Selecting Computer Systems in Augmentative Communication

The article "Two Augmentative Communication Systems for Speechless Disabled Patients" by Newman, Sparrow, and Hospod (August 1989, pp. 529-534) provided a much needed focus on augmentative communication technology's impact on clients seen by occupational therapists. We would like to mention four points that are critical to the selection of appropriate computer systems and software.

First, the prevailing practice for an evaluation involving augmentative communication devices is for a team of therapists and engineers—in conjunction with the clients' input—to determine the clients' needs and then recommend a device. The device that best meets the client's needs is selected from devices that are commercially available. A recommendation to fabricate a device is considered to be a last resort. The creation of a device is the most expensive option and does not ensure success. Therapists should consider the full range of augmentative communication devices, especially those with an established record of utility.

Second, the team considers whether an augmentative communication system requires a dedicated computer or can be run with other standard software. If the device requires a dedicated computer, the person must acquire a second computer to perform other computer-based functions. Again, the implication is additional, and avoidable, expense for the client.

Third, although the Commodore 64 is a relatively inexpensive computer and is widely available, its capabilities and compatibility are extremely limited. Other personal computers and dedicated augmentative communication systems should be considered.

Fourth, because the clients described in the article have physical limitations, other factors should be evaluated before a final software selection is made. The input systems described in the article represent a small portion of the options available to a person with severe limitations. The Trace Resource Book (Borden & Vanderheiden, 1988) for example lists more than 150 input and control techniques and more than 170 augmentative communication systems.

Therapists who are new to augmentative communication might also consider referring their client to an augmentative communication specialty evaluation center where a team can provide a comprehensive evaluation using a broad array of software and hardware systems.

Dr. Newman, Ms. Sparrow, and Mr. Hospod provided an instructive look at how occupational therapy can assist in the area of augmentative communication. I hope AJOT continues to print articles that bring such information to the occupational therapy literature.

Some sources for additional information on assistive technology and augmentative communication devices can be acquired through

1. ABLEDATA
   Adaptive Equipment Center
   Newington Children's Hospital
   181 East Cedar Street
   Newington, CT 06111

2. Augmentative Communication
   Rehabilitation Engineering Center
   University of Delaware
   Department of Computer and Information Science
   Newark, DE 19711

3. Rehabilitation Engineering
   Program
   Louisiana Technical Institute
   PO Box 10426
   Roston, LA 71272

4. Trace
   1500 Highland Avenue
   University of Wisconsin-Madison
   Madison, WI 53706

Authors' Response

Dr. Angelo and Mr. Smith properly focus attention on the separate aspects of augmentative communication systems that include the input device, computer hardware, and software. Although we agree that referral to a specialty speech evaluation center and the use of existing augmentative communication devices is optimal, such centers are not always readily available and existing communication devices may cost thousands of dollars. Access to specialty centers and money, in fact, often limits what can be accomplished for a patient. Our systems were intended to illustrate that it is possible for a resourceful therapist to implement useful augmentative communication even when resources are limited and no specialist is available. The sources suggested by Angelo and Smith should be very helpful under such circumstances. Finally, we share in the sentiment that communication is an essential part of patient care and that occupational therapists can add greatly to patient rehabilitation through the implementation of an augmentative communication system that is properly suited to the patient's needs and abilities.

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Addition to Home Health Care Role

"Home Health Care Revisited: Challenges for the Future" by Sharon A. Stroffel and Carol H. Gwin in the August 1989 issue of AJOT (pp. 499-502) was an excellent article except for an omission regarding the home care occupational therapist's role in working with psychiatric clients. If a home health care agency has a psychiatric nurse, occupational therapy is usually covered, as is a home health aide. The therapist can set up and supervise a home health aide program, which provides the client with organization, planning, and support and allows the client to successfully complete meal, homemaking, grocery shopping, and leisure activities. Frequently, inpatient psychiatric units are limited in dis-
charge planning, and recidivism results from the client's inability to implement a basic daily activity plan. Occupational therapy can be the key to a psychiatric client's ability to regain a successful home life.

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Placement of Articles is Shameful

I was disappointed to see the placement of the issue 1s paper by Helen Cohen, "Testing Vestibular Function: Problems With the Southern California Postrotary Nystagmus Test" preceding the obituary for A. Jean Ayres in the July 1989 issue of AJOT. There are numerous points upon which Dr. Cohen's paper can be debated, especially in relation to the narrow scope in which the SCPNT is discussed and the extremely limited references to Ayres's body of work related to this test. These points will undoubtedly be presented by researchers and clinicians who have a broader perspective on theory development and test and measurement than that presented by Dr. Cohen.

Striking, however, is the irony inherent in the placement of these two articles. Dr. Ayres fought opposition her entire life and it seems especially sad that a memorial tribute to her would follow such a negative attack on her work. Open discussion of issues is undoubtedly important to our profession. The juxtaposition of these two pieces, however, was shameful.

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Editor's Note

The contiguity of the two articles was less than sensitive. Each issue's editorial content is set first and the issue is fleshed out much later with "fillers". In our eagerness to respond to the request to publish the Ayres obituary as soon as possible, we obviously neglected to consider what had already been scheduled for that issue. My apologies.