Augmentative Communication News

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INSIDE THIS ISSUE . . .

Over the past few years I have grown increasingly reluctant to talk (or write) about the "A" thing—Assessment in AAC. One reason is because what I actually do during an augmentative and alternative communication (AAC) assessment looks less and less like the comprehensive approaches described in assessment protocols and book chapters. . . some of which I authored or edited. Gasp!

The AAC field as a whole has moved sharply away from traditional models of service delivery to more community based, collaborative approaches to intervention. Observations made outside a clinical setting have changed our perceptions about what is important and are affecting our assessment practices. It is time to embark on a serious dialogue about the AAC assessment process. In this issue we begin to scratch the surface by asking, "What is the perceived value of AAC assessments? What do various stake holders expect? What is the assessment process as it varies across the life span and for different populations? What should we be measuring?" Thanks to those interviewed for sharing their knowledge and opinions. (See **Resources** and **References** on page 8.)

For Consumers considers the perspectives of participants (or stakeholders) *(cont on page 2)*

For Consumers

AAC assessment: Stakeholder views

Do professionals, consumers, their families and friends, and providers perceive AAC assessments in the same manner? Probably not! Documented examples of differing expectations are:[1]

- #1: **Client**: Feels his alphabet board is adequate.
  Spouse: Wants a laptop computer as an AAC system.
- #2: **Parent**: Wants an outside agency to purchase the Lightwriter because parent believes child can use system.
  Therapist: Believes child would not use device after novelty wears off. Recommends rental of device.
- #3: **Client**: Wants computer for writing and communication.
  Therapist: Wants device for communication only.

Let's consider the process of assessment from the perspective of various stakeholders.

Consumers

One day, an event occurs which causes a severe disruption to your body. This event (e.g., birth, an aneurysm, accident, or disease) propels you into a series of interactions with professionals (mostly physicians). Ultimately, you are diagnosed. You and your supporters gradually learn of the devastating impact this "event" has had, and will have, on your ability to communicate. A long, undesired journey begins.

Irrespective of whether your diagnosis is cerebral palsy, amyotrophic lateral sclerosis, stroke, autism, developmental delay or traumatic head injury, you and your supporters will participate in an ongoing series of assessments conducted by professionals from an increasing number of disciplines. While goals will vary depending on your diagnosis, your age, and the severity and course of your problem, initial intervention probably will focus on ways to remediate your deficits.

In fact, by the time you are referred for an AAC assessment, everyone already knows you have a severe communication impairment that isn't likely to resolve anytime soon. Most professionals and family members understand why your speech is severely impaired and what other problems you might have. Whether that first AAC assessment takes

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(**UPFRONT** continued from page 1)
in the assessment process. **Governmental** uses a Taxonomy of Disability to clarify goals in AAC assessment. **Clinical News** synthesizes information from master clinicians about what they are thinking and doing. The **Equipment** section gives reasons why a loan program should be an integral part of device assessment, and **University/Research** brings forth a suggestion. Finally, please read page 7. I am very excited about our new publication, *Alternatively Speaking,* which is written by Michael B. Williams, an AAC consumer.

Sarah W. Blackstone, Ph.D., Author

For Consumers *(cont. from page 1)*

place in a hospital, rehabilitation center, your home or your school, it almost certainly won't be your last. A long, undesired journey has begun, but things are looking up.

Natural Supports

Communication problems are experienced by everyone who interacts with someone who has a severe speech impairment. Supporting roles chosen by family and friends will depend upon the age, competencies, personality, resources, and preferences of all involved. Roles will vary over time. Supporters also have stresses in their lives. Complex family dynamics and financial difficulties can easily override concerns about communication. Supporters bring their own agendas to AAC assessment, which may (or may not) be consistent with the agendas of the consumer, professionals, etc.

Professionals

AAC professionals (e.g., clinicians, engineers, manufacturers) generally work in teams. They see hundreds of individuals with severe communication problems, and are familiar with a range of tools, strategies and techniques. Their opinions often are highly valued. However, these "experts" can focus on only one individual at a time, and then only for very brief periods. AAC intervention is time-intensive, ongoing, environmentally based, and often technologically complicated. Thus, other professionals and support persons often must carry out AAC team recommendations. No wonder community professionals feel overwhelmed! They may not know what to do when something does not work, or what to do next when something does! AAC specialists, on the other hand, may feel swamped by the amount of work they need to accomplish. If only there were 100 hours in each day!

Providers/payors

Agencies, governments, and institutions who pay for AAC assessments expect them to be done in a cost effective manner. They look for *functional outcomes* and *consumers who are satisfied* with services/technologies provided.

In Summary

Participants bring different perspectives to the AAC assessment process. However, only one group of them is always present at an assessment—the consumer. Shouldn't consumers (and those who support them) be taught to be active participants in the assessment process from its onset? **Shouldn't they take charge of the assessment process?**

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Author: Sarah W. Blackstone Technical Editor: Carol Krezman

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Governmental

The purpose of AAC assessment

What—exactly—is the purpose of an AAC assessment? To get a sense of current thinking from the field, I spoke with communication specialists who said:[2]

- To develop functional communication and use of language across environments.
- To help a person manage communication.
- To provide ways (services and tools) for an individual to develop or retain his/her memberships and roles in family and community.
- To determine current, functional communication abilities and potential expressive options so persons can communicate better.

A Broad Perspective

Table I presents definitions and critical indicators from Nagi's Taxonomy of Disability, a widely accepted permutation of the World Health Organization's approach to classifying disabilities.[3,4] This framework can assist in our international effort to clarify AAC assessment issues. According to Nagi, one need not go beyond examining a person to identify the presence and extent of his/her pathology, impairment, and limitations in function. Communication, by its very nature however, is a relational concept. Thus, AAC intervention lies primarily at the level of Disability. Our unique challenge is to increase functional communication and assist people to develop or retain their connections with family and their memberships in society. Assessment efforts therefore should focus primarily on indicators at the level of Disability.

Table II uses *Dysarthria* (i.e., difficulty speaking caused by paresis of the oral mechanism) as an example of Nagi's continuum across levels. Historically, professionals have focused most of their time and expertise at the levels of Pathology and Impairment. Not

TABLE I. Taxonomy Of Disability: Definitions and Indicators (based on Nagi, 1991)				
	Pathology	**Impairment**	**Functional Limitation**	**Disability**
Definition	Interruption/interference with normal processes. Efforts of organism to regain normal state.	Anatomical, physiological, mental or emotional abnormalities or loss.	Limitation in performance at the level of the whole organism or person.	Limitation in performance of socially defined roles and tasks within socio-cultural and physical environments.
Indicator	Found in attributes of individual.	Found in attributes of the individual. Observed in symptoms and signs.	Found in attributes of the individual. Observed in limitations in various activities such as reasoning, seeing, hearing, talking, walking.	Found in relations and the conditions in the socio-cultural and physical environment. Observed in limitations in ability to function within roles and tasks related to family, work, community, school, recreation, self care and so on.

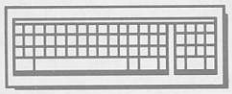
surprisingly, most available assessment tools in communication disorders address indicators at those levels. Also, professional training programs have emphasized intervention at these levels.

> In graduate school, I was taught to observe and measure semantic, syntactic, phonologic, and pragmatic aspects of an individual's language, and to assess speech-motor behaviors, articulation, phonological processes, voice and hearing. Results of these component analyses enabled me, as a speech-language pathologist, to diagnose, describe different types of dysarthria and suggest ways to remediate problems. However, these data told me nothing about how to help a person who was unable to speak manage everyday communication tasks, never mind participate in a regular education classroom or employment situation using AAC devices/techniques.

Nagi's taxonomy makes it easy to understand why the field of AAC was due to emerge. Within the past two decades, an international shift in emphasis has occurred across health care, education, and social-based programs. Disability rights movements and technology have challenged long-held mind sets and moved people with disabilities into the mainstream of their families, communities and society. An increasing number of public policy mandates and laws now insure the stability of this shift. People with severe communication problems need help to participate in conversations, express opinions, talk on the phone, write, go to school, maintain a job, live independently, and so on. AAC is the intervention area charged with solving these communication problems. As such, the primary focus in the field of AAC is at the level of Disability with a secondary focus at the level of Functional Limitation.

AAC intervention shall be judged as successful (or not) on the basis of what consumers, professionals, funding agencies, and the general public perceive as the value of our services, technology, and tools. Assessments provide the information needed to plan and implement interventions that lead to successful outcomes. At the level of Disability, the consumer and his/her partners have the information most essential to the assessment process. We need valid, reliable ways to measure these critical indicators.[5,6] However, we are simply not oriented—at least not yet—to assess people at the level of their disability—where it counts the most!

TABLE II. Taxonomy Of Disability: From an AAC Perspective				
Dysarthria	**Pathology**	**Impairment**	**Functional Limitation**	**Disability**
Indicators	**Cellular/tissue level.** Brain damage in areas affecting movement of tongue, lips, velopharynx, jaw, respiration.	**Subsystem level.** Paralysis or paresis resulting in difficulty moving or coordinating organs of speech.	**Individual performance level.** The impact of speech impairment on the ability to carry out daily activities.	**Societal level.** The impact of severe speech impairment on person's choices, quality of life, and relationships.
Primary Intervention Goals	Reduce underlying pathology in a person.	Decrease paralysis in person. Restore use of oral structures.	Decrease impact on daily life. Increase functional communication skills to meet daily needs.	Increase participation, opportunities, friendships, successful interactions. Remove barriers.
Assessment Tools	Physical exam, CT scan, EEG, MRI, PET scan, observation during surgery.	Tests of strength, range of motion, control of structures related to speech. Articulation tests.	Articulation, speech intelligibility measures. Tasks to measure use of symbols/signs, devices, rate enhancement strategies, etc.	Interviews and observations to identify opportunities and barriers, determine expectations, identify tasks, define socio-cultural and physical environments and measure whether AAC tools, techniques and strategies make a difference in a consumer's life.
Assessors	Physicians, researchers, laboratory technicians.	Physicians, rehabilitation and habilitation specialists.	Rehabilitation/educational specialists, assistive technology teams, manufacturers, family, consumer.	Rehabilitation/educational specialists, assistive technology teams, manufacturers, job coach, employer, instructional assistant, family, community helper, consumer.



Equipment

Equipment loan programs: A rationale

One common misconception is that an AAC assessment is synonymous with the question "What device should we buy." It isn't. While equipment recommendations are appropriately embedded in the AAC assessment process, they are rarely the sole focus of an AAC assessment. Exceptions are:

- a community team asks an AAC team to address specific questions (e.g., best means of access to a device).
- an individual who is computer literate and cognitively intact requests a device recommendation only. People with amyotrophic lateral sclerosis sometimes approach AAC assessment in this manner.

While there are no prerequisite skills for communication other than being conscious,[7,8] there are prerequisite skills for using specific communication devices, signs, and graphic symbols, and for pointing to letters to spell words, for hitting a switch to select a scanned message, and so on. There are also psycho-social and cultural variables that heavily influence a person's use of assistive technology.[9] Just because someone can use a device does not mean he or she will use it to communicate. Studies on the abandonment of technology, and the personal experiences of AAC team members have made many professionals reluctant to recommended purchasing a communication device until after a person has had an opportunity to use it in everyday life. Currently, this is difficult to arrange.

Many AAC manufacturers do rent devices. Equipment loan programs are another option. Since 1987, the Los Angeles Unified School District, the second largest in the U.S., purchased more than 250 AAC devices for students. Many devices had been abandoned or were not being used to the fullest extent possible. Reasons identified were:[10]

- Technology selections were often based on what professionals' believed was correct. The consumer and family were expected to agree.
- Decisions were based on equipment the clinician knew how to use or favored.
- Lack of attention was paid to psychological and social aspects of assistive device selection and use.

With growing concern, the district implemented a Device Loan Program. Since 1989, 152 students have participated prior to a device being purchased. In her presentation *How good is our first guess?* Cindy Cottier reported the results of a retrospective study of 76 students for whom devices were recommended during the 1991 and 1992 school years.[10] Recommendations were based on the district's Augmentative Communication Team (ACT) matching the students' capabilities and needs to the features of devices. Devices considered most appropriate were then loaned to students for approximately two months with the Augmentative Communication team (ACT) providing consultative support.

TABLE III. Breakdown By Disability and Ages

Orthopedic handicap (45)	Aphasia (2)	Autistic (6)	TMR (14)	Multi-handicap (9)
21 elem. 14 middle 10 secondary	2 elementary	6 elementary	8 middle 6 secondary	3 elementary 4 middle 2 secondary

Table III gives information about the ages and disabilities of the students participating.[11] To summarize, students ranged in age from 5 to 22 years and attended both regular education (N=49) and special education (N=27) campuses. Disabling conditions included cerebral palsy, autism, mental retardation, severe language impairment (aphasia) and multiple handicaps. In addition to consultative support from the ACT program, nearly half (42) of the students had one-on-one instructional assistants. Seventy (70) received speech therapy at school, and 25 had private speech therapy.

TABLE IV. Devices Purchased By Age/Grade Level

Devices Purchased For Students	Elem = 32 (5 yrs - 13 yrs)	Middle Sch.=26 (12 yrs - 15 yrs)	High Sch.=18 (15 yrs - 22 yrs)
Original device N=24	20 (63%)	4 (15%)	0 (0%)
Different device N=34	8 (25%)	16 (62%)	10 (56%)
No device N=18	4 (12%)	6 (23%)	8 (44%)

Twenty (20) different AAC devices were ultimately purchased from 10 different manufacturers. Data in Table IV shows less than one-third (24/76) of the devices originally recommended by the ACT were subsequently purchased for the students.[11] An additional 34 devices were purchased after 2 to 5 devices had been evaluated through the loan program. For 18 students, no device was bought. Closer examination of these data reveals the team's original recommendations were more likely to be confirmed with younger students. For example, original devices were purchased for 63% elementary school children, compared to only 15% of middle school and 0% of high school students. Devices which were not originally recommended by the ACT were purchased for 56% of the high school, 62% of middle school, and 25% of elementary students. Cottier[11] concludes that during the assessment process we need to pay more attention to determining:

- If the student is willing to use a device, not just able to use it.
- What the student and parental interest, motivation and attitude are toward the device.
- What the student and family priorities are. For example, high school students were focused on academics, not communication. Many wanted writing systems only.
- The actual strength of a student's support system.

Clinical News

What master clinicians do and think

I believe Carol Goossens[12] was first to write about a case wherein traditional assessments came after, rather than preceded, AAC intervention.[1] A young girl from Vietnam with severe cerebral palsy did not speak or seem to understand language. Traditional assessments were not possible because of second language issues, her lack of speech and her lack of a reliable response mode. Was AAC intervention delayed until her functional status could be determined? Of course not!

The decision to intervene in AAC is not dependent on a person's cognitive, motor, speech, language, or sensory abilities. In fact, the very tools and techniques used in AAC can circumvent even the most severe impairment. The desired outcome of each AAC assessment, then, is to *get started* and make progress so the individual can communicate and thus, realize his or her goals and aspirations. In the case of the young girl, an Etran was introduced. She was taught to eye point to symbols during play activities. Parallel switch training began for computer access. Over time, other things about her became obvious because she learned symbols quickly and used them appropriately. See Goossens' article for a complete description.[12]

AAC professionals rarely begin an intervention knowing a fraction of what they'd like to know. Assessment is the vehicle used to develop a "working hypothesis" about where to start, and once the process is underway, what to do next. Since the assessment process can seem overwhelming, I asked master clinicians, what they really do during an AAC assessment and why. Table V summarizes their responses. The Table and related discussion on page 6 are an effort to consolidate the vast amount of

TABLE V. ASSESSMENT IN AAC: SOME CURRENT PRACTICES

Major Questions	Examples of Tools/strategies	Desired Outcomes
Expectations. What are expectations of stakeholders? How does everyone perceive consumer's communication needs? What is consumer's view of a positive outcome?	**Interview**. Questionnaire. **Consensus building**. Meet to reach consensus before and after each assessment. Clarify reasons for referral.	Stakeholders leave with **expectations met** or an **understanding** of why they are not met. Consumer's priorities are respected. If expectations are unrealistic, time is taken to counsel. List of current communication needs is drafted.
Current ways of communicating Does person show intent? Make choices? What modes are used? Where do break-downs occur. How are they repaired?	**Interview. Observe. Videotape.** Get information about current communication capabilities with family and peers, at home, work, school (p. 112-113).[13]	**Understanding** of symbols, modes, signals currently used. **Decisions about where to start.**
Current intervention objectives. What are current communication and related intervention objectives? How are they working? What else has been tried?	**Review records** (IEP, IFSP, IPP). **Interview. Demonstrate** or use structured tasks to show specific tools, tasks, and strategies being used.	Some understanding of what is working/not working. **Consensus** reached regarding successful and unsuccessful approaches to AAC intervention in the past and present.
Preferences. What activities does consumer like, dislike to participate in?	Interview. Complete an activity inventory (p. 106).[13]	**Understanding** of personal profile with strengths, likes, and preferences. Discuss discrepancies between schedule and preferences.
Communication opportunities. What daily opportunities does consumer have to communicate? Are they sufficient?	**Interview. Observe.** Complete an opportunity assessment (p. 108).[13]	**Ideas** about how to provide additional communication opportunities. **Understanding** of support system.
Barriers. What are the barriers to communication/participation? Can they be removed?	**Interview. Observe. Consensus building.**	**Recognition/consesnus** about barriers (physical, cultural, age, socio-economic, knowledge of technology, attitude) influencing outcome.
Schedule. What is the consumer's daily/weekly schedule?	**Ask** caregivers, teachers, parents to make up a schedule.	**Understanding** of schedule and how many times preferrred activities are done in a day.
Language. What are consumer's representational abilities and preferences? What symbols/signal/signs should we use? Is person literate? What does consumer want to say (i.e., vocabulary)?	**Interview. Review records** to get idea about level of function. **Test**–Callier-Azuza Scale, Peabody, McCarthy Scales were mentioned. **Assess use of real objects, photos, words. Vocabulary inventory.**[13]	**Make decisions** about what representation systems to use: symbols/signals/signs. Decide on way to measure partners' perceptions of progress and consumer's understanding/use of symbols.
Personal strengths and challenges. What are the physical, cognitive, sensory issues that need to be considered?	**Review records. Observe. Interview.** Know about hearing, vision, language, motor, cognitive variables so these can be considered at each step (p. 124-139).[13, 14]	Plan in place to address positioning and seating across contexts, control sites. Referrals made if information about vision, hearing, etc. is needed.
Where to begin? What strategies could help the consumer? What tools could help her/him? What else needs to be done?	**Consensus building**. Meeting with team to reach consensus and develop **plan of action** (p. 154)[13, 14]	Consensus reached on plan re: tools, techniques and strategies. **Plan in place.**
Support system. What needs to be done to support the recommendations?	**Consensus building.** Complete Circle of Partners[15] Resource Inventory (p. 119-120)[13]	Supporters have information they need. Funding sources identified. **Decision made about where to start. Plan in place.**

(continued from page 5)
information shared by these professionals. However, this is only a beginning step along the path of future discussions, which should include other stakeholders, that will lead us to more valid and reliable approaches to assessment in AAC.

***Major questions*:** The questions being asked by those interviewed are consistent with the philosophy and practices unique to AAC intervention as discussed earlier in this issue. For example, the importance of clarifying and meeting the expectations of stakeholders was highlighted in **For Consumers**. Likewise, the need to focus on communication opportunities, existing barriers, and an individual's schedule, preferences, strengths and challenges was underscored in **Governmental** during our discussion of the level of Disability. Finally, questions about selecting appropriate tools for communication reflect the complexity of these decisions as shown in the **Equipment** section.

***Tools/strategies*:** Assessment methods used most often are interviews, observations (in natural settings whenever possible), and a review of past records. Building consensus is also important.

Please note: Standardized tests, AAC protocols and checklists were rarely cited. In addition to validity and reliability issues, existing tools simply do not measure the information AAC professionals say they need.

All concur. We need valid, reliable tools to help answer each major question. In the meantime, refer to references cited in Table V for examples of available tools.

***Desired Outcomes*:** AAC intervention means managing a complex organizational process. Our assessments are an effort to capture that process. The process is continuous, not discrete—assessment begins, but never ends. Diagnostic therapy and diagnostic teaching were thought by many to be better descriptions of what actually happens in AAC where no real dichotomy exists between assessment and intervention.

AAC intervention means managing a complex organizational process. Our assessments are an effort to capture that process. The process is continuous, not discrete—assessment begins, but never ends.

Again, all concur. The desired outcome of an AAC assessment is a "working hypothesis" based on an understanding of the people and situations involved, a consensus, and a plan. Even the most experienced team can not know if their recommendations will meet expectations, enhance opportunities, or overcome barriers. Likewise, only time will tell whether AAC tools, techniques and strategies will improve communication skills in ways that are meaningful to the consumer.

Comparing current practice to quality indicators

The National Joint Committee for the Communicative Needs of Persons with Severe Disabilities, says "assessment encompasses the following features:"[16]

1. Identifies current modes the individual uses.
2. Includes measurement of sensory sensitivity by appropriate professionals.
3. Identifies social functions of communication behaviors.
4. Includes measure of a full range of performance across various environments.
5. Is conducted in natural environments and a) identifies partners, b) measures opportunities across contexts, c) determines responses to communicative acts, d) identifies forms and functions needed in various environments, e) identifies persons who are most responsive across environments and f) looks for spontaneity of communication.
6. Reflects an interdisciplinary model inclusive of consumers and their supporters.
7. Encourages team members to share a common perspective on communicative behavior including an understanding that communication behaviors are social.

Master clinicians in AAC address these indicators—and more!

The Assessment Process

The assessment process in AAC is changing dramatically:

> I used to work in a rehabilitation center (with a hospital, school, outpatient departments, and so on.) We did interdisciplinary assessments, many with an AAC focus. During these assessments, team members read previously written reports, interviewed caregivers, conducted speech, language, and communication testing, designed communication displays, solved positioning and access problems, recommended communication devices, addressed language concerns, made educational recommendations and so on. At the end of the admission or series of outpatient visits, a physician and social worker met with the family. Later (often much later) copies of our long, detailed reports were sent to the home-based team. Follow-up was minimal because we were swamped. Too often, not much changed.
>
> Today, I go to a person's home, school, work-site, or community program. I talk to the individual and his/her family and friends about what they want to accomplish. I observe. Together we form hypotheses about which strategies, forms of representation, access techniques and opportunities for participation might help in situations throughout the day. I work with those already involved to generate an initial set of possible solutions. The team, which I am now on, develops an action plan (i.e., who is going to do what, by when, and how are we going to know that it is done/successful, or not?) We reach consensus. Little by little, step by step, changes are made.

For me, it is a relief to learn that what I currently do, others are also doing. Looking deeper and more intently at assessment in AAC, I now think our approaches to assessment, even though they certainly lack uniformity, have real merit. I even think other professions could benefit from what we've learned. Our challenge now is to move forward by introducing scientific rigor into our evolving assessment practices and procedures.

University & Research

Just an idea!

What if the outcomes of every assessment were to include information about how to validate the approaches a team suggests?

Facilitated Communication (FC) is not the only approach in widespread, enthusiastic use despite limited evidence of its efficacy. In fact, the use of unproven clinical techniques is often the rule, not the exception in rehabilitation. Here are a few examples of AAC techniques we need to validate:

- Aided language stimulation. How should you do it? For whom? Under what circumstances?
- Switch training for various kinds of scanning.
- Teaching someone to use a communication device in the community.

Over the past year, the research community responded to what became a critical need to investigate the validity of FC. As a result, clinicians now have protocols that can assist them in determining from whom a message originates during a facilitated interaction.

What if the AAC research community validated other approaches? What if AAC "experts" included validation techniques as part of each assessment report? In an article entitled *Scientific and Human Integrity*, Ann Kaiser says[17]

> First, we must acknowledge that science is a human process that engages the complete human as both researcher and participant.

The validation of theory and clinical techniques simply is not a matter of statements of support, whether they be by individuals, associations, or other organizations.[18] It is only through inquiry and evidence that efficacy can be shown. Science is a human process. Assessment teams are in a unique position to encourage "science" by providing ways to validate each recommendation made.

Introducing *Alternatively Speaking*

The time has come. The time has come to have an independent publication written by an AAC consumer for the edification of consumers and professionals alike. It's called ***Alternatively Speaking***, and Michael B. Williams is the author. Michael is well-known in the field of AAC for his articles in *The UCPA Networker*, *Communication Outlook*, *Online*, *Communicating Together*, *Parenting for Peace and Justice*, and for his entertaining and informative lectures at meetings and conferences.

> *Alternatively Speaking is for parents, consumers, friends of consumers, school aides, techno-gawkers, and disability rubber-neckers to name a few. (Michael B. Williams, 1994)*

Alternatively Speaking provides a consumer perspective on AAC. Like ***Augmentative Communication News (ACN)***, ***Alternatively Speaking*** contains information gathered from a variety of sources and synthesized for use by AAC users and their families, service providers, researchers and manufacturers. Each issue spotlights a topic of vital importance to the AAC community—no advertising, just news.

Augmentative Communication, Inc. will publish the first issue of ***Alternatively Speaking*** in March/April of 1994. Its focus will be a review of basic AAC tools, i.e., sign language, low tech boards, and voice output devices from a consumer's perspective. Issues will be laced with Michael's humor and unique life experiences. You'll also find information from the literature and popular media, and something special for children who use AAC.

Michael is a man of wit, talent, intellect, drama, and wisdom who has cerebral palsy. Thus, aspects of his life are being lived "differently." Assistive technology has had a profound impact on his life. Yet, he is deliciously irreverent about AAC services and technologies and the systems within which we all live out our lives. Michael says:

> The newsletter **Alternatively Speaking** *is for parents, consumers, friends of consumers, school aides, techno-gawkers, and disability rubber-neckers to name a few.*

I say ***Alternatively Speaking*** is also important for clinicians, educators, researchers, manufacturers, and third-party payors. If the field of AAC is to be credible, the consumer's voice needs to get louder and more people need to be listening (reading ***Alternatively Speaking***).

Michael is married with two children (ages 9 years and 1 year) and has a masters degree in library science from the University of California—Berkeley. Michael knows things that are important for us all to comprehend. I find him a gentle and insightful colleague, teacher, and friend. He will indeed add a fresh, new dimension to the AAC literature.

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Announcements

OUR NEW FAX NUMBER is (408) 646-5428.

WE TAKE CREDIT CARDS

Augmenative Communication, Inc. has begun accepting Master Card and Visa as payment for subscriptions. This is a response to your many requests, mostly from subscribers outside the U.S.

NEVER TOO BUSY FOR YOU

We added a new phone line and voice mail service in January. You won't get a busy signal any longer on the ACN Hotline (408) 649-3050.

FONT SIZE

Some people have complained about the small size of print used in *Augmentative Communication News*. So. . . we increased the font size from 10 to 11 point. Hope you find it easier.

ASHA CEU TESTS

No news is good news! If you completed and returned your 1993 CEU test, don't expect ACN to contact you unless you did not pass the test. It generally takes a few weeks to read the tests and send notification to ASHA. It takes another few weeks for ASHA to process the information.

If you wish to register for 1.2 ASHA CEUs in 1994, send $9 to Augmentative Communication, Inc. to cover our administrative costs. YOU MUST ALSO register for 1994 CEUs with ASHA ($25 for members and $35 for non-members).

YOUR RESOURCES

Thanks to the following people whom I interviewed for their time and willingness to share information, insights and resources.

David Beukelman, 202 F Barkley Memorial Center, University of Nebraska–Lincoln, Lincoln, NE 68583
(402) 472-5463.

Diane Paul Brown, ASHA, 10801 Rockville, Pike, Rockville, MD 20852.
(301) 897-5700.

John Costello, Children's Hospital Communication Enhancement Center, Fegan Plaza, 300 Longwood Avenue, Boston, MA 02115 (617) 735-8392.

Cynthia Cottier, Augmentative Communication Therapies, 7006 Shining Ave, San Gabriel, CA 91775.
(818) 285-2523.

Frank DeRuyter, Rancho Los Amigos Medical Center, Communication Disorders Department, 7601 E. Imperial Hwy., Downey, CA 90242.
(310) 940-7687.

Carol Frattali, ASHA, 10801 Rockville, Pike, Rockville, MD 20852.
(301) 897-5700.

Melanie Fried-Oken, Oregon Health Sciences University, Children's Development and Rehabilitation Center, Portland OR (503) 494-4632.

Hilary Johnson, Spastic Society of Victoria, P.O. Box 181, St. Kilda 3182 Australia. Phone 03 537-2611
FAX 03 525-3274.

Arlene Kraat , Queens College–CUNY, Speech & Hearing Center, 65-30 Kissena Blvd. Flushing, NY 11367.
(718) 520-7358.

Ellen Kravitz, MA Easter Seals Society/MA Dept of Mental Retardation–Region 6, c/0 47 Fairview Avenue, Watertown, MA 02172 (617) 924-8066.

Pat Mirenda, CBI Consultants, Ltd. 2122 Kitchener St., Vancouver, BC V5L 261 Canada (804) 251-1057.

Jane Murphy, Oregon Health Sciences University, Children's Development and Rehabilitation Center, Portland OR
(503) 494-4632.

Howard Shane, Children's Hospital Communication Enhancement Center, Fegan Plaza, 300 Longwood Avenue, Boston, MA 02115 (617) 735-8392.