The midpoint on the continuum is the context-dependent communicator who is able to communicate in a symbolic manner, provided the message content and/or communication partner are familiar. AAC strategies are a valid means of supporting clients at every point on the continuum, including those who may always require partner support to enjoy communicative success.

Recommendations

The recommendations below are intended to provide general guidance to S-LPs whose clients may benefit from AAC interventions. Because AAC tools and strategies can be effectively incorporated into a wide range of clinical settings with an array of clients, the list of recommendations below is very general and broadly organized. S-LPs are strongly encouraged to seek further information specific to their own clientele.

The recommendations below are organized by client population or need. Recommendations under the "Universal" heading apply to all clients.

Universal Recommendations

1. Adopt a client-centered approach that recognizes the client and, where appropriate, family/caregiver as critical members of the care team.
2. Recognize that there are no minimum linguistic or other prerequisites to introducing AAC tools or strategies of some kind (Kangas & Lloyd, 1988).
3. Develop basic knowledge related to:
 - a. AAC tools and strategies for supporting comprehension, including visual schedules, picture and written supports for spoken language, use of picture albums and modeled use of a client's own AAC system.
 - b. AAC tools and strategies for supporting expressive communication, including object- or picture-based choice making, communication displays, alphabet boards, symbol- and text-based speech-generating devices and alternative access methods.
 - c. Unaided communication strategies for supporting expression and comprehension, including pointing, looking, vocalizing, gestures, signs, facial expressions and body language.
 - d. Partner communication strategies, including yes/no tagging and written choice presentation (Garrett & Lasker, 2013), partner-assisted scanning and the use of communication passports/dictionaries (see, for example, <http://www.communicationpassports.org.uk> for information).
 - e. Modeling as a strategy for improving comprehension and expressive communication abilities (i.e., Aided Language Stimulation) (Goossens, Crain, & Elder, 1992).

4. Give consideration to the full range of a client's communication needs, abilities and functions (Light, 1989), including requesting, sharing information, observing etiquette and maintaining social relations.
5. Consider all four areas of communicative competence: operational, linguistic, social and strategic (Light, 1989; Light 2003).
6. Address a client's real world face-to-face communication needs. Where required by the client for social or vocational reasons, an AAC system should also address distance and electronic communication needs (e.g., telephone, email and social media).
7. Design AAC systems in a way that supports opportunities for meaningful participation in activities across environments (e.g., home, school, rehab setting and the community).
8. Recognize that interventions that target communication partners, thereby creating opportunities and expectations for meaningful communication, are an inherent feature of AAC service provision (Ball & Lasker, 2013).
9. Develop AAC systems that are multimodal, if needed, in order to accommodate a client's communication needs in different environments, with different partners or as physical abilities change throughout the day.
10. Consider low-tech (non-electronic) AAC supports for expressive communication and comprehension. Low-tech supports, including communication displays and alphabet boards, can serve as a backup to a high-tech system, as a primary AAC tool or as one component of a multimodal system for use with certain communication partners or in certain contexts.
11. Include, wherever possible, one or more equipment trials prior to making a purchase decision.
12. Select equipment through a process of feature matching, where a client's needs are aligned with the hardware, software and linguistic features of an AAC system (Shane & Costello, 1994, as cited in Costello, Shane, & Caron, 2012).
13. Obtain information from vendors regarding software, equipment and resources, as required. However, do not rely on vendors for clinical decision making.

Recommendations for AAC and Literacy

S-LPs should:

1. Make every effort to provide a system that includes access to spelling for clients who have some literacy skills.
2. Support literacy development in children and adults who use AAC. Literacy plays a critical role in academic success and in gaining meaningful, satisfying employment (Erickson, 2003; McNaughton & Richardson, 2013). Literacy is also essential for autonomy in daily personal affairs, such as shopping, banking or making health-related decisions. It is also valuable in leisure and for quality of life.
3. Advocate and facilitate literacy development for the purpose of face-to-face communication (Light & McNaughton, 2013; Light et al., 2005). The development of literacy skills, including the use of spelling, empowers adults and children who use AAC to fully express themselves through the generation of novel messages. Spelling is the most powerful generative language method.

4. Consider the use of compensatory supports during early stages of literacy development or on an ongoing basis, depending on the needs of the client.
5. Ensure that goals related to language and literacy development are reflected in the design and implementation of an AAC system (Sturm & Clendon, 2004; Fallon & Katz, 2008).

Recommendations for AAC and Children

Services for children who require AAC are complex because S-LPs are not only introducing a new communication tool with a new symbolic vocabulary, but also supporting the development of language in general. Therefore, S-LPs serving children who require AAC should:

1. Introduce AAC early, especially to promote receptive language development and provide immersion in the AAC system (Kangas & Lloyd, 1988; Ronski & Sevcik, 2005).
2. Ensure an AAC system is designed to meet the child's immediate communication needs and also to facilitate further linguistic development (Beukelman & Mirenda, 2012d; Goossens' et al., 1992).
3. Act on the knowledge that AAC does not inhibit natural speech development (Millar et al., 2006; Ronski & Sevcik, 2005).
4. Ensure the child has abundant opportunities to observe proficient use of an AAC system (Ronski & Sevcik, 1996). This will ensure that the child using AAC, like his or her typically developing peers, benefits from observing fluent communication in his or her own expressive modality.
5. Work in conjunction with a child's family, teacher and other professionals to ensure that AAC recommendations are consistent with language, learning and other goals. In schools, these goals would often be identified in a student's individualized education plan.
6. Analyze the communication and participation skills and patterns of the child's peers to inform vocabulary and implementation planning (Ball et al., 1999; Banajee, Dicarolo, & Stricklin, 2003; Fried-Oken & More, 1992).
7. Consider core vocabulary needs to ensure a combination of developmental, environmental and functional vocabulary is included in the child's system (Banajee et al., 2003).
8. Support a child's communication partners in knowing how to use the AAC system and how best to interact with the child using the system.

Recommendations for AAC and Adults

Adults' communicative function can be impaired due to acquired or congenital impairments, sometimes resulting in changes that require consideration of new communication environments and partners, and education on the social, operational, strategic, and linguistic competencies required for communicating effectively using one or more new methods (Light, 1989). As a result, S-LPs serving adults who require AAC should:

1. Work with clients and their communication partners to explain new communication methods, describe how those methods can be of benefit and demonstrate their use (Thiessen & Beukelman, 2013).
2. Implement AAC systems in a way that is minimally disruptive to a client's established patterns of behaviour and involve the client in decision making to the greatest extent

possible. Doing so is likely to facilitate adoption of the system and reduce the risk of abandonment.

3. Anticipate and plan for changes in physical, cognitive or other functions when serving clients who have progressive diagnoses such as ALS or primary progressive aphasia (Ball, Beukelman, & Bardach, 2007; King, Alarcon, & Rogers, 2007).
4. Consider AAC systems for adults who have short-term needs, e.g., due to tracheostomy (Zubow & Hurtig, 2013), or who are undergoing therapy to recover natural functional speech and require a temporary system (Weissling & Prentice, 2010).

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