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Rethinking device abandonment: a capability approach focused model

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ABSTRACT

It is estimated that approximately 97 million people in the world have complex communication needs and may benefit from alternative and augmentative communication (AAC). Although AAC is considered an evidenced-based intervention, device abandonment remains common, and researchers have attempted to analyze the causes of people abandoning devices. These devices have been prescribed following extensive assessment and often a protracted period of negotiation with a funding body. In this paper, we present the process of AAC prescription using a new model called the Communication Capability Approach by adding the Capability Approach from Amartya Sen to the widely used Participation Model. This allows clinicians to see individual daily decision-making as a valid choice of the individual. We propose reframing the concept of device abandonment as the person and their family making a choice to use a full range of multimodal communication to meet their own needs. This changes the tone of the narrative to viewing the person using AAC as competent and able to exercise self-determination and agency in this decision rather than as abandoning the device. AAC choices can be made on a day-to-day basis, according to the context of use so that people do not abandon devices but rather use whichever mode of communication is appropriate to the context.

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People with complex communication needs may rely on alternative and augmentative communication (AAC) to communicate. AAC includes a range of paper-based materials as well as complex high tech computerized devices. AAC devices are often expensive and require not only financial investment but also time to learn to use the system. Despite advances in AAC technology (Kent-Walsh & Binger, 2018) and acceptance of this (Ripat et al., 2020), a significant body of research indicates that device abandonment continues to be common (Johnson et al., 2006; Moorcroft et al., 2020; Waller, 2019).

Johnson et al. (2006) defined *rejection* of the AAC system as occurring prior to any attempt to use the system, and *abandonment* when the AAC system is no longer used, despite an ongoing need identified by the professionals involved. They reported that fewer than 40% of participants continue to use their AAC device 12 months after implementation. Reasons for AAC abandonment include poor usability, high learning demands, a lack of professional expertise and difficulty with physical access (Calculator, 2013; Ripat et al., 2019; Waller, 2019). Moorcroft et al. (2021) identified a number of themes relating to device abandonment for child AAC users, including parental lack of emotional readiness and resilience to implement AAC, parents' perception of the extra work required to implement AAC, parental report of the child not using their AAC system for communication, and a lack of parental satisfaction with the AAC system itself.

Device abandonment is not unique to people with a developmental disability. Individuals with acquired disorders have different AAC challenges, however, they also abandon devices (Pampoulou, 2019). Pampoulou identified the length of time since the onset of disability, the person's acceptance and attitude toward communication facilitators, and perceptions about AAC systems as relevant to device abandonment. Thus, AAC device acceptance or abandonment is an issue for adults with acquired and developmental complex communication needs as well as families of young children new to AAC. Given that continued use of AAC is challenging and the high rate of abandonment of AAC, it is important to consider factors that impact device acceptance. The section that follows considers two factors: choice/preference in AAC and barriers to AAC implementation.

A key issue in understanding device use and abandonment is that of personal choice. Given the multimodal nature of communication, it is common for a person using AAC to use a range of communicative modalities alongside their device. These include facial expression and body language; pointing, gestures, and signing; vocalization or spoken words; alphabet boards; pen and paper; texting on mobile phones; and writing on a computer (Judge & Townend, 2013; Waller, 2019). Many adults (with either developmental or acquired disorders) using AAC report communicating differently with different communication partners and in different situations (Ripat et al., 2019). Some users report using

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their high-tech device if the content of the message is complex but prefer to use gestures and low-tech methods if the content can be expressed as effectively (Ripat et al., 2019). Some parents of children who use AAC report that their child will use low-tech AAC or gestures when the child's needs are simple (Calculator, 2013).

Choice in AAC includes an array of options and devices. Judge & Townsend reported that people using AAC perceive a high-tech device as what they describe as a "minority communication tool" within a spectrum of communication methods (Judge & Townend, 2013, p. 378) by which they mean that the person's high-tech device was used less frequently than other options. One parent of a child in a study by O'Neill and Wilkinson (2020, p. 245) said "At home when it's just us we use a lot of nonverbal communication, she's very expressive... We don't use her talker all the time. It's our own personal style." Speed, intelligibility, and the environment also impact the decision on whether to use an AAC device (Wickenden, 2011).

Communication style is individual, and for those using AAC, their "voice" is inextricably linked to the mode of AAC used. A person using AAC (with either developmental or acquired disorders) may consider that a synthesized voice does not represent their identity (Wickenden, 2011) and personality (Patel & Threats, 2016), consequently, people using AAC may choose low tech rather than speech generating devices in situations where their personality is more important to them than the method in which they communicate (Ripat et al., 2019). This can be challenging for AAC clinicians. Moorcroft et al. (2019, p. 14) reported that clinicians in their study characterized a person's preference to use their "limited speech or a different type of AAC" as a barrier to the "provision" of unaided or low-tech AAC rather than a legitimate choice for the person with complex communication needs. The authors imply that this choice - to use their existing speech or some other form of AAC not currently being recommended by this clinician - interferes with the role of the AAC clinician which is to provide an AAC system. This places the burden to overcome this barrier on the professional. Furthermore, Moorcroft et al. (2022, pp. 4260) noted that when faced with a family who abandon AAC, the SLP may "push ahead" with AAC irrespective of the family's wishes or suggest the family find a different clinician. One SLP in a study by Lynch et al. (2019) expressed concern about the lack of family buy-in, noting that some families are clear that they never intend to use the device. Participants in the Lynch study did not see a lack of buy-in as a deterrent to recommending a device but did state that it would limit their expectations of how it might be used; however, decision making for families is complex. Doak (2021) proposed a model for viewing family implementation of AAC that identified the complexity of managing AAC within the context of all the other pressures on families of a child with complex communication needs. Clinicians need to understand these complexities and balance that with their own frustrations and motivations.

When considering the choices made by the person using AAC, many practitioners and researchers try to ensure that

AAC assessment includes the person's preferences (Murray et al., 2019). The concept of preference refers to both device preference and personal preference. Device preferences can be measured by presenting the same task on multiple devices and observing the responses of the person; however, the term *preference assessment* is also used to determine the personal preferences the person has in their daily life in order to provide motivating activities and to target key vocabulary (Lund et al., 2021). While personal preferences are relatively easy to measure directly or via informant report, it may be difficult for a person who has never experienced successful communication using AAC, to express a preference for any particular mode or device. Some studies have compared different AAC options and measured acquisition and preference within structured settings such as which of two options does the child use to request a specific item (Achmadi et al., 2014; Couper et al., 2014); however, it is not clear whether preferred AAC modes at the time of assessment impact later abandonment of AAC.

In considering device abandonment, it is important to note the range of barriers that can impact the use of high-tech AAC. These include features of the device such as reliability, voice quality, and speed of message generation (Baxter et al., 2012; Waller, 2019); as well as other barriers such as financial barriers, waiting lists for services, and time and availability of support personnel to create resources (Moorcroft et al., 2019). Communication partners need to become skilled in device use (Anderson et al., 2014) and this can pose a barrier to successful implementation. For example, parents are expected to develop skills and technical knowledge to manage the device and to teach their child to use it. Furthermore, attitudinal barriers pose a barrier to effective AAC use (Johnston et al., 2020).

Given the research about device abandonment, it is important to consider how devices are prescribed and the roles of those involved. AAC clinicians make device recommendations based on the skills of the person across a broad range of domains including cognition, motor skills, vision and hearing, and social communication (Lund et al., 2017). Beukelman and Mirenda (2013) suggested that assessment should be guided by the Participation Model, whereby a team of stakeholders consider facilitators and barriers, including environmental barriers, across this range of domains. This process involves individuals' participation needs being identified alongside a range of barriers they may experience, followed by *feature matching*, whereby the operational requirements of the person are matched with the features of a device.

To prescribe an AAC device, the assessment process based on the Participation Model involves the team first identifying access and opportunity barriers and then planning intervention to decrease barriers. Intervention is likely to include an AAC device as well as a range of training to overcome skill and knowledge barriers by communication partners as well as to modify policies or practices that limit participation.

Although clinicians perceive that their decision-making is inclusive of people who use AAC and/or parents of young

children with complex communication needs, AAC users and families do not always feel included (Mandak et al., 2017; McNaughton et al., 2019). Parents have reported not feeling supported by SLPs and feeling devalued and ignored by SLPs who see themselves as the experts in AAC (McNaughton et al., 2008; Moorcroft et al., 2020). In the paper by Moorcroft et al., parents felt that SLPs did not listen to them or their children. Parent voices are very clear in this paper, with direct quotes illustrating the challenges experienced by parents in implementing AAC. “I just felt like all the power was in their hands and I’m the stupid mum who doesn’t know anything about AAC...” Moorcroft et al. further noted that parents felt that they were not given a choice about the use of AAC and that they were pressured or directed toward a particular pathway based on the philosophies of the SLP or organization their child was receiving services from.

Given that successful implementation of AAC relies on the skills and attitudes of a range of people, it is important to clarify the roles of the various stakeholders (Binger et al., 2012; Calculator & Black, 2009; Ogletree, 2012; Ogletree et al., 2018; Schlosser & Raghavendra, 2004). Stakeholders include parents, communication partners, educators, paid staff, and healthcare professionals (Uthoff et al., 2021). Although the involvement of the person themselves is acknowledged, often it is challenging to include the person in a meaningful way. Binger et al. (2012) state that “When possible, the client may serve as his or her own facilitator” and the assessment process should systematically assess the person’s preferences (p. 283). Finding ways to truly value the perspectives of the person for whom the device is being considered is ultimately essential to the success of communication using AAC.

The involvement of families within the AAC process is vital (Binger et al., 2012; Goldbart & Marshall, 2004; Parette et al., 2000) and families need “a voice” in AAC decision making (Parette et al., 2000) so their input is at the center of any decisions about AAC. Yet, it is not clear if families feel included in the process (McNaughton et al., 2019). More than 20 years ago families specified the supports that they want to implement AAC, including not only that professionals teach them how to use the device, but also that professionals understand that (a) families must meet many competing demands in their day-to-day lives, (b) whole families need to be involved in the AAC process, (c) every child with a disability is unique, (d) information is needed from a range of environments including home and school, (e) families differ in many ways including culturally, and (f) before discussing AAC intervention the professional needs to build rapport with each family member (Parette et al., 2000).

One game changer for families is the availability of AAC applications on an iPad¹ (Ogletree et al., 2018; Paterson & Carpenter, 2015). Increasingly, families are purchasing this device and appropriate apps without an AAC assessment (Caron, 2015). iPads are relatively inexpensive and parents can buy apps without consultation with SLPs and trial the

AAC that they choose. There is some evidence that apps can be used effectively as AAC alternatives to dedicated devices (Kagohara et al., 2013).

Decision making in AAC is challenging. Researchers have attempted to address this by creating a number of decision trees and frameworks that guide assessment, device selection, and intervention to support device learning (Sanders et al., 2021; Schlosser & Raghavendra, 2004). While the Participation Model (Beukelman & Mirenda, 2013) is probably the most familiar to those experienced in AAC, other frameworks can also be used to scaffold reasoning and decision making in AAC, including the SETT framework (Zabala, 2020), which considers the Student, Environment, Tasks, and Tools; and the Tri-focus Framework (Siegel-Causey & Bashinski, 1997), which considers the Learner, Partner, and Environment as key aspects for communication intervention. Additionally, there is the International Classification of Functioning, Disability, and Health (ICF), a framework from the World Health Organization (World Health Organization, 2001). Though it was not intended specifically for AAC or even for those with complex communication needs, it is often used by researchers to support AAC decision making (Bornman & Murphy, 2006; Huer & Threats, 2016).

The Participation Model identifies the participation needs of the individual and the features of the environment that might present barriers, such as policy, attitudes, and resources. The focus of an assessment within this framework is on how the person participates in their everyday life and what supports might allow them to participate more successfully. Key parameters relate to the participation of the person using AAC compared to that of their peers. Barriers to participation for people using AAC are termed *access* barriers and *opportunity* barriers. Access barriers relate to the specific skills of the individual, whereas opportunity barriers relate to environmental factors that result in the person not being afforded the opportunity to participate. Opportunity barriers include policies, knowledge, and skills of communication partners, and a broad range of societal and personal attitudes.

The SETT framework (Zabala, 2020) was designed to provide an organizational structure to help students who use AAC to participate more fully in their classes. The aim is for those involved with the student to identify people, the environment, the tasks, and the tools necessary to plan classroom activities for a student who uses AAC. The framework is not a specific protocol or assessment but rather a guiding framework to ensure that all aspects of a student’s needs are considered in AAC planning.

The TriFocus framework, created by Siegel-Causey and Bashinski (1997), encourages those planning intervention for a person using AAC to plan across three different areas: the learner, the communication partner, and the environment. Successful AAC intervention requires changes in not only the person themselves (learner) but also those that interact with them (partner) and in the environments in which the person functions (environment), as each area can impact communicative success.

¹The iPad© is a product of Apple Computers, Cupertino, CA. www.apple.com

The World Health Organization's ICF framework focuses on participation and puts the person with a disability at the center of a network of contextual factors that include environmental and personal factors. The ICF defines disability as "dysfunctioning" (World Health Organization, 2002, p. 10) at one or more levels of impairment, activity, and participation and uses qualifiers to record the presence and severity of the problem at the level of body functions and structures, activity limitation, and participation restriction. The qualifiers include the concept of capacity vs. performance. For a person with complex communication needs, that might involve considering how the person would communicate if they had an optimal device in an optimal environment. This would involve imagining that there were no barriers to participation in the environment such as policies, attitudes, or resources.

Both the Participation Model and the ICF are based on the social model of disability, which situates disability as not being due to impairments but to barriers in society (Oliver, 2013). Whilst these models provide guidance to clinicians and others about assessment and intervention for people who use AAC, there are limitations to both. Trani et al. (2011) argued that there is a missing element in the ICF, that of beliefs, values, and preferences. Mitra and Shakespeare (2019) proposed that the ICF needs remodeling as it has fallen behind the current understanding of disability. Specifically, the authors argue that the ICF is not person-centered and does not have sufficient focus on quality of life. They also query whether the ICF considers the agency of the individual and the extent to which they can "act, participate or live on behalf of what matters to him/her" (Mitra & Shakespeare, 2019, p. 338). Trani et al. proposed that the Capability Approach be considered as an alternate model to the ICF in order to capture individual preferences and choices. In this paper, we present the process of AAC prescription by considering adding the Capability Approach from Amartya Sen to the widely used Participation Model to create a model called the Communication Capability Approach.

Method

In creating a framework for AAC relating to the Capability Approach, we reviewed the literature about the Capability Approach and its use relating to people with a disability. The section that follows introduces the approach with reference

to people with a disability and more specifically those who use AAC. The Capability Approach was developed by economist Amartya Sen (1980) and further developed by the philosopher Martha Nussbaum (2000) as a way of conceptualizing individuals whom they describe as being disadvantaged within society. It is described as a conceptual framework of well-being, development, and justice, which has revolutionized modern welfare economics as well as health and development policy (Paraschivoiu et al., 2020). The Capability Approach views a person's achievements and freedoms as based not only on what they are capable of but also on what they value and ultimately choose.

The Capability Approach defines capabilities not as physical or intellectual features but as a set of opportunities and the freedom to choose what the person wants to do or be. These "doings" and "beings" are referred to as *functionings*. Within the Capability Approach the capability of a person (their potential functioning) is shaped by those around him or her including the individual themselves (age, gender, ethnicity, educational level, disability etc) as well as their family, community, national politics and society. A person uses available resources which they convert into a set of possible functionings, for example, communicating with others. Their final achieved functioning is based on which of the possible functions they ultimately choose as shown in Figure 1. The term *capability* within the Capability Approach has a very different meaning compared to the term *capability* in the Participation Model.

The example of a bike is often used to illustrate the framework. Clearly, a bike is made up of parts, of specific materials and shapes but we view the bike as an object that has value or utility: specifically, it can be used for mobility. Mobility allows us to participate in a range of activities – to get to places faster, and to be independent, which is referred to as valuable functioning. However, a person may not be able to use the bike to achieve that functioning (to participate) if they cannot ride (for example if they have a disability) or if there are no safe pathways for bikes in the location in which the person lives.

Robeyns (2005) explains the bike as a resource (goods or services) that the person can use (conversion) to travel faster and thus it provides them with mobility (capability), which consequently makes it possible (freedom) for the person to visit friends more often (functioning). If we translate this to AAC we can see that some low-tech symbols (resources,

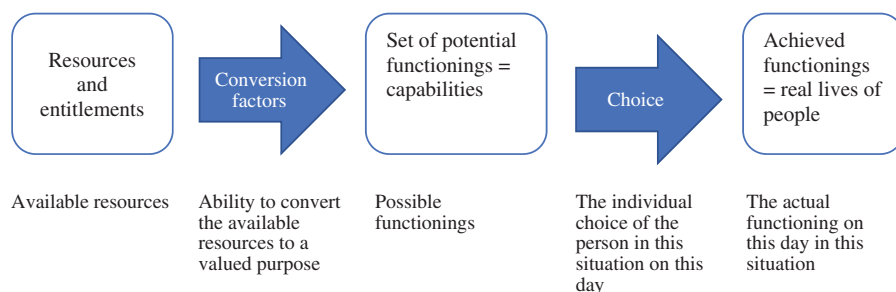


Figure 1. A schematic representation of the capability approach.

Table 1. Illustrating the capability approach using a physical example and a communicative example.

Resource	Physical example A bicycle	AAC Low-tech symbols
Conversion factor	<p>A person who was taught to ride a bike as a child has a high conversion factor to turn the bike into something useful.</p> <p>Someone with a disability who has never ridden a bike has a low conversion factor to convert it to functioning</p> <p>An environment where there are no bike lanes, limits the person's ability to convert the resource to functioning</p>	<p>A person who has symbolic understanding, good vision and motor skills has a high conversion factor to use the symbols to allow them to communicate</p> <p>A person with poor vision, no awareness of symbols or language, poor fine motor skills to point to the symbols has a low conversion factor</p> <p>An environment where no-one else is using AAC limits the person's ability to convert the symbols to communication functioning</p>
Capability	The freedom a person has to choose how to travel to valued places or valued journeys	The freedom the individual has to choose how to communicate to support valued activities or relationships
Possible functionings	Possible functioning includes riding a bike, getting the bus or walking.	Possible functioning includes communicating using low tech symbols, communicating using speech even if partially unintelligible or communicating using gesture and pointing
Choice/Agency	If the person chooses to do so. Choice is impacted by environmental factors, social pressures and societal expectations	If the person chooses to do so – according to the setting, people present, situation, time of day
Achieved functioning	Whichever of the functionings the person chooses on that day	Whichever of the functionings the person chooses on that day

goods or services) can be used to communicate with others. As illustrated in Table 1, the person needs to be able to convert the resource (the low-tech symbols) to a valued purpose; that of communication. In the Capability Approach, this is referred to as capability.

Although the Capability Approach is a complex framework, at its core it asks the simple question: What are people able to do and what do they have the potential to be?

Capability Approach and disability

Within the Capability Approach, as with the ICF, the Participation Model and the social model of disability (Oliver, 2013), disability is viewed as more than just the skills of the person, it includes consideration of environmental and societal factors, and barriers created in society that limit the person's opportunities to fully participate in the life of the community. Terzi (2005) argues that the Capability Approach offers two insights to disability that are not evident in other models: First, that Sen views impairment and disability as aspects of human diversity and second, that he places human diversity at the core of evaluation of people's advantage or disadvantages which results in evaluating disability in relation to relevant freedoms, and ultimately, justice.

Terzi argues that the Capability Approach allows understanding of the relationship between impairment, disability and social arrangements where people with a disability are entitled to effective freedoms, that is, their capabilities for well-being. The Capability Approach reframes impairment and disability in terms of functionings and capabilities. Impairment may affect certain functionings whereas disability is a restriction of functionings. A restriction in functionings results in a restriction of the set of possible functionings available to the person. There it results in a narrower range of capability. Consequently, whether impairments result in disability depends both on the possible overcoming of the impairment itself and on the specific design of the social and physical environment. Therefore, impairment and disability in the Capability Approach imply considering the full sets

of capabilities one person can choose from and evaluating the impact of impairment on these sets of freedoms.

Several authors have directly compared the Capability Approach to the ICF (Bickenbach, 2014; Morris, 2009; Trani et al., 2011). Trani et al. suggest that the ICF is missing the dimension of individual identity. They suggest that individual identity that is grounded in the person's beliefs, values and preferences goes beyond body function and structure, and activities and participation. They suggest that the ICF "completely fails to appreciate this dimension" (Trani et al., 2011 p.147) and state that the environment in the ICF is merely a mechanical facilitator or barrier. Considering this through the lens of the Capability Approach, the individual perceives her/his environment through a capability set.

The Capability Approach and AAC device prescription

Using the Capability Approach to guide AAC prescription would involve identifying conversion factors (including a series of social and personal factors) in order to identify a set of possible functionings. This approach would view the choice-making relating to AAC as a choice made by the person not only once but according to different contexts. The person might have a set of possible functionings that might include using a high tech AAC device but also using communication options chosen according to the activity, environment and people that exist in each situation. This might be viewed as a subtle difference, but it moves the choice away from being that of the clinician and places the opportunity for daily choice in the hands of the person using AAC. It would consider using AAC as being one of a range of possible functionings which would validate user choice and move away from the concept of abandonment instead viewing this need to choose as a daily event. For example, a child who is being teased at school by one particular child about using a device, may choose to not use their device when the bully is in the room. An adult who has carers to help with dressing and personal hygiene may use low-tech and gestures to communicate because it is quicker and easier than using their high-tech device.

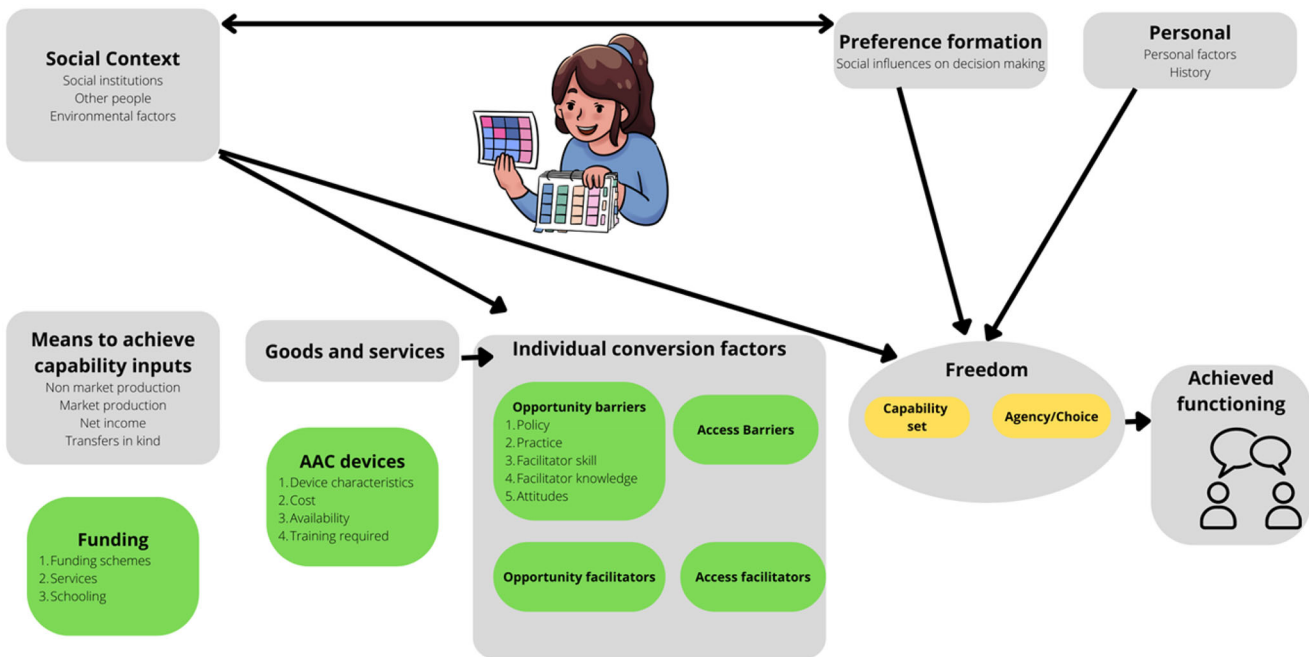


Figure 2. The communication capability approach.

Proposed model: Communication Capability Approach

Several authors have created visual models to represent the complex interchange between components of the Capability Approach (Mitra, 2006; Morris, 2009; Robeyns, 2005). We have created a visual representation based on the model by Robeyns (2017) demonstrating where the participation model overlaps with the Capability Approach in relation to AAC and how the participation model could be incorporated into the Capability Approach to create a Communication Capability Approach.

In the Communication Capability Approach (Figure 2) the grey boxes are similar to the Robeyns model, and the green boxes include aspects of the Participation Model. The availability of devices, specialist assessment teams, funding for devices, and device trials will impact available resources. Conversion factors include the skills and attitudes of the person themselves as well as those of a range of people in a range of settings in which the person functions. Ultimately the interaction of resources and conversion factors results in a set of possible behaviors which are capability sets. Social context influences conversion factors and the capability set. Social influences on decision making, personal history and personality influence agency and choice. The combination of agency and capability results in the freedom to choose the actual achieved functioning. In AAC, the achieved functioning is the way in which the person chooses to communicate in any given situation.

The person using AAC may now be able to communicate in several different ways perhaps in different locations. They may use sign language and gesture at home with familiar communication partners; they may use the high-tech device at school in formal educational settings but may also use low tech AAC when chatting with friends at school or on the school bus. These different options are considered capability sets within the Capability Approach and, combined with

agency, these create freedom for the person to choose how to communicate. Their decision results in their achieved functioning which may be different in different situations with a range of communication partners. The Capability Approach differs from the ICF or the Participation Model primarily in the concept of choice and agency.

Expected advantages using the Communication Capability Approach for AAC

The Communication Capability Approach (CCA) has the advantage of considering the use of AAC as a daily choice rather than a single preference. While the Participation Model is an established framework in AAC, it does not account for the need for the person to have multiple options to choose from for every situation. Adding the concept of "possible functionings" through the incorporation of the Capability Approach will allow clinicians to focus on multiple possible communication options to meet different functional needs. The concept of multimodality is commonly used in AAC but typically refers to the use of both aided and unaided AAC whereby the person uses AAC but also uses a range of body language, facial expressions and gestures. Here we are proposing that the person may use different AAC systems as part of multimodal communication.

Calculator (2013) noted that children who reject a high-tech device may also reject other forms of electronic communication. Calculator surveyed parents and asked them to judge whether or not their child had accepted or rejected the AAC. The wording posed to parents as a binary choice doesn't consider that the child may be using it for some things but not others. Our proposed use of the Capability Approach would support clinicians to phrase variable device use as part of the expected multimodal nature of communication rather than a binary choice of accept vs. reject.

Conclusion

AAC research is complex and this is evidenced by the number of models or frameworks that guide the field. There are articles about family and user experience, speech-language pathologist training, the process of assessment, and device abandonment. This paper proposes including a different framework: the Capability Approach by Amartya Sen with one aspect that is not included in the other approaches: that of choice or agency and the freedom to choose. Multimodal is a concept that is often used to describe how a person using AAC communicates. However, the concept of choosing modes does not seem to exist comfortably with device prescription, which views the provision of a device as a specialist skill carried out by experts (clinicians) and that when a person stops using the recommended device, they have abandoned not only the device but also the expert advice.

Donaldson et al. (2021) interviewed adults with autism spectrum disorder who can use speech, but sometimes prefer to use an AAC device. The participants listed choice as a key factor in their relationships:

What makes communication successful for me is when I can use the method that works best for me in the moment, and when the other person just accepts that method" and "I love multimodal communication. My brain loves it. It is so much easier to communicate with multimodal communication. It is hard to try to force myself to one communication method when I can use multiple. Life is easier with multiple. Different methods have different advantage[s] (p. 319).

In our Communication Capability Approach, a motivated, capable parent who has spent hours researching and clearly knows their own child, can be viewed as a facilitator who has an impact on the conversion factors to allow the person using AAC to include an iPad app, or idiosyncratic sign, or a range of vocalizations as one of a number of possible functionings. Furthermore, an adult using AAC can make choices about which modalities they wish to use in any given situation, with each communication partner and according to the participation requirements in any scenario. Perhaps clinicians need to view non-use of a high-tech device as a valid choice to be made on a daily basis by the person using AAC. The person may not be abandoning the device altogether but perhaps choosing specific situations in which to use it or not use it. The right solution may vary according to the content, the context, the communication partner and the closeness of the relationship. The Communication Capability Approach provides a way of conceptualizing the person and the choices available to them. Over time, using the Communication Capability Approach may allow us to move away from the concept of device abandonment toward a more nuanced understanding of personal choice and how it influences AAC use on a day-to-day basis.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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