With this edition we have come to the ninth birthday of Lidcombe News and it is now ten years since the Lidcombe Program was first introduced into the United Kingdom in a systematic way. It is also nine years since the first training courses were held in this country, led by Sue O’Brian of the Australian Stuttering Research Centre who also became our first our agony aunt with that initial edition. Since then ‘Sue’ has been Elisabeth Harrison, Vanessa Harris and now Margaret Webber, all with their expert teams from the Stuttering Unit in Sydney, Australia.
We have our ‘Dear Sue’ in this edition as always, probably the most popular item in each newsletter, as well as an interesting update on when to start treatment with the Lidcombe Program from Ann Packman and Marilyn Langevin. Samantha David from Kent in Southeast England also shares with us how her department records outcomes of treatment with the Lidcombe Program.
First though we have news of Lidcombe Link days and workshops around the country.

DATES FOR YOUR DIARY
Norwich is holding a Link day on Tuesday, 19th June, 9.30- 4.00 at 40, Upton Road. Bring/buy your own lunch. Contact Mary Kingston for details, directions etc. on tel. 01603 508946 (new number), or email: kingstonamee@talk21.com

The Lidcombe Link meeting at the Apple House, Oxford is scheduled for Tuesday, July 10th 2.00 - 4.00. Lunch together before if you wish. Ring Polly Mitchell for confirmation of date, venue details and directions on 01865 246845, or email her on: polly.mitchell@nhs.net

Margate is holding a Link Day on Friday, October 5th. It will be held at The Speech Therapy Department, Mill Lane House, Mill Lane, Margate. For further details contact Samantha David on tel.01843 282310 or email: samdavid@fsmail.net

Contributions to Mary Kingston. Send your ideas and questions to:
Speech and Language Therapy Department, 40, Upton Road, Norwich, Norfolk, England NR4 7PA Tel. 01603 508946 E-mail address: kingstonamee@talk21.com Fax 01603 506575. I can't promise to include everything and have to reserve the right to edit contributions as necessary. But I’ll do my best!
 COURSES AND EVENTS

Following several requests for another one day update/refresher on the Lidcombe Program, Mary Kingston and Sally Wynne are holding a day in central London at the RCSLT on Tuesday, June 12th 2007. The course is only open to Lidcombe Program trained therapists. For further details contact Sally on tel. 01603 425241 or email: Sally or Mary on robertsallywynne@boltblue.com or kingstonamee@talk21.com

THERE ARE STILL PLACES AVAILABLE

The next training course to take place is in Oxford in July 2007 but I understand all the places are now taken. There are as yet no definite dates to give you for the next workshops but there are several in the pipeline. There may be two in Scotland over the next few months (probably Spring 2008) and one in Southern Ireland. Contact me on email: kingstonamee@talk21.com for more details when I have them: probably in about two months time. I will then give you the contact details of the local organisers of these events.

Norwich is hoping to hold a training course at the end of November/early December 2007 though as yet I have no firm dates to give you. Contact Sally Wynne in July/August and she will have more details by then. Email her on: robertsallywynne@boltblue.com

Mary Kingston and Sally Wynne are planning the annual London workshop at the Royal College of Speech and Language Therapists. This will probably take place in the Spring of 2008 (usually March) but no firm dates as yet. For more details contact Sally Wynne in July/August on email: robertsallywynne@boltblue.com

There will be more exact information about these workshops in the next Lidcombe News which comes out at the end of September 2007.

At the workshops, trainers are often asked about issues which are not covered in depth in the training package: most particularly assessment, but also when to start treatment with the Lidcombe Program. In a previous edition we covered the assessment (see Edition 26, page 11) and while timing of treatment is discussed as part of the research element of the training, it seemed a very good idea to ask Ann Packman to give us her latest take on this very important decision. Ann, in collaboration with Marilyn Langevin who has recently completed her PhD on pre-schoolers attitudes to peers who stutter, has written the following article for Lidcombe News which will give us much food for thought.
When to start the Lidcombe Program
Ann Packman, Australian Stuttering Research Centre (ASRC),
The University of Sydney, Australia
and
Marilyn Langevin, Institute for Stuttering Treatment and Research (ISTAR),
University of Alberta, Alberta, Canada

This is an update on an article by Ann published in Lidcombe News some time ago. Over the last five years, the second author, Marilyn, completed her PhD at the ASRC, with Ann and Mark Onslow as supervisors. Marilyn has had extensive experience working in teasing and bullying with older children who stutter (e.g. see Langevin et al., 1998). The thesis research is groundbreaking, as it includes the first-ever field study of pre-schoolers who stutter in their natural environment. Four pre-schoolers were video-recorded while interacting with their peers in their pre-school. The photo shows Marilyn filming in a pre-school. Stuttering was identified from the recordings and the reactions of peers to stuttering moments coded.

Another part of her thesis involved administering a questionnaire to the parents of pre-schoolers who stutter, to ascertain the impact of stuttering on the pre-schoolers and their families.

This research has provided us with the third domain of knowledge needed to guide evidence-based decisions about when to start the Lidcombe Program with pre-schoolers who stutter. The other two domains are natural recovery from stuttering and responsiveness of children to the program (see also Packman et al., 2003).

It has been known for decades, centuries even, that many children who start to stutter will recover naturally. That is one reason why parents were advised in the past to wait until children were aged 6-7 years before seeking treatment. Professor Yairi and colleagues at University of Illinois have been following stuttering children in the community for many years and have estimated the natural recovery rate conservatively at 74% (although it is likely that rate of recovery is much lower in a clinic caseload). Around half that recovery occurs within a year of onset but, indeed, a small proportion of children do stutter for a number of years before recovering. Unfortunately it is not possible to predict whether an individual child will recover without treatment.

So why do we no longer wait until natural recovery is no longer likely before intervening? Evidence from the second domain—findings from research into the Lidcombe Program—suggests that children become less responsive to the program once they move into the school age years. Thus we settle for a “trade-off”. We intervene in the pre-school years to ensure maximum
responsiveness, even if this means that some children are treated unnecessarily.

Interestingly, however, the treatment research shows that responsiveness is not jeopardised by waiting for a year after the onset of stuttering (see Kingston et al., 2003), on the proviso that treatment starts within the pre-school years. In summary, then, the rule of thumb is that it is OK to wait for a year to see if a child recovers naturally, but if that does not happen, be sure to start the program before the child leaves the pre-school years.

There has always been a caveat to this rule of thumb and that is that individual case variables must be taken into account.

One such consideration for example, is whether the child is socially and/or psychologically disadvantaged by the stuttering. Marilyn’s research indicates that peers may respond negatively to stuttering in children as young as 3 years, and that this can impact negatively on the child’s social relations and perceptions of themselves as competent communicators. These data have not been published yet. The field observations reflected the findings of the parent survey.

It is important to note that the negative reactions of peers to moments of stuttering are quite subtle, and fleeting, and are unlikely to be discernible to the casual observer. We are in the process of developing a checklist for pre-school teachers and speech language therapists, to guide their observations of pre-schoolers who stutter as they interact with peers. If a child is suffering social and/or psychological harm because of their stuttering, then the speech language therapist might suggest implementing the program sooner, rather than adopting a “watchful waiting” approach.


Dear Sue

Adam is 6 years 6 months and has received 7 therapy sessions so far. His SRs have fallen from 6s to 3s (although there was a slight but not unexpected blip over Christmas), and his WC clinic %SS is around 2-3%. The problem we have now come across is that Adam is developing a 'teenager attitude', and currently tells his mum not to tell him when he's doing smooth talking, and that he likes bumpy talking. He's more accepting of unstructured, 'out of the blue' praises, but not within any 1-1 conversations.

We have discussed a couple of possible strategies, from calling his bluff and stopping all therapy for a couple of days (including stopping all rewards and treats linked to it!) to introducing another adult into the therapy, (which will also relieve the pressure on his mum as the current therapy provider), although we are unsure whether Adam will accept any therapy from any one.

What do you advise that I do, as our strategies haven't really worked so far?

Adam has obviously made some good progress to date. I am assuming that he was fine with therapy until recently. He is clearly saying he doesn’t like verbal contingencies in a structured treatment setting. However he is accepting some praise in unstructured treatment. This indicates that there might be other factors to consider about his structured treatment along with his rejection of contingencies.

In the mean time stop all contingencies other than the few praises that Adam is happy to receive. Have the parent continue spending a period of time with Adam doing some activity he likes but not giving contingencies or specifying this as “treatment”. It is helpful to keep this time happening till you decide if it will still be needed. It is fortunate that Adam has reduced his severity ratings to 3s as this indicates that therapy would be starting to consist mostly of unstructured treatment with less need for structured.

Now to problem solve why Adam is no longer comfortable with his treatment. It’s essential to understand this to enable appropriate decisions to be made about any further treatment. The following questions should help.
1. What verbal contingencies are being used by the parent? How frequent are the contingencies? Are there too many contingencies for stuttered speech? What has been Adam’s reaction to the different ones? Is it the same reaction to all or are there some he is happy with and not others? Is there any difference between the praises in unstructured treatment and those given in the structured treatment? Has anyone else in the home or at school, been giving verbal contingencies other than the parent who is conducting treatment?

2. Were any changes made to how structured treatment was conducted that coincided with Adam’s recent rejection of treatment? Check all the usual issues around structured treatment e.g. enjoyable activities, appropriate timing etc.

3. Is Adam’s “teenager attitude” only about treatment or a general change in behaviour?

The decisions you make will depend on the answers to the above questions. Adam needs to be happy with the verbal contingencies for treatment to be viable.

I can discuss some possibilities that might fit Adam’s case. It is possible that Adam is a child who is ok if contingencies are fairly low key. If this is the case continue with praise or acknowledgement of stutter free speech in unstructured treatment and try bringing a few contingencies for stutter free speech into the playtime with the parent. Another way to try would be carefully to increase the number of contingencies given across the day.

Adam may be able to talk about when and what contingencies he is happy with. You may at some point be able to reintroduce some contingencies for stuttered speech. His acceptance of treatment and severity ratings will show whether changes are working.
How long have you been using the Lidcombe Program at the Stuttering unit? Approximately how many children have you treated?

I won’t try to calculate a number but just give you a general idea of our clinic. We have been using the Lidcombe Program since the mid to late 1980’s, over 20 odd years. During that time we have treated a great number of children. Generally the percentage of pre-schoolers on our caseload has probably fluctuated between 30-40%. Our staffing in the early years was around 2.2 full time positions and has increased to 4.7. Although like many public health facilities, we have not always been at our full staffing capacity.

Do you have any information about the impact on children if they don’t complete Stage II?

Of course we will not know the outcome for all children who might fit this category. However we do keep a database that identifies any repeat admissions to our service. We have found that we do get some children in this category re-contacting at a later date because the stuttering has represented.

Margaret Webber has promised to keep Lidcombe News updated on any recent research from the Australian Stuttering Research Centre into long term follow up of children who have received the Lidcombe Program.

The Dear Sue and ‘Just Explain That Again’ once again comes from all the staff at the Stuttering Unit: Margaret Webber, Stacey Sheedy, Wendy Lloyd, Mary Erian and Verity MacMillan. Our thanks go to them all for their time and effort in finding ways to help us to solve the problems we experience in carrying out therapy with our families and children who stutter.
Recording Outcomes of the Lidcombe Programme

The following article comes from Samantha David in Margate in the South Eastern part of England, and we are delighted that she is able to share with us the system used by the Eastern and Coastal Kent Primary Care Trust Speech and Language Therapy Service to record their therapy outcomes. The system she writes about here known as ‘greensheets’ is specifically designed to record outcomes of the Lidcombe Program.

The use of outcomes within Speech and Language Therapy has been in place in a range formats for a number of years now, with the overarching aim that clinicians can demonstrate the effectiveness and benefits of specific treatment packages. Within the Eastern and Coastal Kent PCT SLT Service the outcome measure used is that of EKOS © (East Kent Outcome System). This system allows for information to be recorded through a care plan which relates to both episodes of care and clinical outcomes. Following initial assessment, at the start of treatment, green sheets (care plans) are written and assigned to each client.

Over a number of years there has been a move to develop standardised greensheets, including one for the Lidcombe Programme; this ensures both consistency amongst therapists but also saves valuable time, rather than re-inventing the wheel each time a client is seen for the Lidcombe.

It is acknowledged that the Lidcombe programme works through individual weekly sessions in clinic, with problem solving and discussion between therapist and parent being paramount. Despite the somewhat individual approach to each client, the Lidcombe programme is relatively uniform with a clear overall aim and thus lends itself towards the use of a standard care plan. An up to date greensheet was developed in 2006 for each phase of Lidcombe (i.e. 1 / 2) with each one comprising of;

- Clients needs group: Dysfluent child (3-7 years)
- Health benefit (RSV:resolving; The plan is to resolve the clinical condition (eliminate the stuttering)
- Overall aim (Long term aim for the end of the client’s treatment)
- Baseline
- Specific objectives for the stage of treatment (includes a method of measurement)**
- Clinical Interventions
- Timescale
- Parental consent/agreement with the therapy aim.
- Contributing factor for when the objective is not achieved

**Whilst a mean severity rating is not used as a measure in Lidcombe, within the greensheet it is used in order to provide an effective, measurable distinction between Stages 1 and 2 and is not used as a weekly prediction of how therapy is progressing
Stage 1
At the beginning at Stage 1, following explanation of the Lidcombe programme, parents are shown the child’s care plan (greensheet). The benefit of sharing this with the parent / carer being that;

- It empowers parents to be part of the child’s treatment and collaborate with the therapist.
- It emphasises that parental involvement is paramount.
- It proves useful in explaining the estimated timescale (12-20 individual sessions). This has been of benefit in encouraging parents to be realistic with regard to how long the programme may take and consequently the commitment required.
- It also allows for the parent/carer to observe that therapy is planned, focused and evidence based.

Following success at stage 1, a second care plan (greensheet) is introduced at stage 2; again this is shared with parents. If the child does not achieve stage 1, there is usually a clear contributory factor such as failure to attend / lack of agreed support etc. and this can be recorded on the greensheet.

Stage 1 Greensheet

<table>
<thead>
<tr>
<th>Comcare</th>
<th>Overall Aim</th>
<th>Baseline</th>
<th>Objectives</th>
<th>Actual Outcome</th>
</tr>
</thead>
</table>

**Health Benefit**

RSV

**Aims Achieved (Outcome)**

FUL=Fully (100%) MOS=MOSTLY (70-100%) Partially (<70%) NOT=Not at all (0%)

**Therapy Package:**

12-20 individual sessions over 3-6 months (depending on severity of stammer/response to therapy)

**Beginning of treatment block**

Severity rating of child’s stammer at home (Mean of 1st week)

**End of treatment block**

Severity rating of child’s stammer (Mean of week)

East Kent Outcome System

Speech and Language Therapist

Parent / carer
Stage 2 Greensheet

East Coastal PCT Speech & Language Therapy Treatment Plan

Client Needs Group: Dysfluent Child 3-7 years

<table>
<thead>
<tr>
<th>Health Benefit</th>
<th>Overall Aim</th>
<th>Baseline</th>
<th>Objectives</th>
<th>Actual Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comcare</td>
<td>To eliminate _____________’s stammering</td>
<td>Has achieved stage 1 of the Lidcombe programme. (Mean SR = 1-2 and within clinic &lt; 1.0% SS)</td>
<td>Child achieves Stage 2 of the Lidcombe programme (Mean SR = 1)</td>
<td>✓</td>
</tr>
<tr>
<td>Beg. Outcome</td>
<td>Aims Achieved (Outcome)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FUL=Fully (100%) MOS=MOSTLY (70-100%) Partially (&lt;70%) NOT=Not at all (0%)</td>
<td>Overall Outcome</td>
<td>For this treatment block</td>
<td>Date:</td>
</tr>
<tr>
<td></td>
<td>Therapy Package:</td>
<td>Start Date:</td>
<td>Planned Evaluation Date:</td>
<td>Actual Evaluation date:</td>
</tr>
<tr>
<td></td>
<td>6-8 review sessions at increasing intervals over approximately 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Treatment Plan: Lidcombe Therapy Programme stage 2 (SLT to refer to Lidcombe manual)

- Daily programme to be carried out at home between sessions (including unstructured feedback)
- Regular review clinic sessions to monitor progress in Stage 2
- Parents complete severity rating throughout therapy block

Beginning of stage 2
Severity rating of child’s stammer at home (Mean of 1st week)

End of stage 2
Severity rating of child’s stammer at home (Mean of final week)

Evaluation
Initial feedback of this care plan (greensheet) has been positive, in particular parents have felt involved from the outset. Therapists who are either new to using the Lidcombe programme and / or early on in their career of speech and language therapy have found it to be a useful tool in setting clear achievable aims.

In the long term it is hoped that the results of these greensheets may be analysed in order to provide further evidence into the effectiveness of the programme, which may in turn be of benefit to departments when demonstrating evidence to commissioning boards.

Sam David
Email: samdavid@fsmail.net