Putting it on tape: audio taped assessment summaries for parents

Susan J Ilett

Abstract
Objective—To assess the benefits of giving parents tape recorded child development centre assessment report summaries.

Design—Prospective randomly allocated study.

Setting—Child development centre, Birmingham Children’s Hospital.

Subjects—Parents of 113 consecutive children attending for multidisciplinary developmental assessment.

Outcome measures—Recall of information and use of, and views on, the written and tape recorded summaries.

Results—Parents who received the tape recording showed no increase in recall of the summary six weeks later. Forty-three per cent of English speaking parents favoured the tape recorded summary, as did 89% of Urdu/Punjabi speaking parents.

Conclusions—Tape recorded summaries were popular with parents, but other methods are needed to help parents, especially those whose first language is not English, to understand the implications of multidisciplinary assessment of their child.

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Keywords: audio tape, child development centre, communication.

The practices of inviting parents to attend child development centre case discussions and providing written reports for them are now widespread.1 2 In multietnic inner city areas written reports may not be intelligible to a significant number of parents whose first language is not English, or whose level of literacy is poor. The use of tape recorded consultations has been described, especially in relation to oncology,3 4 but also in paediatrics.5 Evidence of patient or parent acceptability of this means of communication is high. One study has shown improved retention of information in oncology patients interviewed one week after receiving a tape recording of their consultation.6

Information given to parents at case discussions would be difficult to tape record because of the large numbers sometimes involved and the confusion of unfamiliar speakers’ voices. The aim of the present study was to determine whether a tape recording of the written summary was acceptable to parents and enhanced their retention of information about their child.

Methods

The child development centre at Birmingham Children’s Hospital serves an inner city, multietnic population. Non-English speaking families originate predominantly from Pakistan. All parents whose preschool children attend for multidisciplinary assessment are invited to attend the case discussion after their child’s assessment, with an interpreter present if necessary, and receive a full written report in English. They are visited at home by a member of the assessment team, accompanied by an interpreter if necessary, both before and after the assessment. The full report consists of a structured summary to which are attached detailed reports by individual professionals.

The parents of consecutive attenders over a two year period from 1990-2 were randomly allocated to receive a tape recording of the written summary of their child’s assessment findings in addition to the full written report. Parents whose preferred language was English were allocated separately from those whose preferred language was Urdu or Punjabi.

Parents with other preferred languages were excluded from the study because tapes could not be prepared in other languages. The tape recordings were prepared from a written script which was a verbatim transcript of the assessment summary. No changes were made in the words used, but missing small parts of speech in the written version were included in the transcript. Tapes in English were read by a member of the assessment team, those in Urdu and Punjabi translated and read by a trained link worker. The tape recording was normally delivered to the parents by a member of the child development centre staff at the same time as the written report; occasionally it had to be sent by post a few days later. A tape recorder was loaned to the one family who did not have access to one. Six weeks after the tape recording had been delivered, parents were interviewed at home to assess their retention of information and their use of and views on the written and tape recorded versions. For English speaking parents the interviewers were health visitors, for parents speaking Urdu or Punjabi, a trained link worker. None of the families was known personally or professionally to the interviewer. Efforts were made to interview both parents.

Results

A total of 128 children were assessed during the period of the study. Fifteen were excluded: seven because their families spoke a language other than English/Urdu/Punjabi, four (all Urdu/Punjabi speaking) because no interpreter

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was available to prepare a tape or the prepared tape was lost in the post, and one each moved away, lived outside Birmingham, refused to participate, or was a ward of court. The study cohort therefore comprised 113 children.

English was the preferred language for 83 (74%) families and Urdu or Punjabi for 30 (27%). Five of the families whose preferred language was English were of Asian ethnic origin; these families are referred to as ‘English speaking’ and those whose preferred language was Urdu or Punjabi as ‘Urdu/Punjabi speaking’.

Table 1 shows the number of families who received tapes and were interviewed. Although efforts were made to interview both parents together, in practice this was only achieved in 12 (15%) cases. Table 2 shows which parent was interviewed. For five English speaking children the interview was with another carer (grandparent, foster parent). For convenience, all interviewees will be referred to as ‘parents’.

One English speaking father and mother were unable to read English. Table 3 shows the number of Urdu/Punjabi speaking parents who reported that they could read English, Urdu, or Punjabi. In no family were both parents unable to read either English, Urdu, or Punjabi. Sixteen (29) 55% Urdu/Punjabi speaking mothers had received no education, or primary education only, as had 4/27 (15%) Urdu/Punjabi speaking fathers.

The number of recommendations made for each child also varied. The same method of analysis was used as for the number of diagnoses recalled. The mean number of recommendations made was 5·01 of which 2·26 (45%) were recalled. For the tapes group, a mean of 5·21 recommendations were made of which 2·55 (49%) were recalled compared with 4·88 and 2·06 (42%) for the no tape group. This difference is not significant. English speaking parents were very significantly more likely to recall recommendations than were Urdu/Punjabi speaking parents (table 5) but use of tapes made no significant difference to levels of recall. None of the factors examined for recall of diagnoses made any difference to rates of recall of recommendations.

Both groups of parents were most likely to recall recommendations for speech therapy,
physiotherapy, and school placement. This is interesting in view of the Urdu/Punjabi speaking parents' finding to recall that their child had been assessed by a speech therapist and physiotherapist. Urdu/Punjabi speaking parents were less likely to recall recommendations for vision and hearing tests and nursery placement. No Urdu/Punjabi speaking parents and only 7/21 English speaking parents recalled recommendations for assessment under the 1981 Education Act, or the involvement of an educational psychologist. Three (10%) Urdu/Punjabi speaking parents could recall no recommendations having been made. Eighteen of 23 (78%) English speaking and 9/10 (90%) Urdu/Punjabi speaking mothers had listened to the tape as had 12/16 (75%) English speaking and 8/9 (89%) Urdu/Punjabi speaking fathers. In addition 10 relatives and six other people had listened. No one had listened to the tape for one Urdu/Punjabi speaking family, who had also chosen not to read the report. English speaking mothers listened a mean of 2-80 times (range 1–9) compared with 2-22 times (range 1–3) for Urdu/Punjabi speaking mothers. Comparable figures for fathers were 1-73 (range 1–3) and 2-13 (range 1–4). There were no significant differences in use of the tapes by either group of parents. Ten of 23 (43%) English speaking parents preferred the tape to the written report compared with 8/9 (89%) Urdu/Punjabi speaking parents. Twenty one of 23 (91%) of English speaking parents and all the Urdu/Punjabi speaking parents found the tape easy or very easy to understand. English speaking parents who preferred a written report said this was easier to take in and remember, could be kept on file and shown to others, was more detailed than the tape, easier to find the right place and study in detail. Those who preferred the tape said this was easier to understand, remember and take in, was shorter, more precise and to the point than the written report. One parent found the tape slow and hard to follow. Seven of 20 (35%) would have liked the full reports on tape. All Urdu/Punjabi speaking parents who preferred the tape said this was because it was easier to understand because one or both parents did not read or speak English; 5/8 (35%) would have liked the full reports on tape.

Thirty two of 33 (97%) parents who had received tapes agreed or strongly agreed with the diagnoses given to their child, compared with 41/48 (85%) who did not receive or use tapes. Fifteen of 27 (56%) who received tapes experienced an equivocal or negative emotional reaction to the report compared with 21/44 (48%) who did not. Twenty five of 29 (86%) of parents who received tapes agreed with all or most of the report as did 40/44 (91%) of parents who did not receive tapes. No parent expressed strong disagreement with the report. Twenty three of 28 (82%) parents who received tapes found the report helpful or very helpful, compared with 30/43 (70%) who did not receive tapes. None of these differences between the two groups is significant.

Discussion

It was disappointing that there was no evidence that tapes increased recall of information. A six week interval between parents receiving the reports and the interview may have been too long to demonstrate a difference; other studies have used a much shorter interval.6 However, in terms of the implications of the report, especially in relation to planning for educational provision, six weeks is relatively short.

Tapes were preferred by almost all Urdu/Punjabi speaking parents and also by large numbers of English speaking parents. It was not surprising that Urdu/Punjabi speaking parents, many of whom could not speak or read English, preferred a tape in their own language, but it was interesting that this was also the case for 43% of the English speaking parents. It is well recognised that much health promotion literature is difficult for the general population to read,7 and this is an even greater risk with professional reports. In this study, the same words and format were used in the written and spoken formats, suggesting that the expressed preference was for the mode of presentation of information, rather than its content. The results do not support the commonly held view that Urdu/Punjabi speaking parents who are literate in their own language are also literate in English. Provision of a translated written report would have made it accessible to all Urdu/Punjabi speaking families except for one single mother who was totally illiterate.

The first Urdu/Punjabi speaking mother who listened to a tape became extremely distressed. She had listened to the tape alone and, despite her having received a post-assessment

<table>
<thead>
<tr>
<th>Teacher</th>
<th>37 (71)</th>
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<tbody>
<tr>
<td>Doctor</td>
<td>32 (62)</td>
</tr>
</tbody>
</table>

### Table 4 Parent’s recall of the child development centre team members who assessed their child; values are number (%)

<table>
<thead>
<tr>
<th>English speaking (n=52)</th>
<th>Urdu/Punjabi speaking (n=29)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
<td>33 (63)</td>
<td>9 (31)</td>
</tr>
<tr>
<td>Speech therapist</td>
<td>43 (85)</td>
<td>8 (28)</td>
</tr>
<tr>
<td>Teacher</td>
<td>37 (71)</td>
<td>15 (52)</td>
</tr>
<tr>
<td>Doctor</td>
<td>32 (62)</td>
<td>18 (62)</td>
</tr>
</tbody>
</table>

### Table 5 Parents’ recall of recommendations made for their child

<table>
<thead>
<tr>
<th>English speaking (n=52)</th>
<th>Urdu/Punjabi speaking (n=29)</th>
<th>Mean No recommendations made</th>
<th>Mean No recommendations recalled</th>
<th>% Recall</th>
<th>Mean No recommendations made</th>
<th>Mean No recommendations recalled</th>
<th>% Recall</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Tape used</td>
<td>5-05</td>
<td>2-79</td>
<td>55</td>
<td>4-93</td>
<td>1-31</td>
<td>27 (p&lt;0.01)</td>
</tr>
<tr>
<td></td>
<td>Tape not used</td>
<td>5-78</td>
<td>3-30</td>
<td>54</td>
<td>5-00</td>
<td>1-30</td>
<td>26</td>
</tr>
</tbody>
</table>

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visit from a team member and interpreter, it became clear that she had not fully grasped the realities of her child's disability until she listened to the tape. There were no other similar occurrences and no evidence from the interviews that parents found the tapes distressing. We recommend, however, that a professional who speaks the parent's language should be present when the tape is first used.

The method of tape production used in this study was time consuming and the results do not justify its general adoption. We have continued it only for Urdu/Punjabi speaking families. In view of the popularity of tapes among English speaking parents, however, and now that most child development centres have video recording facilities, consideration could be given to video taping case discussions.

The main differences in recall between English speaking and Urdu/Punjabi speaking parents related to understanding of professionals and their recommendations. Use of tapes made no difference to this, which suggests that the problem is not solely linguistic. English speaking parents, and indeed professionals, have difficulty in understanding the complexities of service provision for disabled children. This must be infinitely more complex for a parent from a culture where service provision is very different. It is of concern that both English speaking and Urdu/Punjabi speaking parents failed to recall discussion of the involvement of an educational psychologist, and procedures under the 1981 Education Act, in view of their crucial importance in determining access to education provision. As a direct consequence of these findings, the educational psychology service has prepared tape recorded information about the procedures under the 1993 Education Act in several community languages. The findings overall suggest that considerably more effort needs to be put into ensuring that parents understand that one of the main aims of assessment is to determine the implications of the child's developmental disabilities for his or her future education.

Fiona Wallace, educational psychologist, contributed to the planning of the project and, together with Dr Mary Honeyman, gave valuable criticism. Nikki Ali, Razia Butt, and Ravinder Lotay prepared the Asian language tapes and interviews were carried out by Alyson Brenchley, Nicola Brian, Winifred Kelly, Sukhinder Mahal, and Bilkis Shamsi. The project was supported by a grant from the West Midlands Regional Health Services Research Committee.