

communication

# matters



**Access Matters Aotearoa March to Parliament 2024**

Te Reo Māori Vocabulary for High-Tech AAC • Caring for People with Dementia Together

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**Cover:** Access Matters Aotearoa March to Parliament 2024. Photo courtesy of Juliana Carvalho.

Please contact the editor with your ideas at any time: [editor@speechtherapy.org.nz](mailto:editor@speechtherapy.org.nz)

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1 MAY–  
31 AUG

### Paediatric Feeding Foundations Program

Facilitated by Carly Veness,  
Babble & Munch Learning

Online

More information available at  
**babbleandmunchlearning.com**



2 MAY

### NZSTA Annual General Meeting

Online • 4:30pm

Register in advance on  
**speechtherapy.org.nz**

# NZSTA upcoming events

Email **editor@speechtherapy.org.nz** to list your event on the NZSTA website in future issues!



4–9  
JUL

### NZSTA Area Meetings

Te Tai Tokerau Northland • 4 July,  
12:30pm

Central • 9 July, 11:30am

Canterbury/ Westland • 9 July

Please contact your area  
representatives (see Contact details  
on page 24) for meeting links



27–29  
MAY

### Speech Pathology Australia 2024 Conference

Perth Convention and  
Exhibition Centre

View programme at  
**speechpathologyaustralia.  
org.au**

Email **conference@  
speechpathologyaustralia.  
org.au** for further information



24 JUN

### Assessing and Facilitating Sentence Diversity in Early Language Intervention

Facilitated by Dr Pamela A. Hadley,  
University of Illinois Urbana-Champaign

Online

Tickets at **events.humanitix.com/  
online-assessing-and-facilitating-  
sentence-diversity-in-early-  
language-intervention**



21–22  
OCT

### NZSTA 2024 Symposium – Ngā Hononga

Te Wānanga o Raukawa, Ōtaki campus



15–18  
OCT

### 77th Annual General and Scientific Meeting of the New Zealand Society of Otolaryngology – Head and Neck Surgery (NZSOHNS)

Kirikiri-roa Hamilton – Claudelands Convention Centre

More information available from **conferences@w4u.co.nz**



2025

### 33<sup>rd</sup> World Congress of the IALP

Tel Aviv, Israel • 10–14 August, 2025

Registrations and call for abstracts accessible at  
**ialptelaviv2025.org**



# Access Matters Aotearoa hīkoi to Parliament – interview with Juliana Carvalho

The Access Matters Aotearoa March to Parliament took place on March 3, 2024, with the aim of encouraging the Government to listen to disabled voices in their consultation process when reviewing the Accessibility for New Zealanders Bill. Access Matters Aotearoa lead campaigner **Juliana Carvalho** was interviewed by *Communication Matters* editor **Emma Wollum** about the kaupapa of Access Matters Aotearoa and the outcomes of the March to Parliament.



All photos are of participants in the Access Matters Aotearoa March  
All photos courtesy of Juliana Carvalho

**I'm wanting to let our readership of speech-language therapists know what it is you do, how they can get involved, and how we can make our practices more accessible. How long have you been involved with Access Matters Aotearoa?**

Since 2017 as a volunteer – I'm really passionate about it. Coming from a country where you have disability legislation since the year 2000, and you have that entitlement – when you face barriers you have the backing of the law to do something about it.

**I hear a lot of stories from people who get asked to confirm that they still have the same disability that they had two or three years ago. It seems like it really robs people of their dignity.**

Yes it does, it is a bit of a mixture of misunderstanding plus bureaucracy, unnecessary bureaucracy, and also when people are applying for things like a supported living payment with Work and Income. Depending on the condition, you might need to have

an update, but a lot of conditions are permanent – you know, the person will still have Down’s syndrome next year, I will still be paraplegic. So frustrating for the individual that is having to go all the way and trying to pass on information again, you know even the website or the forms you need to use are not accessible as well.

**With the forms in particular – speech-language therapists work a lot with making forms and processes more accessible. Do you have any thoughts on how to make forms more accessible?**

I would say it depends on the needs of the person – I do get the challenge of making everything accessible to everybody. So you have to have different ways to communicate, because the way you communicate with someone, the way you pass on information or collect information from someone who has a visual impairment will be different from someone who’s Deaf, and different from someone who is nonverbal. It’s about having the flexibility to address the needs of each individual, and that could be pretty basic. For example, if it’s an online form, is that form easy to use with a screen reader? Do you have the information in New Zealand Sign Language? One of the things that you see in a lot of forms is those checks to see if you are a human, and is that accessible for whoever has a mobility impairment? I struggled with the cursor to click on those images. It is an exercise of, okay what does this person need? How can I address that?

**With our roles we often are asked to get people to sign consent forms, so it feels like the language of that can sometimes be quite inaccessible, or the form in which that’s presented can be quite inaccessible.**

That’s the other thing, that’s a very good point. Is that information in plain language, or do we have that information in easy reading format so people who have learning or intellectual disabilities can get the basics of that information? And consent is a big thing – for example I’ve heard stories about people who are blind who get ‘just sign here’. Even when you don’t have any sensory impairment, even then consent is a big issue.

**Have you seen any examples of accessible consent forms written in plain English?**

No, not yet.

**That will definitely be of interest to our readers. I wanted to ask about the hīkoi as well, the March to Parliament – could you summarise what the aims of the march were and what changes you’d like to see in the Accessibility for New Zealanders bill?**

So the march was a very positive demonstration of our resilience, our diversity within the disability community. Our goal was to deliver a petition to the Minister for Disability Issues, asking for a redraft of this Accessibility for New Zealanders bill, in consultation with those who are most impacted by it. We hear over and over from local



councils and businesses that people want to do the right thing, and they don’t know how. That’s why with the redraft of the bill, it is paramount to have enforceable accessibility standards. That’s something that doesn’t need to be reinvented, because New Zealand, it’s quite behind in terms of accessibility legislation. You can get overseas standards that will actually not change at all, the laws of physics don’t change – like the inclination of a ramp, or the way that you do captioning or audio description. So it’s just a matter of establishing standards for industry, introducing specific standards for accessibility for all areas of life. That’s our vision.

**And standards that are led by disabled voices as well.**

Exactly, and in consultation with affected parties. I know that it’s possible – if you think about the Health and Safety Act for example, when it was passed there was a huge revolution. But now there’s a whole industry of health and safety, every single job has a health and safety rep.



It will be the same thing with disability in our vision, there will be standards of accessibility like health and safety. And then you will have representatives for accessibility in businesses, and it will create a new industry, it will lead to innovation. It will be such a win-win in society in all ways. In my opinion the only way that you really create change is when you occupy spaces. So there's been a historical segregation – historically people with disabilities have been excluded and segregated, put in institutions, and the connotation around disability is something that is still negative. And all of this is a social construct. We as human beings, we assign meaning to everything. For some reason, this meaning has been assigned to having a disability as something bad, or having a disability means that you're less valuable than someone that doesn't have an impairment. And all those narratives need to change, they're really harmful, they perpetuate exclusion, they perpetuate the status quo. The only way

that we can change that and create real inclusion and belonging is for people to be able to occupy spaces. Then the difference and the ignorance and the assumptions go away, when we have the chance to interact. I don't blame individuals, this is a social construct, right? For my 19 years growing up, I never had a friend with a disability, I never interacted with someone with a disability in school or when I was doing my training, because people were segregated. So it's not the fault of the individual that they never had access to information or the chance to interact and learn, and this is just part of human diversity. When you have a disability you become aware of the barriers, you become aware of the stereotypes, you become aware of the rights that you took for granted, they just vanished just because you are now sitting in a wheelchair, but you're still the same human being. We all have a role to play in the process of inclusion and belonging. From the government it is paramount

to have disability legislation to establish how we can make sure that people have access to all areas of life and bring about equity. From individuals, respect those rules, and do what they can do to be welcoming of human diversity and be open minded.

**I'm speaking on behalf of an audience of speech-language therapists, but from a health perspective in general, what can we do better to respect and amplify disabled voices?**

I don't know how aware you are of the medical model and the social model of disability. Just shift from the medical model – within health settings the medical model perseveres. Embrace the new narrative that what disables someone is the interaction between the impairment and the environment, when you don't have the elements that provide equity. Be open minded and take an unconscious bias test to try to understand where you stand with your bias towards disability.



**I'll definitely be recommending that to our audience. I also wanted to ask what an accessible Aotearoa looks like for you? If the legislation is enacted and all of the changes are made, what does New Zealand look like?**

I would say the vision is a country where everybody has a place, everybody has a chance to get a job if they wish to, everybody has access to education, everybody feels that they belong. People don't feel they are a burden, or treated as burdens. People are valued just for the fact that they are human beings – I think it will be a country that allows people to achieve their full potential.

It is a little bit philosophical, you know, because at the core of what we're doing is that we need to change the narrative around disability. We're fighting and fighting to say 'please make us disability legislation', and it should be something more like 'everybody should have the same opportunities'. So how can we make that happen?

**It is quite a philosophical question, because it does come down to ideas of equity and of humanity as well.**

Right, if someone asked me before, like the 19-year-old Juliana, and said 'one day you will end up in a wheelchair', I would have said 'I would rather die than end up in a wheelchair'. And now my perspective has completely changed. So we need to create that change in society that it doesn't have to be a negative meaning.

**And the accessibility legislation would come out of having a different mindset from individuals and from society around disability as well.**

It's what I said earlier, if you want to create change then you occupy spaces. And the only way that people with disabilities will be able to occupy spaces is through accessibility. When we are able to do that, the narrative will change. People need to understand that this is really philosophical, it's complex, that this is a meaning that has been constructed by society. Human diversity is a beautiful thing, we come in all forms and shapes with different abilities and disabilities. As a society, what can we do to embrace everybody having the same chance to achieve their potential?

**I really admire what you're doing and I want to bring more attention to it. Are there any other topics that you'd like to talk about or advocacy campaigns that you'd like to feature?**

We have a couple of initiatives coming up – one is called Kōrero for Change. We want to invite people who are not in the sector, but are influencers and decision makers and people who form opinions, to have really courageous conversations about ableism. The first one took place on 10th April on the topic of media and communication. Media and communication is huge in shaping the way we think, the way we behave, and the beliefs that we have. So we want to invite those thought leaders in the area, head of departments of universities

that teach the future journalists and communicators. Do they think about what is their role in the process of inclusion and belonging and challenging ableism? The more people who deconstruct the status quo, and create a new narrative, the better. The disability movement is relatively new, there's a lot to be improved. It's a matter of people not accepting the status quo, and understanding the value and what they can bring.

**Everyone's got a unique perspective. Thank you for your time today.**

Thank you for the work you do, it's really important. ●



For a full transcript of this interview, contact [editor@speechtherapy.org.nz](mailto:editor@speechtherapy.org.nz)

# Paid Placements Aotearoa: advocating for paid training in healthcare professions



**Bex Howells**, Founder, Paid Placements Aotearoa

Paid Placements Aotearoa was set up to advocate for paid training in healthcare, education, and social work professions.

It was born out of frustration that began in 2020 when I enrolled in a Master of Social Work program. The placement requirements meant working full-time for free for six months – in the middle of a pandemic to boot. When I asked my programme coordinator how I might sustain myself financially during this time, he told me to go to the foodbank. It was expected that I would live in financial hardship and risk defaulting on my mortgage to work for free for ‘the greater good.’ All to enter a profession with chronic staff shortages that would never pay me enough to recoup the debt. Madness.

I dropped out of the social work programme but I could not let the issue of unpaid placements go. Fast-track to 2023, and I am in the midst of writing a Master’s of Social Policy on student experiences of unpaid placements in healthcare. The findings of this research are the basis of the campaign for paid training. To explain how I reached this conclusion (albeit a somewhat obvious one), I’d like to lay out the challenges students are up against. For some of you this may be a trip down memory lane, but for those of you currently training, I hope you feel seen and validated. You are not alone in dealing with the struggles of placement poverty.

To be granted a place in healthcare programs, students typically need to have good grades and a solid work ethic. They are hardworking, ambitious, and driven by a desire to help members of their community. Many are mature students embarking on a second career. These professionals have a wealth of work

and life experience. They are an asset to the workforce but juggling children, mortgages, and other life commitments can make unpaid training especially prohibitive for this demographic.

Students enter their training programs eager to learn and gain some practical experience. Then the reality of unpaid placement begins to set in. Travel costs, uniforms, immunisations, textbooks, equipment, parking, childcare costs, and double rent if students are sent on placements away from home. They are paying fees to work for free, all while collecting debt to cover living expenses and course related costs. On top of unpaid placements, students have ongoing study requirements and inevitably need to find paid work to sustain themselves financially. StudyLink’s offerings do not cover the basics – rent, food, bills – in the current economic climate.

The cost-of-living crisis has really brought this issue to a head. For too long we have relied on students’ good will and a desire





### Supporters of Paid Placements Aotearoa present a petition

Photo credit: Bex Howells

to serve their communities, but that good will is running out. These hidden costs become compounding when students are juggling unpaid placements, study, paid work, and personal commitments. For many, it understandably becomes too much, and we are seeing this in dropout rates as high as 45 per cent. Those who do complete their training report feeling burned out before they've even begun. Riddled in debt, this system incentivises people to move overseas for better paid jobs in order to pay off their huge student loans. We are losing our future professionals at an alarming rate.

The current training set up is doing little to address the chronic staff

shortages across the healthcare sector. With an ageing and retiring workforce, a comparative trickle of students entering the workforce, and professionals moving overseas for better pay and conditions, those who are still here doing the mahi are feeling the pinch. Long waitlists and high caseloads create pressures that make it difficult to provide quality treatment and rehabilitation. Efforts to recruit from overseas have not proved fruitful as those who do move here tend to stay short-term, en route to Australia. This system is failing all of us – students, professionals under the pump, and members of the community who cannot access the services they need, when they need them.

We need to rethink the way we train these highly skilled, highly qualified professionals. For sustainable, long-term workforce development we need to train people domestically and recognise (read – remunerate!) the value of people's time whilst they train. For every hour a student is on placement, they are effectively losing income. We must compensate them in such a way that they can meet their basic needs, focus on their training, and complete their qualifications. If it seems like a pipedream, let's take an example of paid training in action. Police recruits spend 20 weeks at Police college and are provided food and accommodation during that time. They earn **\$56k/annum** during this

period and then start on \$75k/annum as a probationary officer. No student loan, no debt, and no stress about whether they can afford to eat and put a roof over their heads. Since 2017, the Police force has **increased the number of officers by 21%**. The workforce is the most diverse it has ever been with more women, Māori, and Pasifika officers than ever before. Paid training works.

Another key factor to address is how unpaid training is directly connected to issues of pay equity. For those of you who are long since qualified but sense you are not remunerated fairly for your mahi, it is worth noting that **low wages are driven by unpaid training** – because if you're willing to work for nothing, you will graciously accept something. By championing your students to be paid, you are building a foundation from which to advocate for your profession to be better paid too.

Paid Placements Aotearoa is advocating for paid training in healthcare, education, and social work because we believe that our future professionals deserve to live with dignity whilst they train. We are advocating for students to be paid a universal, annually increasing stipend to reflect the year-on-year increase in placement hours, skill development, and responsibilities. First-year students would receive the equivalent of a training wage,

second-year – minimum wage, third-year and above – living wage. It would be paid through StudyLink on a fortnightly basis, just as students currently receive student allowance or living costs. Most importantly, this money is non-repayable.

The idea of the stipend is that students have a regular, reliable source of income throughout their training, whether they are on placement or not. We want students to be able to focus on their studies, and to be able to graduate fresh and ready to provide quality care to their patients. The stipend is particularly beneficial to students working in one-on-one client-facing work. An hourly wage might mean they were only paid for the time they were seeing clients. The stipend covers their time writing up notes or treatment plans, attending meetings, supervision, and other tasks associated with training. The stipend will not make students employees and will not require any changes to training, practice, or supervision. Their placement providers would not be responsible for paying them a salary, which we know would likely result in the disappearance of many precious placement opportunities. The only condition is that students must meet their course requirements. Essentially, everything carries on as it is, except students are remunerated so they can complete their training and join the workforce as soon as possible.

One way or another, we all benefit from paid training. Funded workforce development will improve accessibility to training, lighten the load for our practicing professionals, increase the diversity of staff, & enable better access to quality services for whānau & community. ●



If you support paid training for healthcare professionals please sign and share the petition **Grow the workforce: paid training in healthcare, education, and social work** which can be found on the **Action Station website** or the **NZSTA website**.

You can also follow Paid Placements Aotearoa's ongoing advocacy on **Facebook**, **Instagram**, and **LinkedIn**.

Bex Howells is a Master of Social Policy student. Her thesis explores student experiences of unpaid clinical placements in healthcare professions. She is the founder of Paid Placements Aotearoa and leading the campaign for paid training in healthcare, education, and social work.

# Ko tōku reo tōku māpihi maurea – Te Reo Māori vocabulary for high-tech AAC

Sarah Doran and Mary Browne, TalkLink

Ko tōku reo tōku ohooho,  
ko tōku reo tōku māpihi maurea  
*My language is my awakening,  
my language is the window  
to my soul*

Kei ngā Kaihāpai Reo Kōrero e pikoko nei ki te tukuna te reo Māori ki te ao, tēnā koutou katoa!

He pānui tēnei e pā ana ki tēnei mea te AAC i te reo Māori. E mihi ana ki a koutou katoa kua mahia hei hanga ngā rauemi kōrero Māori mō ngā tāngata whaikaha!

Over the past few years, many SLTs have been involved in the development and sharing of low tech AAC resources in Te Reo Māori, such as translated core boards. As more AAC users, SLTs, kaiako, and whānau work to develop high tech AAC in Te Reo, we were keen to consider how we can share these resources across the motu.

While the Tua o te Pae kaupapa is on its way to develop a synthetic Māori voice that can be used with speech output devices, and hopefully a high-tech Māori system will be developed in the

future, we are conscious that Te Reo Māori AAC is needed now. Translation of currently available English language apps is not an ideal solution; however, it is an interim measure that makes Te Reo Māori AAC more accessible in the short term. This mahi to translate and edit pronunciations is time-consuming, so we wanted to consider how we could share this more widely as a koha to help others communicate in Te Reo Māori.

A working rōpū was formed of Mary Browne (Te Āti Awa, TalkLink Christchurch), Sarah Doran (TalkLink Wellington), Amy Isbister (MoE Christchurch), Jemma Bridge (Ngāpuhi, MoE Taranaki) and Kerry Heslop (Tūwharetoa, Tūhoe, Ferndale Special School) and we came up with a process for this alongside the Aotearoa AAC Special Interest Group. The AAC SIG currently hosts a Google Drive where SLTs can access and share high-tech vocabulary sets translated or partially translated into Te Reo Māori:

**[bit.ly/TeReoMaoriAAC](https://bit.ly/TeReoMaoriAAC)**

We would invite anyone working with clients who wish to use Te Reo Māori AAC to access this folder. However,

please, as always ensure that this continues to be a collaborative process with whānau involved in adding their own personalisations and reo rather than a resource that is just handed out. If you have developed a Te Reo Māori vocabulary set yourself and would like to share this, please email this to the AAC SIG: **[aotearoaacsig@gmail.com](mailto:aotearoaacsig@gmail.com)**. We have developed a set of guidelines for this, including a sample consent form template for use where a client, whānau member, kaiako, or another person has translated the resource. We would ask that any consent forms are held by the SLT themselves and all identifying information is removed before sending to the SIG, to avoid any privacy issues. We hope that this will become a resource bank for SLTs and whānau going forward!

We would like to acknowledge the mahi of all members of this working rōpū, the AAC SIG, and especially tangata whaikaha, their whānau and kaiako who have been involved in this mahi so far.

Mō tatou, ā, mō ngā uri ā muri ake nei.  
Kia kaha Te Reo Māori! ●

A Te Reo vocabulary set for high-tech AAC

Photo credit: TalkLink



# Caring for People with Dementia Together

**Kong Chan**, Project Manager, Chinese Dementia Project – Caring for People with Dementia Together (CPT)

Imagine a world where memories fade, faces become strangers, and the once-familiar rhythm of life dissolves into confusion. For those facing dementia, this heart-wrenching reality is their daily struggle. Yet, the impact of dementia extends far beyond the individual – it touches families in profound and often overwhelming ways.

As the disease progresses, the person afflicted slips further away from recognition, leaving families grappling with an excruciating paradox: a loved one who is physically present but mentally distant. Simple tasks become insurmountable challenges, and the roles within families shift dramatically as caregivers step into new, demanding roles. This emotional rollercoaster is accompanied by financial strain, as the cost of care compounds over time.

This is where the **Caring for People with Dementia Together (CPT) project** emerges as a beacon of hope. A joint effort between Dementia Auckland, Age Concern Auckland, Te Whatu Ora Health New Zealand Counties Manukau, The University of Auckland and The Vagus Centre, the CPT project is a cross-community partnership with a mission to bring meaningful change to the lives of Chinese families impacted by dementia in Auckland.

Chinese individuals access dementia services less than other ethnic groups due to a complex interplay of factors – a lack of relevant resources, issues of accessibility, and the weight of cultural stigma. The urgency to rectify this situation is underscored by projections that the number of Asian individuals living with dementia will skyrocket from 4.8k in 2020 to a staggering 17.9k by 2040.

The CPT project isn't just about statistics; it's about transforming the lives of Chinese people living with dementia and their families. Our focus lies in three critical pillars:

## 1

### **Awareness and Prevention**

We aim to empower the Chinese community with knowledge about brain health and dementia risk reduction through various initiatives, including information sharing on our project website at **[chinesedementia.org.nz](http://chinesedementia.org.nz)** and public awareness talks on understanding dementia. These talks are designed to raise awareness of dementia and promote brain health in the Chinese community. The talks cover topics such as What is Dementia?, Diagnosing Dementia, Symptoms of Dementia, The Journey through Dementia, and Brain Health and Dementia Risk Factors. We have received valuable feedback from the participants of our previous talks, which highlighted the significance of the public awareness talks within the Chinese community. The positive response confirmed the community's demand for more of such informative discussions.

The CPT Project has been launched to provide support for dementia in Chinese families and communities in New Zealand

Photo credit: [chinesedementia.org.nz](http://chinesedementia.org.nz)



To make a donation, please visit our project website at **[chinesedementia.org.nz](http://chinesedementia.org.nz)**. To be part of this transformative journey, you can reach out to our project manager, Kong Chan, at **[kong.chan@chinesedementia.org.nz](mailto:kong.chan@chinesedementia.org.nz)**. Together, let's paint a brighter future for Chinese families touched by dementia.

However, for our project team to continue to serve the Chinese community with the above initiatives, we need your support. With no current funding from Te Whatu Ora Health New Zealand, the project relies on community collaboration and donations.

Our project group is steering the ship, but it's a voyage that requires every hand on deck. Your involvement can bridge the gap and make a lasting impact. Your generosity can help us create a future where understanding, empathy, and comprehensive care redefine the journey of those facing dementia. ●

## 2

### Education

Our education training programme aims to support dementia-friendly Chinese healthcare professionals to provide culturally appropriate dementia assessment and management for the Chinese community. This programme runs twice a year, featuring a total of six sessions. The first three sessions are scheduled for April, May, and June 2024, followed by three sessions in September, October, and November 2024. We are very grateful to have invited Dr. Yu-Min Lin (Consultant Geriatrician), Dr. Joanna Wang (Old Age Psychiatrist), Julie Yap (Gerontology Nurse Specialist), and Jim Xu (Nurse Practitioner) to be our guest speakers. The programme will cover topics such as Diagnosing Dementia, Types and Symptoms of Dementia, Medication Management, Communication Strategies and Supports for People with Dementia, their Carers and Families, BPSD assessment and interventions, Capacity Assessment, EPOA and PPR process.

## 3

### Living Well Programme

We aim to enhance the well-being and quality of life for people affected by dementia through running a range of programmes, including the Cognitive Stimulation Therapy (CST) Programme. The CST Programme, a proven and evidence-based psychosocial intervention, aims to enhance the quality of life and cognitive functioning of individuals diagnosed with mild to moderate dementia. Originally developed in the United Kingdom, CST is a structured and manualised group cognitive intervention that involves 14 sessions of themed activities. Sessions are aimed to actively stimulate and engage people with dementia, whilst providing an optimal learning environment. CST has been shown to improve cognition, quality of life, and communication; and is recommended for people with mild to moderate dementia in the UK's National Institute for Health and Care Excellence (NICE) dementia guidelines. The evidence for CST on cognition is highlighted in the Lancet-commissioned report on dementia prevention, intervention, and care, which states CST is 'the psychological approach with the strongest evidence for improving cognition'.

# Early access to augmentative communication – a single subject case study

Joanne Byrne, SLT (Ferndale Specialist School, TTANZ, private practice)

This article describes the early introduction of high tech personalised AAC to a young child, and their progress over the next ten months.

Neo was referred by their mother in March 2023 for communication support. Neo was 24 months old and nonverbal. There was concern from Neo's preschool about their development, and Neo had been to see a paediatrician for developmental delay to see if there was a reason for the differences in development. The paediatrician was not ready to make a diagnosis. Neo was on the waitlist for a Ministry of Education SLT, and the family had already received a phone consultation from MoE.

Neo was the first child of Pākehā parents, who provided rich play opportunities, daily book reading, and quality preschool experiences. Despite this linguistically rich environment, verbal communication had not developed. Neo had a younger sibling (six months of age).

Neo was noted to be a very active child. Neo played with toys in unusual ways, for example would play with toy cars by laying them on their side and opening and shutting the door. Neo was noted to flap their hands, and to enjoy playing by themselves in isolation from others. Neo would hide behind their hands and peek at people. Neo was reluctant to engage with new toys or activities and would look away from them. Neo enjoyed physical play and spent long periods of time doing circuits of the obstacle course set up in a living area.

An observation visit at preschool showed that Neo was withdrawn from the class group, and preferred to watch from a distance and only when music and singing were occurring. Neo would become overwhelmed and start crying when the environment proved too demanding. Staff were experienced with nonverbal children and had low tech communication boards available in the environment, using visuals to support transitions.

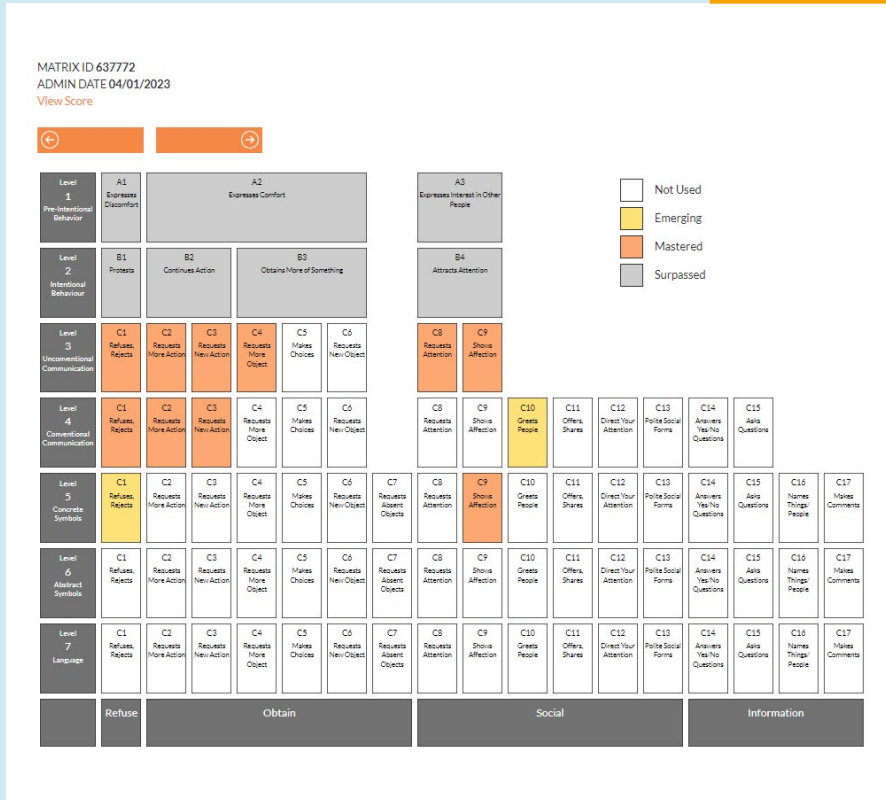
Neo presented with social communication disorder. A Communication Matrix assessment was completed in early April 2023 (*Figure 1*) to obtain a baseline of skills.

The SLT provided parent training, and encouraged traditional language facilitation techniques. Makaton signs were introduced. In April a long term loan iPad was provided with TouchChat with WordPower, featuring a 60-cell setup personalised for Neo with family members and favourite toys and foods. The SLT spent time supporting Neo's parents with language modelling techniques, and training around core words in AAC. In weekly therapy sessions of one hour, the SLT provided modelling without expectation or obligation.

There was little initial engagement with the device from Neo. The family provided Neo with a small table and chair where Neo sat for meals. The iPad was set up for Neo each day on the table so it was readily accessible for them.



Figure 1



By May of 2023 Neo was making some progress and using “Go”, “Uh oh” and “b-b” for goodbye. The SLT brought additional iPads to sessions so everyone had one to access. Neo began to show increased interest in the device. Neo responded well to the iPad Pro with the larger screen and larger icons. By the end of May Neo began to copy the SLT by slowly and deliberately extending their index finger and touching specific icons the SLT had used. By June when the SLT was using animal puppets in play, Neo would lean forward and look directly from the animal being used to the animal modelled on the screen. They would lean forward and focus on the icon. By the end of June Neo began to explore the device with increasing independence. Neo’s mother reported that Neo would spend considerable time at their table, exploring the device and listening to words.

Communication Matrix  
4 January 2023

By July of 2023 Neo's mother reported that Neo was understanding more language and that transitions were easier. More social interaction was noted with increased smiling, and eye contact and enjoyment of the company of others. Some verbs were beginning to be used verbally.

In August of 2023 the Communication Matrix was readministered (Figure 2), showing considerable progress.

By September Neo started occasionally using two words together to create simple phrases (e.g. Yummy chips).

Neo's Ministry of Health-issued communication device was finally delivered following delays in set up with a new system put in place by TalkLink. An early intervention teacher began to work with Neo at preschool. Neo's mother reported she was finding it difficult to keep up with the constant increase in verbal language from Neo. Neo was reported to know colours and could count to five and began to use some prepositions.

By December of 2023 Neo was noted to be using phrases of up to four words, e.g. "Poppa coughing, you ok?". Neo's family are delighted with Neo's progress and have reduced SLT support as they are managing well. Neo will continue to be monitored and the SLT will be available if the family requires further assistance. The family also noted that their younger child was developing extensive speech, and also enjoyed using the communication device.

Research indicates that early access to AAC can support children's communication development. Early Augmentative Communication needs to be personalised to the needs of young children who are observed to have complex communication needs. Having early access to a robust Augmentative communication system proved an effective intervention for Neo. Early AAC provides a rich language tool to support language development. Allowing a child

Figure 2



Communication Matrix  
Late August 2023

“

Neo’s mother commented in late 2023, that she initially thought AAC was a bit ‘weird’ but now believes AAC has made huge changes in her child and enabled them to make fast progress in communication acquisition after a rocky start. It would be good for more children to have these opportunities.

to explore a system enables them to do this at their own pace, to start making sense of word beginnings and endings and how language works. They can control how they experience language, so that it becomes more meaningful for them.

It is concerning that often children who cannot communicate verbally, are starting school in New Zealand without a communication system, and without regular access to quality early intervention. In New Zealand children are able to access free communication devices funded by the Ministry of Health. Access does not appear to be equitable, and often depends on the skill set of

the SLT working with an individual child. The author urges early referral to TalkLink for assessments when an SLT is not able to complete the assessment. Due to demand, TalkLink unfortunately has an extensive waitlist. The writer encourages therapists to seek Communication Assistive Technology 1 (CAT 1) assessment qualifications so that they too can provide assessments and early access.

AAC opens the window to communication for many children. It is a rewarding and interesting area of practice. There are considerable free resources available online for people wanting to upskill, and many of the makers can assist with free copies of software for trials. ●

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**Jo works at Ferndale Specialist School, as a Communication Assistant for TTANZ, and in private practice. Jo has been working with children and young people with disabilities for over twenty years.**



# Kōrero Mai: How a weekly kōrero is increasing the cultural competence of the entire TalkLink organization





Rosanna Tilyard, SLT, Talklink

*He waka eke noa – we are all in this together.*

Wahanga Tū Kōrero (The TalkLink Trust) have a dedicated focus on recognising the Rangatiratanga of Tangata Whenua and our responsibilities under Te Tiriti o Waitangi. In 2023 a new forum was introduced to allow all TalkLink staff to upskill in their Te Reo and tikanga Māori.

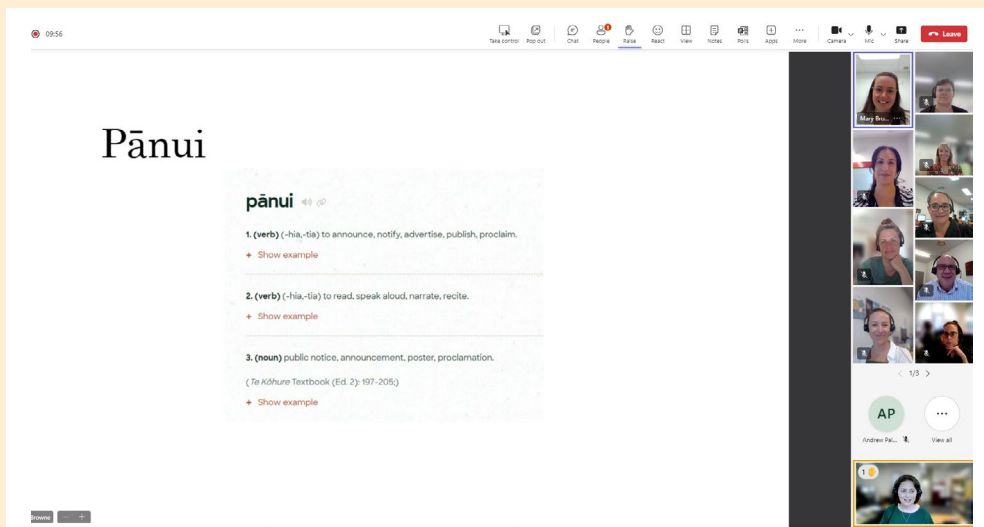
Kōrero Mai is a weekly 30-minute online Teams meeting held nationally for the TalkLink Team. Mere (Mary) Browne (TalkLink Pou Awhina and SLT) from Te Ātiawa facilitates each session with a reliable weekly structure consisting of karakia, waiata, pānui and a short lesson and activity in breakout rooms. Topics covered have included connections to the land, Te Tiriti, Matariki, clinical practice, common Te Reo sayings and kiwaha, pepeha/mihimihi and whakataukī. A large proportion of the TalkLink workforce including clinical, administrative, management and technical support attend these hui weekly and are gradually growing in confidence to share and lead discussions.

## **In the year since Kōrero Mai started we have seen the following outcomes;**

-  The majority of TalkLink staff feel comfortable opening and closing hui with karakia
-  TalkLink staff feel comfortable greeting others in basic reo
-  TalkLink clinicians have an understanding of the effect of culture within the clinical relationship
-  TalkLink staff have researched the Māori history and pūrākau of the land they live/work on

Mere developed the idea of the Kōrero Mai hui as part of her Pou Awhina role after being inspired in her own Te Reo learning environments and Kaiako such as at Te Wānanga o Aotearoa and Kā Poupou reo o Tahu. She wanted to come up with a bite-sized way to increase the competence of the entire workplace. Mere met with managerial staff and had their full support. She attributes the success of this initiative in the TalkLink setting to dedicated time allocated, managerial support, and the online setting. Mere also receives tautoko from other Māori staff including Geneva Hakaraia-Tino (Ngāpuhi, Te Aupōuri and Ngāti Awa) and Claire Crooks (Ngāpuhi and Ngāti Hine) as well as Tāngata Tiriti who support with planning and facilitating Kōrero Mai.

A big part of the success of Kōrero Mai is how it was created with the busy schedules of travelling clinicians in mind. The online forum allows all staff to attend, including those working remotely and travelling to the regions. The day alternates fortnightly to allow part-timers to attend. Keeping meetings bite-sized and regular has allowed us to learn little and often. This way knowledge builds slowly and gives us time to incorporate our learnings into clinical practice.



A Kōrero Mai Teams meeting

Photo credit: Rosanna Tilyard

“ When always so busy with large caseloads, the little and often approach of Kōrero Mai has worked so well. Regular little bite-sized pieces of learning every week that you then take away, reflect upon, and put into practice has made a huge difference to my confidence and use of reo and tikanga.

Polly Thomas – Specialist Teacher

Clinicians are also eager to increase their knowledge of Te Reo and Te Ao Māori, and many of us have incorporated engagement with Kōrero Mai in our quarterly goals and NZSTA CPD logs.

TalkLink clinicians report feeling more confident working with Māori and their whānau in a culturally safe and respectful way.

An additional benefit of this weekly hui has been the whakawhanaungatanga across our organization. The forum presents an even playing field across roles where we are all learning together. The breakout rooms have allowed us to get to know staff from other offices who we may not come into contact with otherwise. The tuakana/teina

relationship that is developed has created an open learning space where we can all be both learners and teachers in a non-hierarchical way. As a result, stronger organizational relationships have developed with staff working more closely with each other nationally.

Kōrero Mai will be continuing throughout 2024 as it has become an integral part of TalkLink. Mere’s hope for the future is that learning will be continually enriched by sharing the roles and responsibilities of leading the hui across the organization and encouraging staff to continue to direct their own learning. ●

# Mental health & nutrition in dysphagia

Helen Duyvestyn, Registered Nurse, One Life NZ

We all understand the importance of nutrition when it comes to physical health. What is less discussed and recognised is the importance of nutrition when it comes to mental health.

In my work as a mental health nurse – I have a strong focus on how diet and nutrition can impact a person’s mental well-being.

A wholefood, nutrient-dense diet with adequate fibre is associated with better mental health. Studies show that changing a diet from a SAD (in this case a Standard Australian Diet) to a modified Mediterranean diet can result in a significant reduction or elimination of depression in over 30% of participants.

On the other hand, consumption of ultra-processed foods (UPFs) – such as packaged food, premade meals, commercially made cakes, pastries, doughnuts, sausages etc – has been associated with poorer mental health, including depression, anxiety and sleep-related issues.

UPFs are foods that have been modified in some way beyond what would normally be done in food preparation at home, and contain ingredients that are not usually seen in the average kitchen such as preservatives, additives,

emulsifiers, flavours, and other substances that may not be considered ‘food’. As part of the manufacturing and packaging process, they may also contain advanced glycation end products (AGEs), industrial trans-fatty acids, bisphenols, microplastics, mineral oils, and phthalates.

Some of these additives have been associated with poorer mental health – for example, industrial trans fatty acids have been associated with increased irritability, aggression, and poor emotional regulation.

## Modified diets

As a speech-language therapist, you may need to recommend modified diets for those with chewing or swallowing difficulties. Beyond the impact a modified diet may have on their social life and their experience of enjoyment in food texture and taste – they may also be missing out on essential components of a healthy diet associated with better mental health.

Modified, pureed, and soft diets may be deficient in fibre, potassium, and certain vitamins such as vitamin C and folate (vitamin B9). Diets low in fibre may compromise digestive health and alter gut microbiota composition – a more varied microbiome is associated with better mental health outcomes.

Food supplements (such as Fortisip, Ensure) used for people who need extra nutrition contain vitamins and minerals, which are essential for neurotransmitter production. However, they may lack amino acids (the precursors of neurotransmitters obtained from protein), fibre, polyphenols and other natural substances found in other foods which support microbiome health.

Supplemental foods and thickeners also fall into the UPF category – ie they contain ingredients not used in the kitchen, contain foods that are modified, and may contain additives or preservatives. It’s important to recognise that there are degrees of ultra-processed foods (eg most plant-based milks are considered UPFs) and it’s impractical to



remove all UPFs from our diets. However, we may be able to reduce UPFs and the associated negative effects of packaged pre-made foods if we take a little extra care and thought to the quality of the diet the individual is receiving.

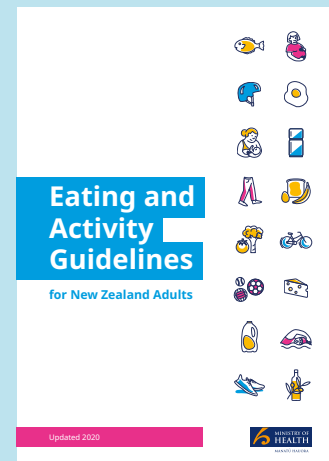
### What can you do?

On discussion with the individual and their whānau – it may be helpful to think outside the square. One of the questions you can ask yourself is: What can we add? How can we make this contain as many nutrients as possible? For example, if the food is pureed or made into a smoothie with a fortified supplement, can we add extra fibre? Can we add in some extra green leafy vegetables? Or is the individual willing to prepare a few meals a week, e.g. a thick soup containing pureed vegetables and meat, that can be frozen and eaten in batches? Can we substitute packaged modified food for real food that won't harm their overall nutritional intake? In general, the question is: can we add in real food?

Adding pre- and probiotic foods such as onions, garlic, apples, flaxseeds (prebiotic), kombucha, kefir, and fermented miso (probiotic) have been shown to support the gut microbiome. Can these be added to their daily diet?

Some studies suggest that making even small additions to a diet can improve mental wellbeing. While safety remains a top priority, the impact of dietary modifications on quality of life and mental well-being cannot be overlooked. As a speech-language therapist, your input and extra care in modifying a diet to be the most nutritious may also help to improve an individual's mental well-being. ●

Although a complicated case may need dietitian input – you can utilise the guidelines from the New Zealand MOH: [health.govt.nz/publication/eating-and-activity-guidelines-new-zealand-adults](https://www.health.govt.nz/publication/eating-and-activity-guidelines-new-zealand-adults)



Helen Duyvestyn is a registered nurse and life coach who specialises in a holistic approach to mental health. She has a strong focus on how food can impact mood and mental wellbeing. She has a Master's in Health Science and an advanced diploma in nursing. Thank you to Anneke Duyvestyn (SLT) for her input on this article.

Please contact the author for a full list of references.  
[onelifenz.com](https://www.onelifenz.com)

Disclaimer: Helen is not a nutritionist or a dietitian – please consult a registered health practitioner as appropriate when modifying a diet.



# Mental illness and the family: Where have we come from?

**Darren Mills**, Te Kura Whakaora Ngangahau / School of Occupational Therapy Principal Lecturer, Otago Polytechnic



Until the mid-20th century, the prominent treatment for those diagnosed as mentally ill included long-term incarceration in psychiatric hospitals. The idea of community care materialised in the 1950s, but it wasn't until the 1980s that it became the preferred method of mental health service delivery in the West and colonised nations, including Aotearoa.

In my research I have been conducting a historical and contemporary analysis on family and whānau involvement in mental health service provision, with a focus on consultation practices under the mental health Acts. Looking back, the 1950s and 1960s witnessed growing interest in causes of mental illness, in order to reduce prevalence and hospital admission. Identifying illness led to the involvement of family who had previously been excluded. Family was often seen as a catalyst for the emergence of illness, due to the occurrence of stress within intimate relations and anti-social behaviours including bad parenting. The family unit was identified as problematic. For example, rehabilitation clinics for out-patients of the 1970s encouraged treatment for family members who were sometimes seen as more sick than the person presenting for help. With a greater focus on care in the community, family were viewed as unreliable but necessary, in order to observe and give feedback on the behaviours of their relative now living in the family home.

My research on the family from the 1950s to the 1970s strongly identified the

promotion of European norms concerning family. Māori and Pasifika notions of family and whānau, such as extended systems, were often categorised in Western research as deviant and harmful. Non-Western family practices were positioned as primitive and used by governments to justify continued colonial suppression of indigenous practices, including alternative forms of family and whanaungatanga. Māori were constrained from participating within mental health service provision, as Western systems such as educational qualifications limited their participation. The 1980s onwards witnessed increased critique of systems and institutions, including mental health services, as racist and exclusionary, and as strategies of social control to maintain Western ways of doing. Taha Māori (a Māori perspective) challenged Western thinking and doing, government agencies acknowledged Te Tiriti o Waitangi as a founding document, and the notion of biculturalism materialised. The concepts of whānau and whanaungatanga began to appear in policy and guidelines by the turn of the century in Ministry of Health documents. However, mental health service provision continued an individualistic approach to assessment

“ With a shift from individual actions and identity towards collaborative and collective approaches in health care, greater focus on inclusive practices is emerging.

and treatment, with family and whānau usually represented by members of the immediate family units of the person receiving services. Over the past 25 years, the importance of including family and whānau in practices has been a continual message in guiding documents and policy.

### **Mental illness, family and whānau: Where are we now?**

The ongoing promotion of family and whānau inclusion suggests that mental health services continue to exclude family and whānau. The latest national inquiry from 2018, He Ara Oranga : Report of the Government Inquiry into Mental Health and Addiction, noted the need for patient privacy was often inappropriately used by services as a barrier for family and whānau involvement. Marginalisation, culturally inappropriate services, and poor levels of information and support were key concerns raised by family and whānau from their experiences with services. The report called for a transformation in services, to move away from 20th century practices, often dominated by notions of risk, towards a ‘this century’ approach.

One of the interesting findings in my research was how the notions of equity and wellbeing are being used in contemporary policy and guidelines to promote greater involvement of extended family systems, of iwi and hapū, and community. Whānau Ora, an initiative to tackle health disparities for Māori, has highlighted the importance of partnership between government, iwi, and community organisations. The notion of better supporting family and whānau as a strategy for improving the health and wellbeing of its individual members has been taken up in recent policy and guidelines by Te Whatu Ora. Whānau Ora as a contemporary strategy for equity has provided greater opportunities for family and whānau within decisionmaking, questioning individualistic, Western approaches to health. The notion of wellbeing, a common term in policy and guidelines of the Labour government (2017-2023) has drawn from Sir Mason Durie’s Te Whare Tapa Whā model of health and wellbeing. Incorporating taha whānau (family and social) and taha wairua (spiritual) to Western notions of physical and mental health, places greater emphasis on

connection with family and whānau as a determinant of health, for Māori and non-Māori in Western health service provision.

### **So what: Implications for practice**

I hope that this brief article encourages reflection on *how* we think about family, whānau (and extensions, including iwi, hapū, and community), whether our perceptions are influenced by the past, and whether we promote their inclusion in the services we provide. With a shift from individual actions and identity towards collaborative and collective approaches in health care, greater focus on inclusive practices is emerging. ●

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**Darren Mills is a principal lecturer at Te Kura Whakaora Ngangahau / School of Occupational Therapy, Otago Polytechnic. He also works for Te Whatu Ora in a mental health crisis assessment team. Darren is completing a PhD in Public Health and Interdisciplinary Studies at AUT.**

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