

Communicative Access Guidelines

A ‘Call to Action’

Many people affected by stroke are unable to participate in simple, everyday activities—activities like conversing with friends, relatives, and staff, or making decisions about whether they want to participate in a recreational activity. Why? Because they have a language/communication disorder, such as aphasia, which makes it difficult for them to communicate with other people.

The *Communicative Access Guidelines* presented in this brief document are a call to action. They provide information that explains the importance of creating an Annual Accessibility Plan (**which is now a legal requirement in Ontario**), and provide tools that will assist you to create your plan.

If you have any questions about these guidelines, or about the tools that are provided, please call (416)226-3636.

What is ‘communicative access’?

Communicative access refers to the ability of people with language/communication disorders such as aphasia to gain barrier-free access to services, participate in communicative events, give and get information, and make informed decisions (Simmons-Mackie, et al, 2007).

What is a barrier?

Within the Ontarians with Disabilities Act (ODA), a barrier is defined as “anything that prevents a person with a disability from fully participating in all aspects of society because of his or her disability, including a physical barrier, an architectural barrier, information or communications barrier, an attitudinal barrier, a technological barrier, a policy or a practice” (ODA, 2001).

For people with reduced communication abilities, communicative access often requires accommodations or “facilitators” to reduce these barriers and the disability experienced by people with aphasia (Howe, Worrall & Hickson, 2004). There are many potential barriers to communication for people with aphasia. Moreover, each individual with aphasia has unique needs and it is important to consult with each person to address individual needs. Keeping this in mind, the following table suggests some of the common barriers faced by individuals with aphasia:

Barrier Type	Example
Physical/Architectural	- Lack of clear signage
Information and Communication	- Background noises - People speaking too fast and in language that is too complex

	<ul style="list-style-type: none"> - Lack of skilled facilitators and appropriate communication resources (alternative communication strategies and methods) - Lack of information readily available in accessible format
Attitudinal	<ul style="list-style-type: none"> - Discrimination due to a lack of understanding and awareness of aphasia - Being ignored and excluded from important decisions - Being treated as incompetent - Losing friends due to an inability to participate in conversations
Policy and Practice	<ul style="list-style-type: none"> - Staff do not routinely receive education and training about aphasia - Absence of policies on communicative access - Forms such as consent to treatment or release of information have not been adapted into an accessible format (pictures, keywords, etc.)

(Howe, et al. 2004; Simmons-Mackie, et al., 2007)

A focus on increasing communicative access and opportunity for full-life participation within the healthcare system is in line with the World Health Organization’s definition of health. This is exemplified by WHO Director-General Dr Gro Harlem Brundtland’s address at the 2002 Conference on Health and Disability:

Health is the ability to live life to its full potential. For many people with disabilities, the realization of that ability is dependent on factors in society. When a person in a wheelchair finds it difficult to enter into her office building because it does not provide ramps or elevators, the ICF identifies the focus of the intervention: it is the building that should be modified and not the person who should be forced to find a different place of work (Brundtland, 2002).

Reducing communication barriers can help to ensure that information is presented in an easy-to-understand way, and that people with aphasia are able to participate fully in making decisions that affect them (and that is now a legal requirement in Canada: for example, "Accessibility for Ontarians with disabilities Act," 2004; "Act to promote patients' rights and to increase accountability in Ontario's health care system," 2006; "Health Care Consent Act," 1996; "Substitute Decisions Act," 1996).

Despite these legal requirements, research and anecdotal experience indicates that patients and clients with stroke and communication difficulties do not enjoy equal access to service. For example, within health care facilities, patients with language/communication difficulties often are not included in day-to-day decisions such as choosing menus or in major decisions such as choice of treatment, therapy goals or discharge/transition plans.

What is being done?

Recently, a team of Aphasia Institute researchers carried out a project funded by the Ontario Stroke System. This project was designed to increase communicative access to information and decision making in health care. The project targeted a “systems” level of

health care via a team-based intervention called the Communicative Access Improvement Project (Simmons-Mackie et al., 2007).

Here is how the project worked. Three teams were assembled with representatives from different disciplines from acute care, rehabilitation and long-term care. These teams attended a two-day training session that covered Supported Conversation for Adults with Aphasia (SCA)™, guidance on how to translate site-specific materials into “aphasia-friendly” format, and help in developing institution-specific communicative access improvement goals.

After the two-day training, all teams demonstrated increased knowledge of methods of supporting communicative access and improved understanding of access and inclusion for aphasia. The Aphasia Institute researchers followed-up with participants later on, and discovered that the rehabilitation and long-term care teams had achieved their communicative access improvement goals. The researchers were able to identify examples of systems changes and increased participation of people with aphasia within their programs.

This research project provided insights into the factors that facilitated or impede communicative access in different health care settings. As a result, the Aphasia Institute researchers concluded that targeting systems-level change can be a useful approach to improving access to health care information and decision making for people with aphasia.

What can you do to achieve systems-level change?

On June 13 2005, the Accessibility for Ontarians with Disabilities Act (AODA 2005) became law and is now in effect alongside with the Ontarians with Disabilities Act (ODA 2001). The AODA states that organizations are required to create an annual accessibility plan addressing “the identification, removal and prevention of barriers to persons with disabilities in the organization’s by-laws, if any, and in its policies, programs, practices and services.” (ODA, 2001)

As a service provider, you are therefore required to create an annual accessibility plan.

We are providing you with three questionnaires to help you create the communicative accessibility component of your annual accessibility plan. The first two are internal evaluation tool for administrators and staff and the second, a pictographic questionnaire for clients/patients with aphasia.

These questionnaires provide a user-friendly way of rating and evaluating communicative access within your facility. The questionnaires will allow you to:

- Identify barriers to communicative access
- Create communicative access goals based on the results
- Measure changes in levels of communicative access over a period of time

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