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Welcome

We all need to be able to communicate, to convey information, to make ourselves understood, but the ability to do so is often compromised after a brain injury. Problems with speech, language and communication can lead to frustration both on the part of the injured person and their families and carers.

In this issue, consultant speech, language and cognitive therapist Lisa Harris considers the effects of brain injury that impact the communication dynamic and how the individual and their family can be helped to adapt in order to maintain their relationships (page 3).

On page 11 Tim Farmer of TSF Consultants demonstrates how an inability to communicate does not automatically imply an inability to understand – a critical element when considering an injured person’s capacity to make decisions for themselves.

On page 6 we’re introduced to some of the arts-based therapies that support more commonly used interventions by Daniel Thomas, Managing Director of Chroma. Neurologic Music Therapy in particular has been shown to stimulate cognitive and communication processes.

When it comes to making a personal injury claim, an individual’s relationship with their lawyer can last for years and must be based on trust. Julia Hurlbut of Jackson Lees looks at managing the communication touchpoints throughout a clinical negligence claim on page 9.

Complex injuries can require a significant support team, with a case manager ensuring that the needs of the individual and their family are understood and addressed. Helen Ovans of ILS demonstrates how successful communication between a disparate team can fuel recovery on page 14.

Assistive technologies have moved at a rapid pace in recent years and help many people with communication disorders to keep connected to the rest of the world and retain a degree of independence. Mick Davies of Liberator UK considers how things are progressing on page 12.

You can find further information and resources at www.braininjurygroup.co.uk, or if you need help with a legal or welfare issue, call us on 0800 612 9660 or contact one of our member firms whose details are on our website.

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Communication disorders following a brain injury can lead to frustration and challenging behaviour. Speech and language specialist Lisa Harris considers how individuals can be affected, and how they can best be supported.
Communication can be affected by a brain injury in both subtle and severe ways, changing the way we interact with the people around us. A brain injury can impact the intrinsic way we communicate – including the actual formation of words, finding the right words to say, understanding what is being said, reading and writing (as seen in the condition aphasia) – or can cause cognitive changes that affect our ability to communicate.

A person with aphasia will have difficulty expressing their thoughts and feelings verbally, and often in written form too. Many experience mild to severe problems finding words, say words they didn’t intend to, have difficulty forming words with the correct sounds, or have no meaningful words at all. They may seem tangential, repeat themselves or get stuck saying the same word or phrase. Some may find it difficult to understand language as easily as they once did, causing confusion.

**Cognitive changes**
Cognitive changes may be diagnosed independently of aphasia or in combination with it. The changes can be subtle, for example causing temporary lapses in ability and behaviour, or they can be profound and affect basic life skills. Not all of the following will occur, but examples of things that may affect the communication dynamic are:

- A change in personality – such as difficulty controlling anger or not being able to self-monitor and inadvertently saying things that are inappropriate and out of character
- An altered sense of humour
- A tendency to inflexible thinking – insisting on one opinion and being unable to consider an alternative point of view
- A variety of memory problems – such as forgetting what’s been said, an important event, or to relay information
- Struggling to initiate or follow a conversation
- Difficulty with sensory stimulation – a reduced tolerance of ambient noise, making interactions in certain environments more challenging and negative
- Difficulty coping with more than one person talking at a time or taking turns in a conversation, affecting social interactions

It’s clear that aphasia and cognitive problems are likely to affect both the way someone is received and communicates with others. Support and understanding are essential to enable a person with a brain injury to communicate and interact as successfully as possible given their individual circumstances, and to reduce the frustration they often feel.

**Relationships**
Where a person has difficulty expressing their thoughts and feelings clearly, their relationships will inevitably be impacted. The dynamic between partners in a
Marriage can fundamentally change in some cases, as can relationships with other family members and friends. At family meal times or social occasions, for example, a brain injured person might find it difficult to find the words to respond quickly enough before conversation moves on. The frustration and loss of confidence that comes from this can ultimately lead to social isolation.

In a work situation, it may be difficult for the injured person to communicate and process information quickly enough and to manage the executive tasks required – speedy responses in meetings, composing error-free emails, notetaking, phone calls, remembering names, events and details, keeping up with banter, interjecting are all often very challenging.

What can be done?

Firstly, these changes need to be identified and acknowledged as symptoms and not passed over. Cognitive changes are not always easy to recognise and can appear more readily once a person tries to get back to their normal life. It is imperative that professional support is sought for an assessment, either by a speech and language therapist or a psychologist. This can be done at any point post injury.

Once symptoms are identified, knowledge and advice of how to support and manage them can be provided, and all those involved will have a greater opportunity to work together to find solutions to cognitive and communication difficulties. Families will be more able to react to challenges in a constructive, supportive manner, and those injured will potentially have greater awareness of their own condition and be able to develop coping strategies to manage particular situations.

Families are crucial

It is helpful for families to consider their own reactions to a communication behaviour and be ready to adapt their responses where possible to help the interaction more positively, using their own awareness of where the behaviour is coming from and their own support strategies. Their loved one may seem like a different person in many ways which can be hard to accept, but education can help families to navigate the difficulties, understand the changes, and recognise the individual before them.

If difficulties are not identified as symptoms related to a brain injury, and there is no support in place, the impact on the injured person and their family is often devastating. If loved ones react to challenging behaviour adversely, for example, a harmful situation could get worse.

Once diagnosed, treatment can be sought to rehabilitate communication and cognitive skills as far as possible, working with a therapeutic team to devise long-term goals either in a rehabilitation unit or through services in the community. But families are crucial here too. They can learn with the therapy team what will aid communication, what strategies they can use to facilitate better understanding and expressive ability, and how to be a supportive communication partner.

There will be a steep learning curve for everyone involved: firstly in discovering and understanding the communication issues, and then in learning how to support the person with a brain injury to manage their new situation and communicate as effectively as possible.

Case study

A 49-year-old high level executive sustained a brain injury falling down a flight of stairs. After a medical examination he went on holiday, not noticing any significant changes to his communication or cognitive ability.

By the time he returned, he was aware he was having some problems finding the right words to say, had a mild stammer, and short-term memory difficulties. A speech and language assessment found that he had a mild expressive dysphasia, affecting his ability to express himself as well as usual. For example, he:

- had difficulty reading due to his limited attention span and could not retain what he had read
- found it difficult to control his anger, leading to road rage incidents and aggressive outbursts with strangers, which worried him enormously.

Being assessed and treated raised his own awareness of his difficulties. He realised that returning to his high-level career would not be possible immediately, and he needed rehabilitation.

He could address each issue he was experiencing and focus on the short-term goals devised in therapy to work towards rebuilding his life, with hope of a gradual return to work. He could discuss his difficulties with his supportive family, and explain to his workplace – with the help of professional reports – that he was experiencing considerable difficulty despite no apparent outward physical signs of difficulty.

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Communication problems that result from traumatic brain injuries vary significantly and depend on many factors, such as an individual’s personality, pre-injury abilities, and the severity of the brain damage. Focal or site-specific damage may result in longer-term or permanent difficulties. Improvements are possible and can occur as other areas of the brain learn to take over the function of the damaged areas. This is a process called neuroplasticity and is at the core of all rehabilitation approaches such as speech and language therapy and less well-known, but increasingly emerging, evidence-based models such as neurologic music therapy (NMT).

The most commonly used interventions to aid communication rehabilitation are speech and language therapy, physiotherapy and occupational therapy. Each has a particular role to play because communication is a whole-brain activity that activates the language, affective, sensorimotor and cognitive areas. Neurologic music therapy works alongside these other therapies, but is distinct from them as it aims to capitalise on the way the brain processes music, initially via the auditory nerve.

NMT is an approach based on neuroscience research into music perception and production. Since the 1990s, research and brain imaging studies have shown that music has a distinct influence on the brain by stimulating physiologically complex cognitive, communication, sensorimotor and affective processes. Within rehabilitation, all therapies referred to above aim to use neuroplasticity, but NMT is an approach that specifically works across hemispheres and across key neural centres while also stimulating cross-neural pathways, for example the auditory-motor pathway.

Regardless of the particular developmental stage or clinical profile of our patients, neuroplasticity needs activating. Successful rehabilitation does this by increasing adherence to the rehabilitation programme and increasing repetition of the rehab exercises. It also assists with the functional transfers of skills acquired as part of rehabilitation back into everyday life.

Using rhythmic cueing to aid communication
A speech and language therapist working with a patient may seek to use verbal or sensory cues that enable the patient to initiate motor functions linked to speech production. Neuroscience research tells us that external rhythmic (musical) cueing plays a vital role in the priming and planning of motor functions linked to speech production (Thaut et al., 1999), as opposed to verbal or sensory cueing alone. This is due to interactions between the auditory and motor neurons, and the auditory-rhythmic entrainment of neural signals.

As well as its musical definition as “a series of regular repeated patterns or beats”, rhythm, from the Greek “rhythmos”, is also defined as “any regular recurring motion” (Liddell & Scott 1996), or as “timed movement through space” (Jirousek 1995). In this context, motor functions primed through musical rhythmic cueing become more regular, predictable and internally activated. This is particularly helpful in rehabilitation.
settings and especially when working with a patient who has poor receptive understanding or cognitive deficits due to the brain injury. It is for these reasons that NMT is increasingly being used by hospitals, case management firms and solicitor practices around the UK.

As the UK’s only national provider of NMT, art psychotherapy and dramatherapy, Chroma works closely with speech and language therapists to ensure that patient outcomes are optimised though joint sessions and close alignment of goals. One of the 20 certified NMT techniques, rhythmic speech cueing, has been documented to “stimulate the speech and language system to help organise oral motor behaviour and prime motor neurons that innervate the orofacial muscles” (Thaut et al., 2001).

Rhythmic speech cueing is a particularly useful approach when working with dysarthric speech. This is defined as a motor speech disorder resulting from neurological injury of the motor component of the motor-speech system, and is characterised by poor articulation of phonemes because dysarthria occurs when there is damage to parts of the nervous system involved in the control of muscles used for speech. Using the auditory neurons to fire the damaged motor neurons in a predictable and rhythmic way builds neuromusculature, and produces enhanced oral performance. A pilot study by Tamplin (2008) supported this finding which neurologic music therapists see time and again with clients and patients. There are many other certified NMT techniques, such as oral motor and respiratory exercises (OMREX), which are also used in work with people living with brain injury.

A traumatic or acquired brain injury can have significant psychological and social impacts on a person’s self esteem, self image, social network and overall sense of hopefulness in life. In many cases, people with brain injuries have tremendous unmet psychological needs that can act as a barrier to accessing more traditional therapies and from successfully participating in neuro-rehab. This is when experienced case managers may call on the expertise of music therapists, art psychotherapists or dramatherapists, all recognised Allied Health Professions and regulated by the Health and Care Professions Council, to work alongside the other therapy professionals.

Art and drama therapy
At Chroma, we are fortunate to have art and drama therapists who work to support patients and family members around the wider impact of a brain injury. Working with partners such as the Royal London Hospital and Child Brain Injury Trust, our therapists work with parents through arts therapies to enable them to begin to acknowledge the still very raw and conflicting emotions they have even many years after their child or loved one was injured. McGuinness and Schnur (2013) suggest art therapy can help individuals understand the changes in their brains during and after an injury to normalise their experiences. Art therapy can express complex information in a simple and manageable way for patients. It can also help with executive function training, including organisation, problem solving, and memory when the frontal lobes have been affected. In cases of severe brain injuries where the brain stem is compromised, the environment in which art therapy takes place is adjusted to reduce stimuli or improve comfort for the individual. Specific adaptive tools and activities may be needed when lower parts of the brain are impacted. Finally, art therapy promotes mirroring and attunement between the therapist and individual with a brain injury to support their recovery goals. Attunement, or being in harmony, is at the basis of all successful therapy and underpins how a patient and their family may interact post injury while they all try to adjust to the “new normal”.

Bringing neurologic music therapy, art psychotherapy and dramatherapy into the multi-disciplinary team, together with more well-known interventions, is the direction of travel for inter-disciplinary teams jointly working to support people with a brain injury. Functional and psychological rehabilitation work together to optimise patient outcomes and support the whole person to recover from their injury.
Drama therapy in practice

A man in his mid-20s who had recently fallen off his motorbike required bowel surgery. The young man was so angry about his injury and the impact that it had on his life that he refused to attend hospital, and eventually the operation had to be postponed indefinitely. In this case, dramatherapy helped to stabilise the young man’s emotions and thoughts. It provided a way for him to acknowledge and express his anger in a meaningful and safe context, eventually allowing him to attend hospital for his operation.

In harmony

Parent-child attunement is particularly important to support. We currently have a client emerging from a coma who doesn’t yet understand that they have a three-year-old child. The child feels a great deal of uncertainty and anxiety, but through the process of regular therapy sessions, parent and child are starting to discover a new and shared non-verbal language via the arts which is helpful to re-establish their loving bond.

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Clinical negligence specialist Julia Hurlbut reflects on the communication touchpoints and skills required to progress a complex injury claim.

As a clinical negligence lawyer I have dealt with cases involving serious injuries to practically all parts of the body, although my focus for the last 10 years has been brain injury. The majority have involved young children who sustained brain damage at or around the time of birth. Others have involved adults whose brain injury is due to the lack of oxygen during surgery, or as a result of an asthma attack, or suffocation by incorrect placing of ventilation equipment.

Understand the injury and the family dynamics
Whatever the age of the injured person or the cause of their injury, I have to understand not only the injury, but also the family dynamics and living situation before and after the injury, in order to ascertain their needs, aid communication between us, and build a relationship.

The most severely injured people I work with are those who were starved of oxygen at birth, typically down to a delay in being born, resulting in severe physical as well as intellectual damage. They may need 24-hour specialist care for the rest of their lives.

But when I first speak to a family affected by this kind of injury, there is often little or no help from the state which means that day-to-day caring usually falls on the family – a family member might have had to give up work to look after their loved one.

In birth injury cases, parents rarely get a good night’s sleep and are simply exhausted. Anxiety and depression is typical. There is little or no respite, but their dedication and devotion to their child is constant.

Helping any family in this situation is a huge privilege. It’s a heavy responsibility to make sure that I offer the right advice to secure the best outcome for the injured person, and the relationships that develop must have honesty and trust at their core.

Severely injured children are most often represented by a parent. Of all the brain injured adults I have acted for, only one was able to instruct me directly.

The person representing another who is unable to provide instructions is known as a ‘Litigation Friend’; on one occasion through misinterpreted dictation, the term appeared as ‘Best Friend’, which I think is possibly the most appropriate description!

Contacting a solicitor is usually the last thing on the family’s list, but if they have a concern that something went wrong at the hospital and they are considering making a claim, it’s unavoidable. Any injury claim will likely be uncharted territory for most people, and the thought of what lies ahead can be daunting. My job is to listen carefully, advise on the options available, and allay any fears and misconceptions.

Once instructed to bring a claim, I will agree the practicalities of every day communication with the injured person and their family, including what form that will take (telephone, email, meetings), the time of day, day of the week, and exactly how closely they want to be kept informed.

I try to manage expectations about what to expect of the process itself and the likely longer-term outcome if our investigations reveal evidence to support a claim.

Continued on page 10
As part of the litigation process, the injured person’s needs and the cause and extent of the problems they face must be ascertained, which involves instructing experts (expert witnesses) from multiple disciplines who will each need to visit them to produce a report.

**What to expect**

A document identifying which experts the family can expect to see, when, and what to expect from each meeting generally makes life a little easier. If the family struggles to understand the content or the implications of an expert’s report, I will talk through the key points which could be vital in making decisions that will affect the claims process or the care their loved one receives.

Often the defendant in the claim will require their own experts to do the same. They might have a different appreciation of what the disabilities and needs of the injured person are, which can be distressing and it’s important that the family is prepared for this possibility.

Sometimes a defendant might admit a claim and issue a letter of apology, usually quite some way down the line. Unfortunately, in my experience such apologies tend to be very impersonal and often leave the family feeling dissatisfied. They aren’t usually reassured that lessons have been learned and may be left with an understandable feeling that their loved one is being injured again.

If there is an admission of liability, then obtaining an interim payment of some of the damages (compensation) up front becomes a priority so that any gaps in the care and therapies being delivered can be addressed as soon as possible. This is another key point in the case where I will discuss in detail with the family what to expect, as this can be another bumpy and lengthy road.

Once an interim payment is received, the team (MDT) meetings arranged by the case manager to review progress and adjust the rehabilitation programme accordingly.

It is important that family members attend MDT meetings to contribute to and be fully aware of what is going on with the rehabilitation package. I also attend certain MDT meetings in case any issues are raised which might require input from the expert witnesses, deputy or barrister instructed in the case.

**Encourage the family to ask questions**

The injured person and their family are very much involved in progressing any claim. I always encourage them to air their views and ask questions – of me, of experts, of anyone involved in their case.

There can be differences of opinion among the expert witnesses and the treating doctors and therapists. For significant differences, I would arrange a discussion with all parties to try and resolve the issues. There are two key reasons for this. Firstly, it’s of paramount importance that the injured person receives the appropriate support and provision, whether that’s accommodation, care, equipment or therapies. Secondly, we don’t want evidential disagreements causing problems as the case progresses.

I also believe it’s very important to keep the defendant in the loop and send regular updates of medical and case management records. It is more likely they will co-operate with any further requests for interim payments if they know what’s being spent, and it’s better to address any issues the defendant may have early in the claim rather than leave it to the end when it’s too late.

Everyone I instruct on a case – experts, case managers, barristers – is chosen because of their ability to connect with people in a stressful situation as well as their track record. There will inevitably be differences of opinion and occasional personality clashes along the way, but open and honest communication can usually resolve those issues – especially when the focus is squarely on the best interests of the child or adult facing a life affected by brain injury. Making sure that person ultimately receives the appropriate accommodation, care, therapies and equipment is immensely satisfying for everyone involved.

**Key points for building trust**

- Listen to the injured person and their family’s concerns
- Manage their expectations
- Keep the family informed as the case progresses; reiterate and refine advice
- Work collaboratively with the deputy and case manager to address any concerns at an early stage
- Keep in regular contact with the defendant

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Jackson Lees
Understanding versus communication

There’s a big difference between communication and understanding, as mental capacity expert Tim Farmer explains.

One of the most common mistakes made when assessing mental capacity is to confuse an inability to communicate with an inability to understand. It is a mistake that is not just limited to understanding but is often extended to a person’s ability to retain or weigh up and use information.

Allow me to demonstrate: if I were to tie up your hands, tape up your mouth and ask you your name, you are unlikely to be able to tell me. This does not mean you don’t understand the question or know the answer, that you have forgotten your name or that you can’t weigh up information. It just means that you can’t tell me.

This is where the second principle of the Mental Capacity Act is so important and its direction to the assessor to support ‘P’, the person being assessed, in every practical way. People often say that they think the ‘communication’ element of the two-stage test is the simplest, but I would beg to differ as it is, at times, arguably the most difficult, certainly when we are dealing with people diagnosed with a brain injury.

Threshold of understanding

What does it actually mean to understand? Google ‘understanding’ and you will find a host of meanings and examples that revolve around three key concepts:

i) The ability to understand something or comprehension
ii) The power of abstract thought or intellect
iii) An individual’s perception or judgement of a situation

To my mind, setting the threshold of understanding using a model such as CRAFT – Concept, Risk, Actualities, Future and The here and now – is vital. Only once you’ve done this can you determine what information a person needs to understand to make the decision, and the level at which they need to understand it.

When you have established the threshold of understanding you can set the questions you need to determine whether the individual meets the necessary threshold to make a decision. And only once you have done this can you determine how the individual can present this information to you. For example, does it have to be verbal? Can it be in pictures, written or merely a nod?

A two-way street

Communication goes two ways. Think of it like a game of catch: one of you drops the ball and the game ends. As such it is vital that you consider how you present the information to the individual to enable them to ‘return the ball’. For example, is it in English, Makaton, written, pictorial or a combination of them all?

Case law tells us that we cannot expect a person to work from a blank canvas. There is an expectation that if an individual doesn’t know something then we tell them and then work out their ability to understand, retain, weigh up, use and communicate. It may seem obvious, but if we can’t communicate that information to the individual in the first place, are we demanding too much by expecting them to be able to understand, retain, weigh up, use and communicate it back to us?

We must never forget that at the heart of everything we do is an individual, with unique abilities, skills and modes of communication. If we lose sight of the individual, we lose sight of how best to support and communicate with them.

You’ll always find me in the kitchen...

My favourite place to do an assessment is in the kitchen; it has pretty much everything I need and use to visually demonstrate things such as the size of someone’s estate, or to assist the person to communicate – from tea bags and chocolate to pens and sticky tape.

I was once assessing an individual’s testamentary capacity and using his tin of chocolates to demonstrate the proportions he wished various family members to inherit. I asked him to imagine that the contents of the box were his estate and to divide it up accordingly. His mum got a Twix; his two children received large Galaxy bars. His ex-wife? A single Malteser!

A registered mental health nurse, Tim is Managing Director of TSF Consultants and a leader in the field of mental capacity having conducted hundreds of assessments in both clinical and legal settings.

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We live in an age when communication is switched permanently to ‘On’ for the majority of people. A plethora of devices vie for our attention wherever we are, whatever we’re doing – shopping, travelling, having breakfast, doing the school run, watching a film, or dining out in a fancy restaurant.

Whether verbal, non-verbal or electronic, communication is fundamental to all aspects of life and it’s constant. It’s the way we express our thoughts and personalities, how we make decisions and how we build relationships.

People who have suffered a brain injury frequently experience significant communication challenges due to cognitive impairment, whether temporary or permanent, and communication disorders can lead to frustration and challenging behaviour. Assistive technology (AT) can help to relieve some of the frustrations, enabling people with disabilities to undertake everyday tasks that other people take for granted. It refers to assistive, adaptive and rehabilitation devices that encourage greater independence. It’s a broad term that encompasses wheelchairs and ramps as well as communicating using gestures or synthesisers, using a computer, controlling a powered wheelchair or playing a games console.

**Strategies, techniques and support**

Alternative and augmentative communication (AAC) is one component of AT, another umbrella term that refers to a range of strategies, techniques, systems and devices used to supplement or replace speech or writing for people with communication difficulties. They range from non-technical methods such as signing, through to picture boards and on to sophisticated technological solutions involving adapted computers and voice activated communication aids (VOCAs).

**How have these technologies evolved?**

Assistive technology devices have been available in various forms for many decades, but the speed of technological innovation in recent years has certainly accelerated that development. We have moved from simple systems to advanced modes of communication on dynamic touchscreen display devices, with integration for mobile phones, internet access, environmental controls for TVs, stereos, doors, curtains, etc.

The vocabularies found on many devices now provide quick access to important features, such as word prediction or the ability to send a text or whatsapp message, to access social media such as Facebook, or play your favourite song through YouTube. What’s more, this functionality can all be available on the same device and can be accessed through various methods including touch or eye movement, head switches, knee switches and joysticks.

Technological advances have opened up channels of communication as never before. Mick Davies from Liberator UK provides an insight into how technology can help people with communication disorders to join the conversation.

Assistive technology: Join the conversation
Who decides if someone with a brain injury might benefit from AAC/AT?
An individual’s abilities and situation must be fully assessed before any recommendation can be made. That assessment should take into account many variables including mobility, motivation, educational needs, cognition and seating.

An assessment would typically involve a professional such as a speech and language or occupational therapist. They will normally be in a position to make recommendations and to advise on device trials before deciding on the most appropriate product.

How do they decide which option is best?
Once a therapist or case manager has identified the best type of technology, specialist manufacturers and suppliers will normally carry out a free hospital or home visit to assess the person’s suitability to use high-tech AAC. Many will follow this up with a free trial of the device and also look at the best method of access for the individual – for example, direct touch access, switches, head pointing or eye gaze.

Do suppliers deliver training to carers and therapists too?
Usually the person using the device will be trained alongside their therapists and support teams, helping them to set goals. It is always wise to check with suppliers to understand what training and ongoing support is available and whether there is a cost.

Are updates and personalisation available?
Technology is shifting constantly – and quickly. With most AAC systems, vocabularies can be personalised to include exactly what the user wants to say with them. As new technological advancements occur, vocabularies will be updated to keep them ‘current’ as new devices are developed and manufactured.

Do many rehabilitation facilities advise on AAC/AT?
In 2015, NHS England set up what has been described as the AAC ‘hub and spoke’ model, with a number of regional hubs around the UK. The regional hubs are able to provide highly specialised services and support to a number of associated centres (‘spokes’) within their region which then provide the services locally.

The AAC hubs not only assist with assessments but also have access to funding for high-tech AAC devices for people who meet their criteria. For more information visit the NHS website: www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/guid-comms-aac.pdf

Assistive technology and AAC enable people to communicate; that immediately improves their quality of life, influencing relationships with family and friends and enhancing the potential for independence as well as offering social, educational and employment opportunities.

Technology in action – a success story
Liberator has worked with a young man, born with athetoid cerebral palsy, for several years. Now 17, he attends a specialist college and has been using a high-tech communication aid since he was eight years old. He is a keen sportsman and enjoys the performing arts.

Having started with a head switch to access his device running a page-based system, he moved on to use Liberator ECO2 with ECOpoint Eye Gaze, making his selection with a foot switch once he has fixed his eyes on the icon required. With 144 icons he uses the device to study, to order food in restaurants, and to chat with his friends!

Progressing to the Unity Minispeak language system accelerated his language development; he can use the ECO2 to speak in complete sentences with correct syntax and has become a confident and competent communicator with his peers.

He uses technology to full advantage – he controls his PlayStation with a bespoke switch system, drives his electric wheelchair with head switches, plays music through his ECO2 and can also send and receive text messages using the ECOpoint Eye Gaze system. He has a smaller communication aid mounted on his walker.

NB. The ECO2 with Ecopoint has been superseded by the Accent 1400 with NuEye.

Mick Davies, Sales and Marketing Team Leader, has nine years’ experience with Liberator and is passionate about finding the right solutions for the individuals they support.

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Multi-disciplinary work is the key to successful rehabilitation – and managing a team of professionals in the home often falls to a case manager. Case management and rehabilitation specialist Helen Ovans of ILS looks at how good communication can help drive recovery.

When it comes to working with adults or children affected by complex injuries, the initial role of a case manager is to assess the person’s level of need and identify the most effective interventions to promote their recovery, independence and wellbeing. Essentially, a case manager will access and co-ordinate a comprehensive package of care and rehabilitation that spans specialist therapies, home care, community support and more.

A case manager’s experience informs how they manage the multi-disciplinary team (MDT) they put in place. However, they must never lose sight of the injured person and their family as the ultimate decision makers when it comes to the care they receive in their own home.

In a domestic setting, a case manager is usually supporting an injured individual and their family in a particularly vulnerable situation. The roles, responsibilities and identities of each member of the family unit will feel the impact of a serious brain injury, and the case manager must be sensitive to the wide range of emotional, psychological and sometimes physical reactions used as coping strategies by clients and their families. These reactions can complicate the case manager’s role of enabling and facilitating communication of the family’s values and what they want in terms of support and care.

Care, sensitivity and respect

When clients and families agree with the therapists’ assessments, decisions are made in a positive and collaborative way from the start. If not, it’s up to the case manager to ensure that the client’s voice is heard and that therapy is done for them, not to them.

Providing care in a domestic setting comes with its own challenges, such as asking for space to be freed up for equipment, asking for room for therapy sessions, or for meetings to be held in private. Again, because we’re talking about a family home and not a clinical setting, a case manager must approach these issues with care, sensitivity and respect to ensure a positive working environment.

MDTs comprise skilled professionals brought together by the case manager. Their decisions must be guided by the client and their family where practical, safe and legal. To make this work requires clear, uncomplicated and timely communication – taking time to listen, to understand how each client and family functions, and to establish how input can be tailored to their needs to secure the best rehabilitation outcome.

The key communication skills of the case manager are to listen to what is said and not said, and to ensure that everyone involved – family and professionals alike – understand and adhere to an agreed process of gathering and sharing information. Adaptability is also crucial as this will differ vastly between families. Sometimes the case manager will control the flow of information between all parties; sometimes they will be supporting the client and their family to regain some control and autonomy in their lives as they establish new roles and identities.

Positive, open and well-structured communication

Regaining control is a vital skill to be encouraged and supported. To promote the best possible recovery, it’s equally important to maintain collaborative multi-disciplinary input. Again, the case manager’s role is to listen carefully and to communicate the client’s priorities clearly to the MDT. They need to find efficient ways of sharing new information and to make sure that the team is fully speaking the same language:

The communication role of a case manager

Jamie story

Jamie, 28, suffered a severe brain injury at the age of seven and spent 10 years in and out of hospital undergoing rehabilitation. Jamie needs round-the-clock care, and he and his family have been supported by ILS case managers for more than 15 years.

Support for the family has included:

- assisting his transition through education facilities
- recruiting and supervising the right support workers to aid his rehabilitation
- engaging physiotherapists and occupational therapists
- choosing vehicles that can be adapted for his wheelchair
- introducing him to a charity supporting people with disabilities to get involved in sporting and creative activities

His case manager also arranges bi-annual team meetings for Jamie, his family and his support workers to get together, review progress, and set goals for the future.
Helen Ovans is a case manager working with children, young adults and adults who have a variety of conditions and complex needs including acquired brain injury and spinal injury.

Call Helen on 01722 742442 or email her at helen.ovans@indliv.co.uk

www.indliv.co.uk
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- Personal injury & criminal injury compensation claims
  - Matrimonial & family matters | Education
  - Personal health & care budgets
  - Care or treatment issues

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