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BRIEF COMMUNICATION

Speech Therapy Where There Are No Speech Therapists: The Task Force for the American Cleft Palate–Craniofacial Association

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This paper describes the outcome of the 2013 American Cleft Palate–Craniofacial Association Task Force entitled "Speech Therapy Where There Are No Speech Therapists." The membership and goals of the initial task force are presented. Survey methods, communication of the members, and meeting discussion of the task force at the 12th International Congress for Craniofacial Anomalies in Orlando, Florida, in May 2013 are described. Conclusions of the task force and recommendations for the future comprised four areas: organization and communication, protocols, service delivery models, and development of training programs/modules in speech-language pathology for craniofacial conditions.

The "Speech Therapy Where There Are No Speech Therapists" task force was charged with initiating collaboration among professionals who are or have been providing speech pathology services or training community health care workers in developing contexts. The task force built on the work completed by the International Speech Working Group in 2002. This group produced a report that outlined five recommendations for expanding speech pathology services in developing countries. The task force members concluded that "there is a significant need for programs and materials aimed at young children with clefts to help prevent the development of abnormal speech and language patterns. No programs are available for use by community-based workers for this purpose" (D'Antonio, 2003, p. 311). The recommendations of the task force included developing materials for information, education, and communication and using media to increase awareness of the needs for speech pathology. The task force suggested that a network be established to mobilize and share resources, involve rural community health workers in planning and implementing services, and influence governmental policies. The task force identified four goals: promoting international collaboration for providing speech therapy for children with cleft palate worldwide; survey task force members for current practices; identify service delivery models in use; and develop recommendations for next steps.

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Task Force Functioning

Membership Acquisition and Demographics

The key members were chosen by the American Cleft Palate–Craniofacial Association (ACPA) from those indicating interest in this task force. The original task force consisted of 10 members from Nepal, India, Taiwan, Thailand, Switzerland, and the United States. This membership was selected by ACPA based on the individuals' active participation in providing speech services in developing countries. The membership was expanded during a lunch meeting at the 12th International Congress for Craniofacial Anomalies in Orlando, Florida, in May 2013 to include 70 additional members.

Method(s) of Interaction

Given the range of countries and time zones represented by members of the task force, the committee had discussions by e-mail. This method was not particularly conducive to continuity of communication. Alternative methods of communication included a website and social media.

Initial Issues

We initially did not have a good sense of what speech therapy programs were in existence, so we developed a questionnaire and had all committee members complete the form. The task force committee also solicited other responses to the questionnaire as a starting point. Thirty questionnaires were distributed to task force members and 20 responses were received. The results of the questionnaire indicated that the speech therapy programs available fell into two general types: those programs that existed in countries with the profession of speech pathology and those programs that were delivered in countries without speech

pathology. The former programs had more continuity, even though many of the services were provided by remote teams or visiting professionals (D'Antonio and Nagarajan, 2003; Jobe et al., 2007; Prathanee et al., 2011; Prathanee, 2012). Six of the 10 task force members surveyed were involved with providing services in speech camps, most of which were 3 to 5 days in length and included networking with community health care workers. All of the programs responding reported training parents or health care workers to provide therapy; however, the data on the effectiveness of this training are still limited and warrant further attention. In addition to providing training, the programs focused on providing articulation treatment, stimulating language and social skills, offering dental and hearing assessments, and educating parents on interdisciplinary care. The majority of the task force members were collecting data via paper or audio or video recordings. Audio and video recordings are the preferred method of data collection; however, the quality of those recordings in the field is problematic. The Sri Ramachanda group in India is exploring the use of cell phones to record in the field.

Conclusions of the Cleft 2013 Task Force

The conclusions of the task force were determined from analysis of the survey and notes from the discussion at the International Craniofacial meeting in Orlando, Florida, in 2013. The committee reviewed these data sources, and the first author grouped them into four general areas: organization and communication, protocols and resources, service delivery models, and development of training programs/modules in speech-language pathology for craniofacial conditions.

Organization and Communication

A plan for maintaining communication among task force members was discussed. A webpage, blog, and social media options were discussed to facilitate communication and could provide the framework for updating the member list, sharing resources and expertise, and working on joint projects. In order to foster coordination, more information is required regarding where professionals are providing services. The website could also provide a registry for stakeholders in each country. Funding for maintenance of a website is needed.

Protocols and Resources

There was considerable discussion regarding the sharing of protocols and training resources. Posting of protocols, therapy principles, handouts, videos, and materials that are currently being used was suggested by the task force members. We will need to have some agreement regarding use of the posted protocols and referencing of the protocols to give proper credit to the authors. There was some discussion about using technology to assist in collecting data. The Sri Ramachanda program is using cell phones to record speech samples during assessments in the field. Use of available technology is a model that may prove helpful in other contexts. The use of this technology could be used to expand access to clinical populations by training community health care workers. D'Antonio and Nagarajan (2003) trained community health care workers in a rural district in India. These health care workers routinely visited families with health concerns, and they provided access in communities that the speech-language pathologists (SLPs) were not able to cover. The study indicated successful training of these health care workers to identify children with craniofacial conditions.

Service Delivery Models

There are a number of programs that are training community health care workers to provide assessment and treatment under the direction of an SLP; however, it is unclear whether these training programs result in changes in parent behaviors or child speech outcomes. Few training programs collect data on how well the health care workers are applying the programs to the families or changes in the child's speech. The task force concluded that data collection protocols should be developed. The speech camp model (Pamplona et al., 2005; Prathanee, 2011) is being used in many countries, and we thought that this model needed more attention in terms of assessing the numerous variations that are being used. The members wanted to be able to share protocols for their speech camp and develop collaborations with others using this model. Another model of service delivery includes training parents or caregivers to provide intervention. Scherer and Kaiser (2010) have demonstrated the efficacy of parent training in the United States, and there have been adaptations to traditional models in developing countries.

Training Programs/Modules for SLPs

The task force discussed the need to assist universities to start SLP training programs in developing countries. The task force advocated for a visiting scholar program to bring SLPs from developing countries to centers and universities to train so they can go back and establish training programs in their own countries. It may also be appropriate to develop a certificate with online courses for professionals providing speech and language services in developing contexts.

Recommendations for Cleft 2017 Task Force

1. Create a website and blog hosted by the ACPA to facilitate communication and collaboration and sharing of information among all task force members.
2. Update the task force list with additional participants and select a new chair. Thanks to Shankar Rai for his serving as our initial chair and getting us together.
3. Consider a name change to include emphasis on both countries that have the profession of speech-language pathology (but insufficient to cover the need) and those that do not have SLPs, (i.e., speech therapy in rural and developing contexts).

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