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Abstract

The Makaton Vocabulary is a vocabulary rather than a signing system especially designed to provide a basic means of communication; to encourage expressive speech wherever possible; to develop an understanding of language through the visual medium of signs and the logical structure of sign language. This paper describes how the Makaton Vocabulary came into being, how it is taught and its use with British Sign Language. **Keyword: Access**

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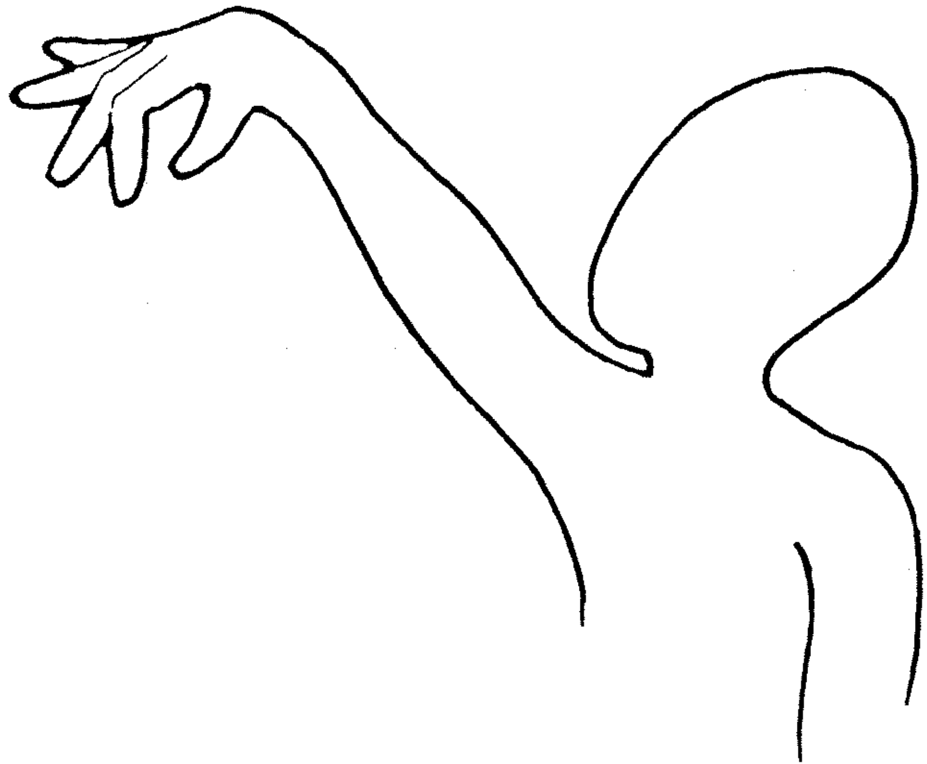

The Makaton Vocabulary

Margaret Walker,
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The Makaton Vocabulary is not another signing system. It is, as its name suggests, a vocabulary, which has been specially designed to provide a controlled method of teaching British Sign Language to mentally handicapped children and adults and other language-handicapped people, in order to provide a basic means of communication; to encourage expressive speech wherever possible; to develop an understanding of language through the visual medium of the signs and the logical structure of the sign language.

British Sign Language (BSL) has existed for centuries. It is the natural sign language which is in daily use amongst the deaf community, numbering approximately some 20,000 people, throughout Britain. The idea of teaching this sign language in a structured manner according to a selected vocabulary and of teaching it to people with handicaps other than deafness is, however, unique. In order to appreciate the scheme it is necessary to understand the development of the Makaton Vocabulary.

Background to the Makaton Vocabulary

It was originally devised by MArgaret Walker, Senior Speech Therapist at Botleys Park Hospital, Chertsey, Surrey, KAthy Johnston and TONy Cornforth, Psychiatric Hospital Visitors from the Royal Association in aid of the Deaf and Dumb – hence its name – MAKATON. Kathy and Tony have now left the Association and Margaret Walker and other staff from the Royal Association continue the work.

In the late 1960s, staff from the Royal Association (RADD) working in the large Surrey hospitals for the mentally ill and the mentally handicapped highlighted

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the problems of the deaf mentally handicapped resident, living amongst a hearing SSN community but completely isolated because of his/her lack of communication. Simple attempts were made to introduce some signing and the deaf residents responded eagerly.

In 1972-3 the RADD were invited to introduce signing to a group of deaf residents at Botleys Park Hospital. Mrs Margaret Walker joined the team and carried out a research project to evaluate the use of British Sign Language with a group of deaf mentally handicapped. This was the pilot study for the Makaton Vocabulary.

A group of fourteen residents was chosen from the hospital's Register of Deaf. The age range was from 16 to 68 years. Sex distribution was uneven, being eleven males to three females. Hearing loss ranged from moderate to severe. IQ was measured on the Performance Scale of the Weschler Adult Intelligence Scales and the range was 35-98, the mean of the group being 54.3. Three subjects had rudimentary speech but it was not adequate for communication. Several had additional physical handicap or behaviour problems.

A vocabulary of 145 signs was selected, based on our experience of the language of SSN institutionalized people, and by reference to the work of other researchers - Mein and O'Connor (1960) and Mein (1961). Training was given for a two-hour period once a week over nine months.

Initially, twenty signs were introduced, then gradually over a period of four to five months the remainder were taught. Signs were always accompanied with normal grammatical speech.

The research aims were:

1. To measure how easily deaf mentally handicapped people could learn sign language.
2. To assess if they could develop an understanding of and learn language through the sign language.
3. To attempt to discover if any factors, measurable before training began, could be used to predict ability in mentally handicapped people to learn sign language.

Summary of results of the project:

1. The deaf mentally handicapped learnt the signs very quickly and easily.
2. On a vocabulary test, measuring both comprehension and expression of the signs taught, results showed that over half the group learnt 90% of the signs and even the lowest scorer learnt 60%.
3. An adapted version of the Reynell Developmental Language Scales using Speech and Signing was given before and after training to measure if any language development occurred. Results on both scales of the test after training showed considerable gain. Individual scores were analysed and the results confirmed that satisfactory language development had occurred for everyone in the group. (Further details - Walker 1973-5.)
4. Most noticeable and immediate was the improvement in attention. Eye contact in those where it had been poor before was quickly gained and sustained and this made teaching easier.
5. There was a marked increase in sociability as the new skill was being taught. The residents spontaneously began to sign amongst themselves. Often, where there had previously been frustration and difficult behaviour, there was a reduction in these problems.
6. All the people in this study became more vocal and attempted to imitate speech spontaneously. Also the length of their verbal utterances increased. British Sign Language is very relaxing to use. Being a more primitive form of communication than speech, it removes the pressures to talk - something which often tends to be overlooked. Thus it often has a liberating effect and, surprisingly, sound patterning and expressive speech emerges freely.
7. Those residents in the group with poor motor movement due to mild/moderate spasticity or clumsiness were able to make good approximations to the signs and were understood. BSL does not require too great a precision of fine movement. Most of the signs are large and clear and allow flexibility of production.
8. Finally, various initial assessments were correlated with the results gained on the Vocabulary Test and the adapted Reynell Developmental Language Scales to discover if any could be used in future to predict ability to learn BSL. The assessments used were: *a.* IQ measured on the Performance Scales of the WAIS; *b.* The Vineland Social Maturity Scale; *c.* Socialization Assessment compiled from the Socialization sections of the three Gunzburg Progressive Assessment Charts (PPAC, PAC1, PAC2); *d.* Lip-reading and *e.* Natural gesture ability were assessed on an *ad hoc* test based on observation of residents' use, and scored on frequency of use; *f.* Hearing losses were measured in detail; *g.* Age.

Results showed that the most significant factor with possible predictive value was socialization as measured on the Gunzberg Progressive Assessment Charts. Lip-reading and natural gesture ability were also significant in indicating a desire to communicate. The remaining factors, IQ, hearing loss and age, had no significance.

The importance of intelligence in language acquisition cannot be overlooked, but as an initial measure, where some mentally handicapped people may be withdrawn and inattentive due to lack of communication (which was probably the case for many subjects in this project) they may underscore on the IQ tests and therefore not give a true result of their ability.

Summary

The research project results showed very convincingly that BSL could be learnt easily by mentally handicapped people, and that it could also be used as a tool in teaching language.

Application of the Makaton Vocabulary outside a hospital environment

The results of the research project gave encouragement for the scheme to be developed further and expanded. The original version of the Makaton Vocabulary for use in hospital environments was completed. Then the vocabulary was given a trial in school in the community

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with mentally handicapped and autistic children who were not deaf, but had little or no expressive speech and poor comprehension.

Similar successful results to those described in the research project were gained with the children using the Makaton Vocabulary. The only criticism was that extra vocabulary appropriate to the school/home environment was needed. In 1976 the Revised Makaton Vocabulary was completed to overcome this and is now in current use. It is being used with:

1. Mentally handicapped deaf children and adults
2. Mentally handicapped non-deaf children and adults with little or no expressive speech and poor comprehension
3. Mentally and physically handicapped (mild/moderate) children and adults
4. Autistic children
5. Young normal deaf children
6. Children with severe articulation problems, e.g. articulatory dyspraxia, as a temporary alternative means of communication to relieve frustration and relax the children whilst intensive articulation therapy is being given. It also helps to train overall imitative ability.
7. Some stammerers to relieve tension and frustration during treatment and until ongoing therapy begins to have effect
8. Certain normal adults suffering communication problems following, e.g. strokes.

The Makaton Vocabulary is also being used in other unexpected areas:

9. Certain groups of trainers providing horse-riding facilities for the disabled are finding it helpful in their work with handicapped children, especially where the children have already been trained to use it.
10. In some areas of the country, the adult Deaf Literacy Scheme are using the Makaton as a basic/foundation vocabulary for their work.
11. Some teachers teaching reading to ESN(M) children find the signing very helpful in explaining word/language concepts and in helping children remember them.

British Sign Language

The deaf community in Britain, which comprises pre-lingually deaf people, people with acquired severe hearing losses, their families, the chaplains and social workers with the deaf, some teachers of the deaf and workers in the various associations and clubs for the deaf, will all be using Total Communication of which the sign language is a very important part. Total Communication is a fairly new title being given to the combination of – lip-reading, finger spelling and sign language – which the deaf community has always used.

Lip-reading needs little explanation. It is the way a deaf person follows the speech of other people by watching their lips. Success in lip-reading varies from one individual to another. It will be considerably helped by the use of residual hearing with or without a hearing aid.

Finger spelling is the manual alphabet spelt on the fingers, known familiarly to most people as the finger spelling they learnt in their youth in the Scouts or Guides.

Sign language will be explained a little later in the chapter in detail. Before that let us look at the scope of Total Communication. Total Communication can convey information ranging from a technical, scientific lecture to a bit of gossip; a Shakespearean speech to a joke; a prayer to the words of a popular song. If required, the information can be presented literally word for word with complete grammatical form using lip-reading, finger spelling and sign language; or it can be given in an abbreviated form, similar to normal conversational speech using lip-reading, less finger spelling and more signing. It can also be reduced to a very simple level to suit, for example, the mentally handicapped person where signs alone are used to convey the key, i.e. information words, to the message, as in the Makaton Vocabulary scheme. Whatever level of signing is used it must be accompanied with normal grammatical speech.

For the purposes of the Makaton Vocabulary only the sign language and lip-reading elements of Total Communication are used, but it is important to know the full scope of Total Communication and be aware that a child could progress, if ability is present, from the Makaton Vocabulary to a fuller communication system.

British Sign Language is not a devised language to translate the speech of hearing people into sign language. It is a natural sign language that has been developed by the deaf themselves from their experiences of life and it has evolved over the centuries as any language does.

Most countries have their natural sign language used by the deaf community and recently linguists and other researchers have begun to acknowledge that these natural sign languages, British Sign Language included, are languages in their own right, with their own grammar and syntax. They are in fact part of the culture of the community that uses them.

In BSL many of the signs are ideographic, indicating the chief characteristic or function of the words they represent. In many ways the signs are very similar to natural gesture, but they are part of an established system which, with the exception of dialectal differences, are widely used and known. There is a rich vocabulary which is continually being augmented as new experiences occur.

Natural sign languages are generally agreed to be easier to learn than speech and often the visual descriptive quality of the sign is the key to the understanding of language concepts, where speech alone has been meaningless. For example, if one says any English words aloud to oneself, it is soon obvious that there are hardly any that convey or indicate, even remotely, the concept they represent. Perhaps 'zip', 'crash', 'splash' manage it, but there are very few others. However, add a sign to a word and the meaning/concept is soon clear, and the association of meaning with the spoken word begins to form.

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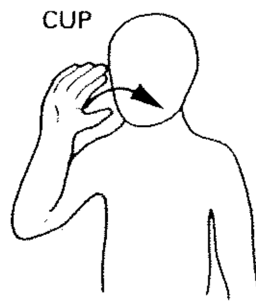
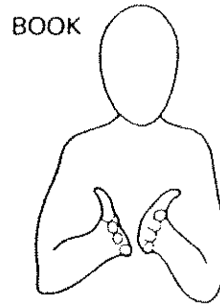
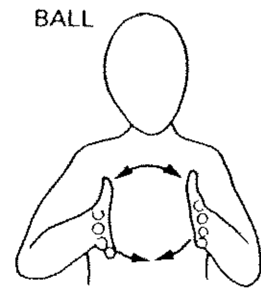
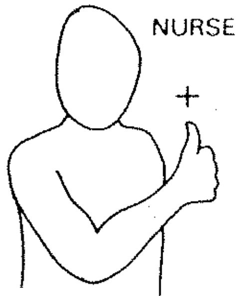
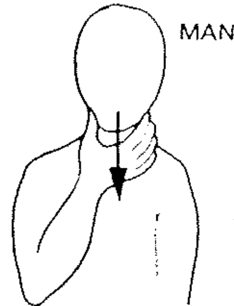
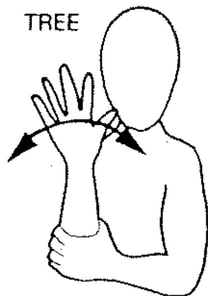


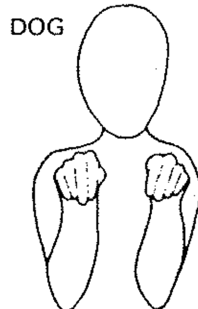




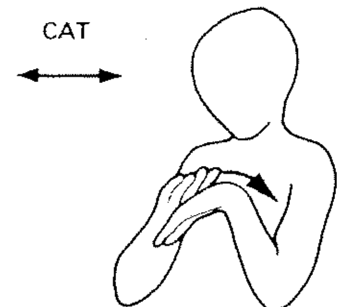


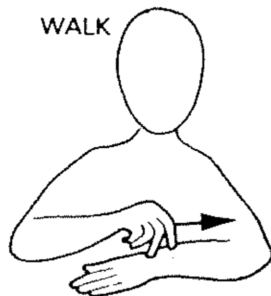


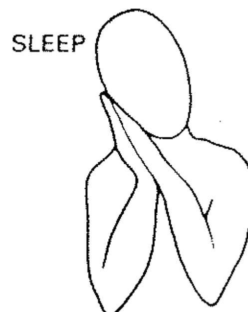


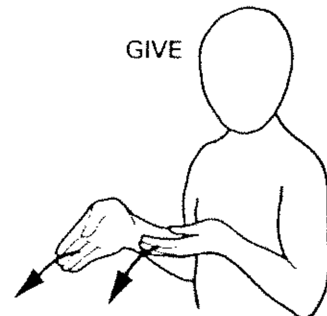


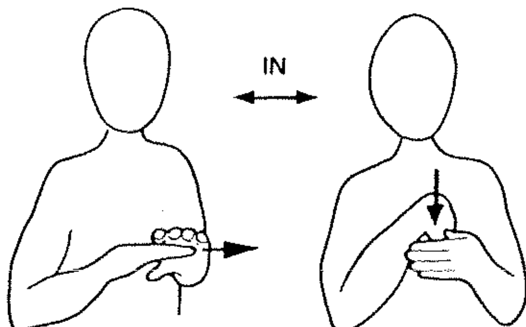
CAT

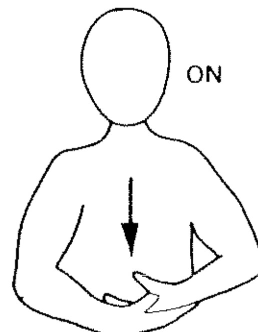


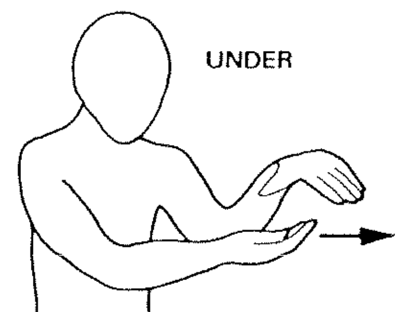












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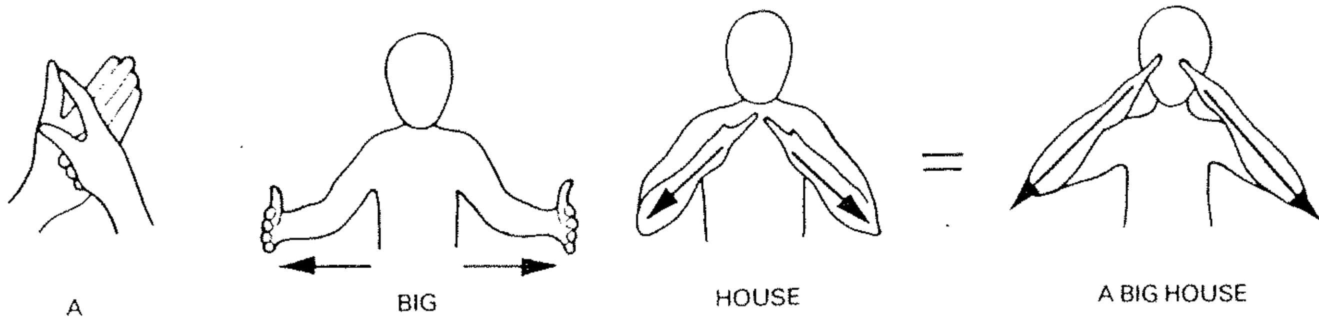


There are no strict rules as regards the precise performance of the signs, e.g. the actual size of the sign or the distance from the body. These details are dictated by the needs of the message to be conveyed. This has a great advantage and flexibility for those people who have difficulty in achieving precision of fine movement.

Even people with a hemiplegia have shown they can manage to sign BSL by signing half of each sign; their adaptation can be understood by others.

Because the sign language is a living language, the whole body is used to convey the communication – facial expression, natural physical posture and attitude also play their part. For example, it would be impossible to sign 'happy' with a slouched posture and a miserable expression on one's face. All the ingredients of non-verbal communication are present and provide additional clues in helping to convey the nuance of meaning.

BSL can also be used very economically, which is especially valuable for the mentally handicapped person with limited memory span and poor attention. Take the phrase 'A big house'. It may be signed in full as shown in the above illustration.

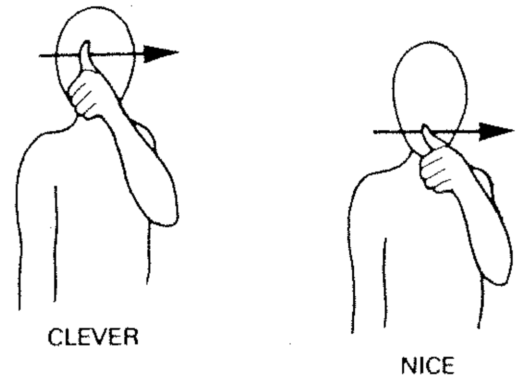
But, if necessary, one sign can be used instead by simply making 'house' very large.

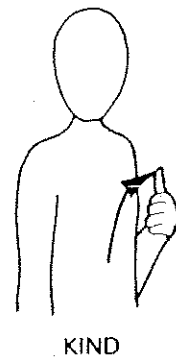
From the description so far, it will be becoming obvious that BSL is a logical signing system. As a person becomes more familiar and experienced in using it, he will soon realize that there is a logical structure running through it, so that word groups occur from the same stem.

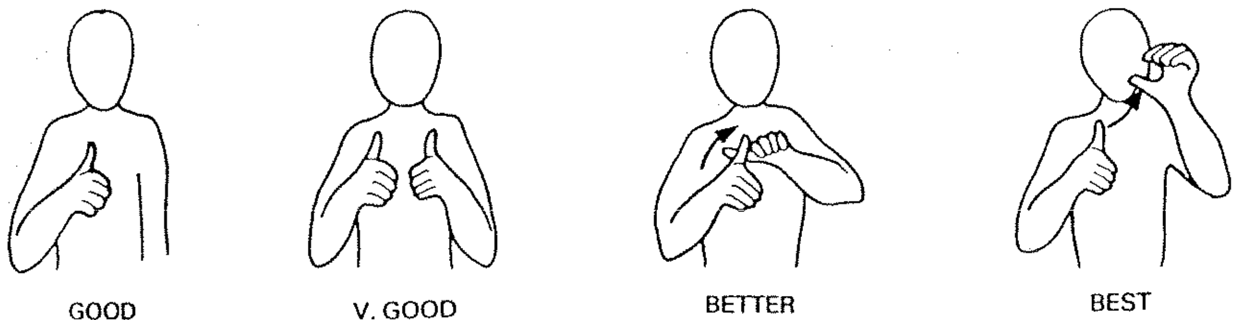
Take for example the sign 'good'.

If the sign is made on both hands, i.e. double sign = very good
If one thumb gently strokes the other, twice (two syllables) = better
If one thumb briskly strikes the other, once (one syllable) = best

Adjectives which indicate the element 'good' are produced:







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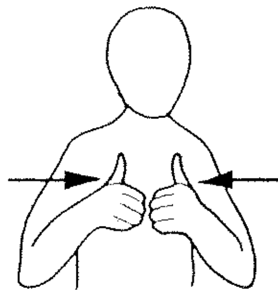
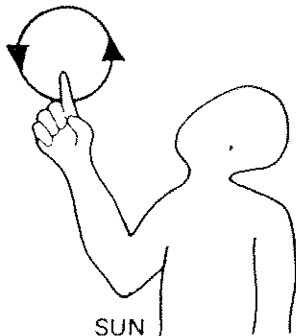
Verbs indicating 'good/or approval':

TO KNOW

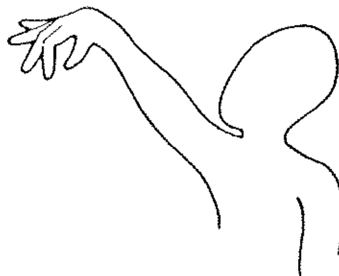


TO AGREE

Composite signs are also formed easily; in practice, even when ESN(S) children are learning to sign, they spontaneously develop some of the composite signs which are correct, for example:

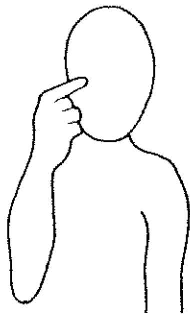


SUN +

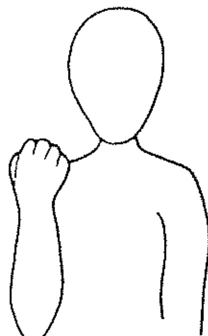


LIGHT

= SUNSHINE



TO THINK +



TO HAVE

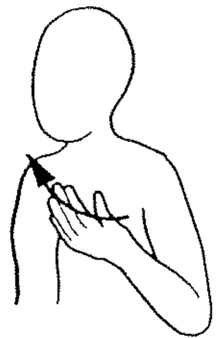
= TO REMEMBER

There soon develops a natural feeling for the sign language which is easily understood by a wide range of people. This natural feeling forces the user to be specific in the choice of speech used. When talking to the mentally handicapped it is very difficult, even when considerable care is taken and speech utterances are reduced in length, to avoid ambiguity.

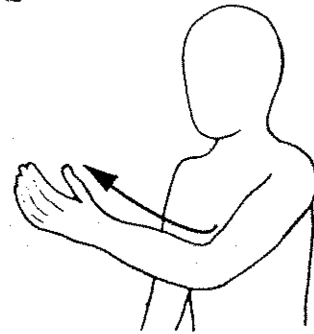
Take for example the word 'like'. We say: 'I like mummy' or 'I like sweets' indicating the emotion of 'liking'; but on another occasion we might just as easily use 'like' in this manner: 'Give me another like this', indicating 'same':

In BSL, as familiarity with the language grows, one would become aware quite spontaneously of the correct sign to use. The signs for the emotion 'like' follow a natural sequence:

TO LIKE

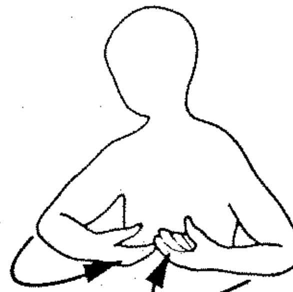


TO WANT

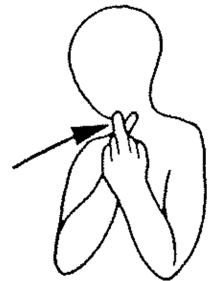


TO HOPE

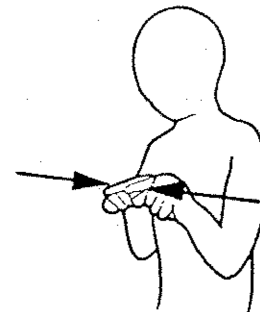
One could not sign from this group at all comfortably and would be forced to be specific and use 'same'



GIVE ME



ANOTHER



THE SAME

Prior to the recent growth of interest in using BSL with other groups of language-handicapped people, there was little reason for psychologists, speech therapists, teachers, nursing staff etc. to study this signing system in any depth. However through this new experience we are not only learning a means of communication but are gaining a unique insight into the ways that people without any knowledge of the speech system interpret and code their experiences of life, and how their learning and thought processes develop and differ from people with a heavy dependency on speech.

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The Makaton Vocabulary

The Revised Makaton Vocabulary comprises approximately 350 words/signs presented in eight stages with a ninth stage for specific additional vocabulary. Each stage contains about 35–40 words. The vocabulary was devised after careful consideration of these factors:

1. It had to be small and limited because it was envisaged as a basic vocabulary for communication and language learning.
2. It was essential that it followed the normal development of language.
3. It had to be appropriate for mentally handicapped people.
4. It needed to be selected in such a way that the signs would easily combine into short phrases and thus provide a very basic and useful communication system.

Why is it so small? Up to the 1960s very few people had studied the vocabularies and language development at the mentally handicapped. Then Dr Richard Mein and Dr Neil O'Connor investigated and measured the vocabulary and language development of SSN hospitalized adults and compared the results with the attainment achieved by young schoolchildren in the 5–6½ year age range.

Their findings showed that in general both groups had a small vocabulary of words – which they named 'core' vocabulary – which were used very frequently, and then each had a larger specialized vocabulary which was used less frequently when specifically required. Comparison of results:

Core vocabulary
SSN adults = 350 different words
Normal children = 270 different words

Total vocabulary (core + specialized)
SSN adults = 2,400 different words
Normal children = 3,500 different words

Mein and O'Connor considered that both groups drew heavily on the core vocabulary but that SSN adults were more heavily dependent on it than the normal children. When it came to a broader descriptive ability, the normal children's vocabulary was more flexible and expansive, and had more scope.

In this study two points must be stressed:
1. The SSN people were adults and were being compared with children, whose experience of life would have been very limited. Presumably with increasing experience their specialized vocabulary would be greater.
2. The SSN adults were institutionalized and there might be a reduction in their specialized vocabulary due to lack of opportunity, when compared with mentally handicapped people living in the community.

Further investigation of mentally handicapped children living outside hospitals was then carried out by numerous other researchers. From the many studies the original results were largely confirmed. The use of a core vocabulary and their description of early language development was found to be general. Differences were found in the amount of specialized vocabulary that individual mentally handicapped people gained. Outside a hospital environment a person with a matched IQ might know more specialized vocabulary if stimulated more, but it was in no way as flexible as that of a normal child. Also it related narrowly to the specific area of training that the vocabulary covered and did not reflect overall growth.

All recent researchers (see further reading list) are agreed that the mentally handicapped child's development of language follows the same progressive stages as that of the normal child's, *but* (and this is very important) whilst the normal developmental sequences occur, the size of the vocabulary, the length of the developing utterance, and the complexity of syntax do not increase with the same expansion as the normal child. This is considered to be due to: short attention span; limited memory; limited learning ability.

All these considerations had to be borne in mind when the Makaton Vocabulary was devised, as it was designed to be a core vocabulary. Also one needed to remember that it would be used with children and adults whose potential ability for communication and language development could not be predicted. Until one starts on the signing scheme, one can never assess how far the child or adult can go.

Therefore the philosophy behind the Makaton was to structure into graded stages the signs to be taught, in the hope that knowledge would be gained progressively and that when the limit was reached the child/adult would have at least a workable communication medium related to its understanding and ability. Those people with basic intellectual functioning would therefore have a small basic communication system, and those more able intellectually would progress through the stages, gaining a larger vocabulary suitable to their ability. If any were able to complete the entire vocabulary, then they would, if required, be able to progress to Total Communication.

The need to adhere to the stages of the vocabulary *is vital.* Even when confronted with a mentally handicapped person above the mental age range of the first stage, it is still necessary. The technique is to work progressively from Stage 1 to each subsequent stage in order to establish the foundation of the scheme. If the person is more able, they will learn the first stages very rapidly, so there is little delay or frustration.

The Makaton Vocabulary – Summary

The Makaton Vocabulary is presented, with the exception of Stage 9, in stages of increasing complexity.

Stage 1 (Language level = approx. 1–1½ years)
This stage presents extremely basic vocabulary upon which the other stages build. By using single signs or short phrases of combined signs from Stage 1, basic needs and simple instructions may be expressed, e.g. come (and) sit down; go (to the) toilet; give me (a) drink please; good morning, how are you?

The number of words in Stage 1 is deliberately kept small to facilitate learning. The aim is that one should

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STAGE ONE	STAGE TWO	STAGE THREE	STAGE FOUR	STAGE FIVE	STAGE SIX	STAGE SEVEN	STAGE EIGHT
Mummy (Mother)	Man	Sweets	Teacher	Priest	Country	Numbers 1-10	To choose
Daddy (Father)	Lady	Cigarettes	Boss	Milkman	Town	How much?	To win
Brother	Boy	Apple	Friend	Postman	Sea	How many?	To dance
Sister	Girl	Orange	Children	Policeman	Cinema	How old?	To find
Nurse	Baby (Doll)	Banana	Name	Fireman	Holiday	Many (A lot)	To understand
Doctor	Bread	Fish	School	Church	Colour	Some (Few)	To remember
Drink (Cup)	Butter	Rabbit	Work	Shop	Red	Time (Hour)	Birthday
Biscuit	Egg	Horse	Outside	Road	Blue	To-day	Christmas
Dinner	Milk	Cow	Cupboard	Garden	Green (Grass)	To-morrow	Party
Toilet	Tea	Pig	Pen (Pencil)	Fire (Blaze)	Yellow	Yesterday	Parcel
Bed	Sugar	Sheep	Paper	Post box	Black	Next week	Balloons
Chair	Cake	Butterfly	Scissors (Cut)	Money	White	Next year	Photograph
Table	Jam	Boat	Picture	Bag (Carry)	Brown	Last week	Camera
House (Home)	Ice-cream	Train	Sand	Letter (Stamp)	Orange	Last year	Mirror
Car (Bus)	Door	Aeroplane	Water	Time (Watch)	To begin	Long time ago	Radio
I (Me)	Window	Bicycle	Thread (String)	To carry	To finish	Saturday	Newspaper
You	Fire	To have	Paint	To throw	To bring	Sunday	Sandwich
Where	TV	To walk	Key	To catch	To ask	Night	Beer
What	Lamp (Light)	To run	Box	To stop	To speak	Day	Sausages
Here	Telephone	To kick	To put	To help	To listen	When?	Meat
There	Dog	To dig	To make/do	To like	To be able (can)	Always	Potatoe
To sleep (Bed)	Cat	To ride (Horse)	To sew	To want	To forget	Again	Bacon
To drink (Cup)	Bird	To jump	To cook	To quarrel	To grow	Late	Cheese
To eat (Food)	Tree	To climb	To sing	Quick	Same	Early	Coffee
To look (See)	Flower	To swim	To play	Slow	Different	Before	Tomato
To stand-up	Knife (Cut)	To fall	To know	Happy (Pleased)	New	After	First
To sit	Fork	To shave	To think	Sad (Miserable)	Old	Wages	Last
To wash	Spoon	To brush hair	To work	Difficult (Hard)	Beautiful	To buy	Next
To bath	Plate	To brush teeth	To read	Easy (Soft)	Smart	To save	Over
To go	Book	Big	To write (draw, pen)	Strong	Nice	Sun	Through
To come	Teddy	Small	To paint	Heavy	Kind	Rain	Near (Close)
To give	Bricks	More	To teach	Clever	Ours	Wind	Between
Good (Alright)	Ball	Up	To build	Angry	Theirs	Snow	Lucky
Bad	And	Down	To break	Frightened	Another	Stars	Hungry
Yes	Hot	My (Mine)	We (Us)	Patience	With	Moon	Thirsty
No	Cold	Your (yours)	They (Them)	Mistake	Who	Sky	Worried
Please (Thank you)	Clean	Sorry	In	Trouble	Which	Careful	Really (True)
Good Morning	Dirty	Now	On	But		Expensive (Pain)	Why?
Goodbye			Under				Because

STAGE NINE — ADDITIONAL VOCABULARY

Handicap		Specific		People	
Deaf	Medicine	Sick	Hearing Aid	Soldier	Farmer
Dumb	Tablet	Ill	Spectacles	Sailor	People
Blind	Injection	Pain	Wheelchair	King	God (suggest sign Jesus)
	Operation	Dead	How are you?	Queen	

Clothing: Mimed

Parts of the Body: Mimed

Names: For family or close acquaintance, often the initial letter of the name is finger spelt, or some noticeable feature, e.g. little boy - spectacles is signed.

Rooms: No specific signs for rooms, e.g. classroom, bathroom, but the deaf sign the verb e.g. to bath conveys bathroom, to cook conveys kitchen, for classroom suggest school.

communicate within this small nucleus of signs and thus help the learner to become familiar with them quickly and realize the impact of this form of communication.

Some of the signs in Stage 1 may not be appropriate to everyone's environment. For example, 'nurse' and 'doctor', which are important to a hospital patient, may be unnecessary to a child in a home/school environment. Whilst it is important to keep strictly to the stages, in such a case as this it is permissible to omit 'nurse' and 'doctor' and introduce them later when required. In certain circumstances, a specific sign may be required at an earlier stage than it is presented in the vocabulary, e.g. 'teacher' may be needed at the Stage 1 level if children are already at school. If this is the case, then it can be taught earlier. Do not, however, change more than a noun for a noun, or the developmental sequence of language will be disturbed.

Stage 2 (Language level = approx. 2–2½ years)
This stage presents additional basic vocabulary at an early language level and serves to enrich the vocabulary taught in Stage 1.

Stage 3 (Language level = approx. 3 years)
Stage 4 (Language level = approx. 3½ years)
Stages 5 and 6 (Language level = approx. 4–4½ years)

Stages 3 to 6 increase the growth of vocabulary in a structured manner and gradually introduce language concepts which are graded according to the normal development of language.

Stages 7 and 8 are slightly different. The vocabulary in these two Stages provides complex language concepts and vocabulary necessary to expand previous stages, if the ability of the learner is high enough to comprehend them.

Stage 9 (Additional vocabulary)
There will inevitably always be some words/signs that are needed in a specific environment which are not included in the Makaton. If they are considered to be *absolutely essential* then they may be introduced as additional vocabulary by the teachers/therapists co-ordinating the scheme, but the size of Stage 9 must be kept very small – approx. 30–40 signs at the most. Suggestions for signs for this stage based on the author's experience are found in Stage 9.

This additional vocabulary may be introduced into the main vocabulary where it is needed, but extreme care must be taken to evaluate the language level of these additional signs. If they represent an advanced language concept, then they *cannot* be introduced until that stage of the vocabulary is reached.

Information about the signs for any additional vocabulary may be gained by reference to your local signing expert, i.e. social worker with the deaf.

Background information

The size of the vocabulary has of necessity to be small, so that memory loading is low. For this reason there has to be considerable economy in the choice of signs to be

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included and those which can be utilized most in different forms of communication are given preference.

In Stage 1, 'give' and 'where', apart from being used for their obvious meanings, can also be used in situations where, had that vocabulary been known, 'bring', 'fetch', and 'find' might be used, e.g. 'bring me cup' = give me cup; 'find your shoes' = where shoes?

Another example of this economy of choice is seen in Stage 4. Only 'to think' and 'to know' are included in this Stage although one might consider that 'to forget' and 'to remember' and 'to understand' should also occur. (They appear in Stages 6 and 8.) A mentally handicapped person's communication at the Stage 4 level is such that he cannot discern the fine differences between these five signs. 'To think' and 'to know' seem most essential at this stage. It is more economical for the others to appear later rather than take up valuable space in Stage 4, where other words/signs of that level could be taught.

It is necessary to bear this in mind if it appears that an obvious word is missing. Try to utilize signs provided; they should be adequate for communicating at the level of a mentally handicapped person.

It may be noticed that some adjectives are presented in pairs and others are not. This will sometimes depend on the descriptiveness of the sign, but more often it has deliberately been presented this way to be in keeping with the mentally handicapped person's assimilation of the concept, e.g. a mentally handicapped person is able to comprehend 'strong' easily and to use it, and then spontaneously will sign 'not strong' rather than 'weak'. Comprehension of 'weak' as the opposite of strong is not easily made and is a more advanced concept.

As the ability to communicate one's needs and to express oneself is the aim of the Makaton Vocabulary, these logical steps in concept development should be respected.

The concept of time is a later development in normal language and only people who have attained fluency up to Stage 7 would normally comprehend it. For this reason, only the present tense of verbs is used. This is an advantage to the mentally handicapped since it simplifies signing and reduces memory loading. Nouns relating to time can be used with verbs to indicate present, future and past events, in a very simple manner, e.g. Yesterday, I walk – past; After dinner, I walk – future; Now, we dig the garden – present.

Essential points to remember

1. Signs should always be accompanied with normal grammatical speech.
2. Appropriate facial expression is essential to accompany the signs.
3. Signs for clothing and parts of the body are mimed.
4. It makes little difference whether or not the person signing is left or right-handed, provided the preferred hand is used constantly.
5. The social aspects of this type of language teaching must be emphasized and a relaxed and happy atmosphere is vital for maximum motivation.

Recent developments and progress reports

One-day workshops have been held *a.* to provide instruction in signing; *b.* to illustrate teaching methods and the use of language programmes; *c.* to provide opportunities for discussion on the practical application of the scheme; *d.* to put the participants in contact with their local signing expert, e.g. chaplain or social worker with the deaf, for further instruction and support.

Attendance at a workshop provides the best all-round introduction to the scheme.

The first workshop was held in July 1976 at Botleys Park Hospital, Chertsey, Surrey, and up to the end of 1977 many others were held there and at other venues throughout Britain, such as Ipswich, Banbury, Chesterfield, Exeter, Chelmsford, Leicester (2), Taunton, Aberdeen, London, Bristol and Sidcup. Considerable interest has also been shown from Europe, Scandinavia, Israel, USA, Australia, New Zealand and Japan. Several Australian and New Zealand speech therapists have attended workshops whilst visiting Britain and consider that they could easily use Makaton with their country's signing system as they closely resemble the British Sign Language of the Deaf.

Through these workshops well over 1,000 people – teachers, speech therapists, occupational therapists, nurses, social workers, psychologists, parents and others – were trained. Many more have also gained the expertise from those people who attended, representing an entire establishment.

For example: a few speech therapists from Cornwall attended the Exeter workshop and now the scheme is being introduced into that county's ESN(S) schools and hospital units, and the knowledge is being spread through signing courses given by the local social worker with the deaf combined with the speech therapy service. The same has occurred in North Wales, the West Midlands, Staffordshire, Cumbria and Lancashire where, as a result of one or two people from the various areas, e.g. teachers, speech therapists etc., attending the Chertsey workshops, the scheme is gradually being introduced into their schools and the knowledge has spread.

During the summer of 1977 questionnaires were sent out to 300 people who had attended workshops 6–12 months before to discover how the scheme was working. The response to the questionnaires was 68 per cent. From these replies the information shown opposite became available.

It is interesting to note that improvement is related to time. Obviously eye-contact is first established then attention, sociability etc. follow. This agrees with the original research findings (Walker 73/75).

Success of the Makaton Vocabulary

The improvement in the subject's ability to communicate through the use of the Makaton Vocabulary, found in the earlier research project, has been repeated when applied on a nationwide scale to a range of handicaps. The questionnaire results for a sample of 1,004 subjects shown in Figures 2 and 3 clearly show this.

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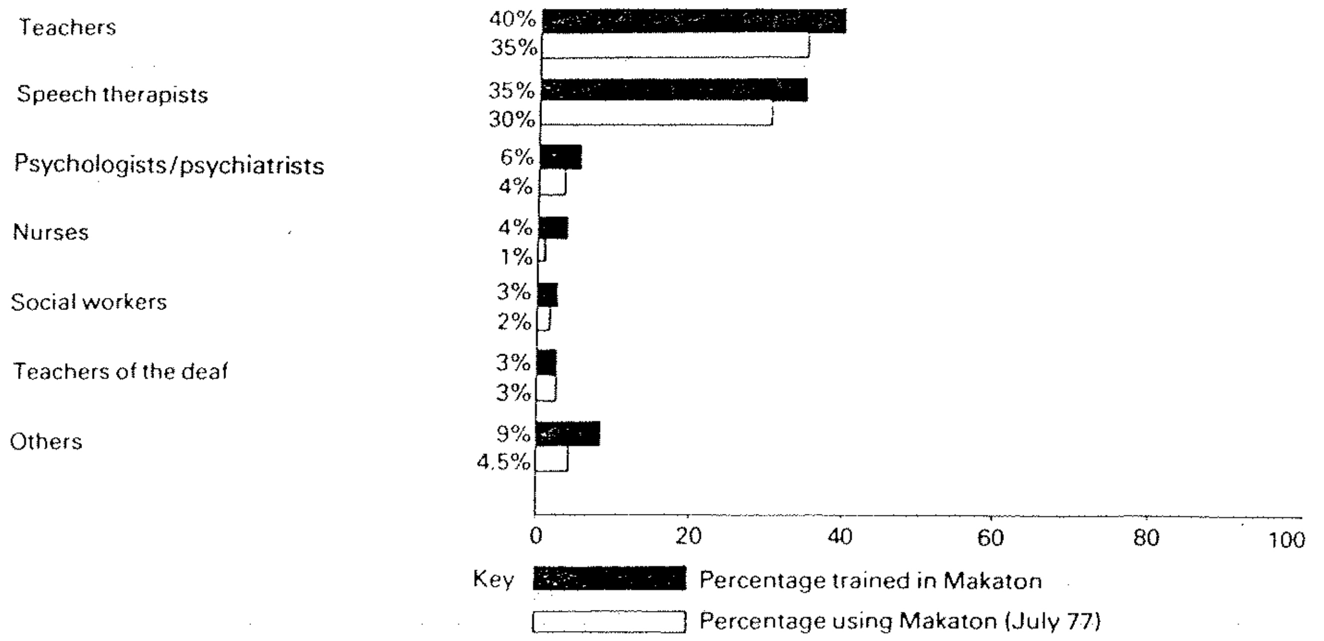

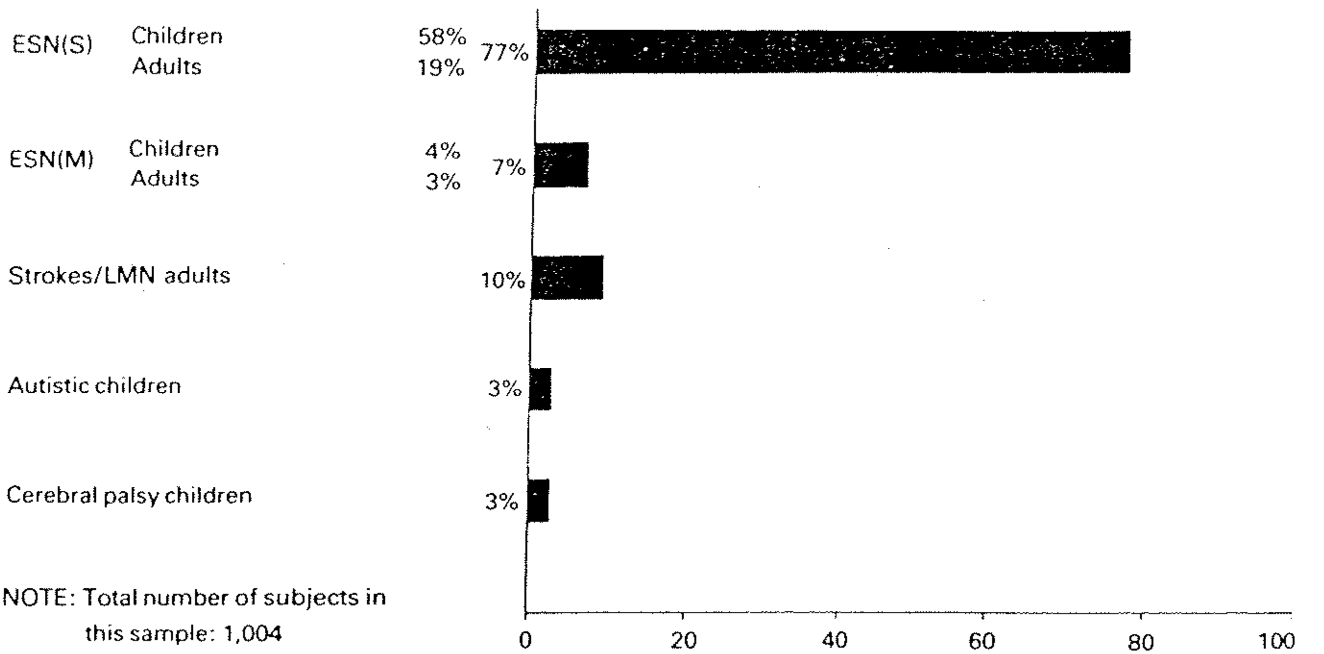

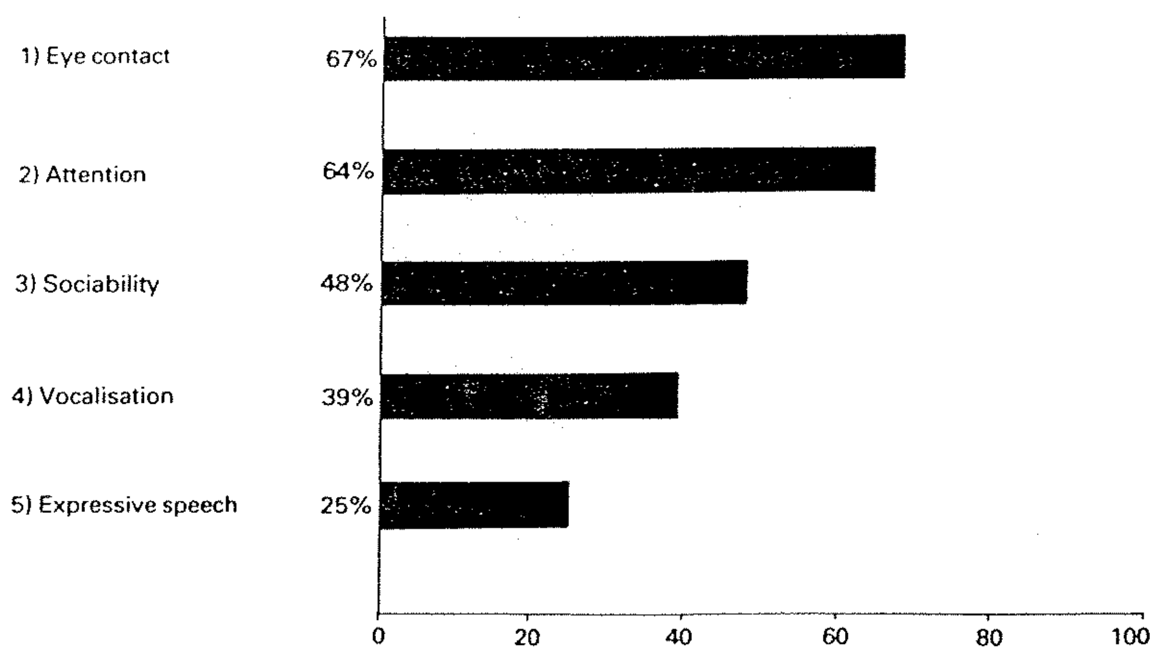

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Patterns of learning, observed from the author's experience, have now been confirmed by others using the scheme. It can be stated with confidence that Makaton can be used successfully through the entire ESN(S) range, even with subjects having mental ages as low as 18 months. Those in the low mental age range are able to learn and understand the first two or three stages, thus gaining a basic and useful form of communication, and those with more ability progress much further.

The speed of learning the vocabulary will depend on the number of teaching sessions per day or per week. To give some idea of the learning rate: a child/adult with a mental age of 2 to 2½ years will understand and sign most of Stages 1 to 4 in three months if given a short teaching session daily, and in six months they will know them thoroughly. Ideal teaching conditions would be twice daily for short periods.

Expressive speech, when it emerges, follows the normal pattern of development: for example, single words first, followed by two, then three-word phrases. Comprehension supersedes expression as in normal language development.

Policy for implementing the Makaton Vocabulary

The feedback from the questionnaires also gave details of how the scheme had been introduced in various establishments, e.g. schools, hospitals, training centres etc. From these a fairly clear, workable policy emerged:

1. Whatever the nature of the establishment in which the Makaton is to be used, it is necessary to realize that it will be used at two levels:

Formal level The children/adults for whom the Makaton Vocabulary is being used will need to be taught in a formal, structured manner, along the lines suggested in the Language Programme Manual. In this way, they will gain a thorough knowledge of the signs and, most essentially, will understand the underlying language concepts. This formal level of teaching needs to be given frequently for short periods and will need only a few staff, suitably trained to carry it out. The choice of people to do this teaching will depend on the type of establishment and its resources – it could be a teacher, speech therapist, occupational therapist, workshop manager etc. The main criteria are: *a.* They should be able to sign well; *b.* They should have a thorough understanding of the Makaton Vocabulary; *c.* They should have attended a workshop; *d.* They should liaise closely with the speech therapist.

Informal level The general use of signing from the Makaton is desirable by as many as possible of the staff who have contact with the children/adults being trained. The aim is to give the children/adults a wide opportunity to use their new skill in real, everyday situations outside the formal teaching setting.

2. It is essential to enlist the assistance of the social worker or chaplain to the deaf to provide signing instruction. Manuals of the signs may be purchased from RADD, but these, whilst excellent as memory aids, are not teaching manuals. Live instruction from an expert cannot be rivalled.

The time it takes to become proficient in using the simple level of signing required to use the Makaton Vocabulary is very short, if reliable follow-up instruction is received after workshop attendance. Evidence of this has been shown when we were able to invite people who had attended earlier workshops at Botleys Park, to become instructors on 'away' workshops six to nine months later, in their own area of the country.

The speech therapist must be asked to advise on language development and language teaching methods and to assist in the assessment and selection of subjects for training.

3. Does one teach in groups or individually? The type of subject will decide this. The hyperactive, highly distractable subject will require individual teaching to begin with, but once attention improves the introduction of small groups of five or six can increase motivation and the competitive element may often be used to advantage.

When starting to teach the Makaton for the very first time, it is advisable not to select the most difficult children/adults. Allow yourself time to develop your teaching techniques and personal expertise first, with less problematic cases if possible. Then undertake the difficult ones as experience grows.

4. Co-ordinators of scheme It is most useful to appoint someone as a co-ordinator of the whole scheme. Ideally, it can be one of the teachers/therapists involved in the formal training. The object is to liaise between the various groups involved in the scheme *a.* to arrange signing classes for staff; *b.* to keep the general staff informed of the children's/adults' progress during formal training so they know the level/stages of the vocabulary to use in their communication with them; *c.* to keep parents, houseparents, hostel staff, nurses and other groups outside the establishment informed and to arrange signing for them if necessary; *d. (most important)* to keep in contact with the Makaton Information Service for the latest developments and information, such as details of publications, newsletters, pamphlets etc.; manuals of language programmes; equipment lists; lists of local schools and hospitals using the Makaton; recommended list of assessments + tests to record progress during training; details of research projects; details of future workshops; availability of video films for teaching aids and illustration and promotion of the Makaton Vocabulary.

5. Record keeping It is worth while keeping simple records of progress and training and to have assessments carried out before training begins, if possible. Details of simple record-keeping and suggestions for assessments may be obtained from Makaton Information Service.

6. Language programmes A manual of language programmes for use with the Makaton Vocabulary has been produced by the author. The questionnaire results showed that where these programmes or similar structured teaching techniques were used, speed and quality of learning were most noticeable.

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7. *Workshops* A workshop provides the most useful background to the entire Makaton Vocabulary scheme. The questionnaire replies, without exception, were enthusiastic about their value and importance. It is strongly recommended that co-ordinators and staff carrying out the formal teaching should attend a workshop. It would also be of great value for as many as possible of the general staff also to attend.

Conclusion

The Makaton Vocabulary has been a very exciting project. It has aroused the interest of a wide variety of disciplines and each has made its unique contribution. Not only has the Makaton provided a means of communication for handicapped people but it has indirectly encouraged communication amongst all levels of professional workers in the field:

Speech therapists, teachers and occupational therapists have shared their teaching and remedial techniques.

Psychologists are helping to select and devise new assessments better suited to measure language concepts and non-verbal communication systems.

The social workers and chaplains to the deaf have given immense support and help in signing instruction throughout the country. They are also providing, in some areas, support and advice to the families of mentally handicapped people that they have encountered through this scheme and they have been able to give valuable advice to those carrying out the training.

The born-deaf themselves, in certain areas such as the Midlands of England, have involved themselves wholeheartedly in the scheme and have gone into some of the SSN hospitals to teach staff to sign.

Numerous research projects have been started by a variety of disciplines to gain more knowledge about signing systems and these will provide valuable information.

Finally, delightful work has been contributed in unexpected ways: for example, the music therapist at a large hospital for the mentally handicapped is composing songs to be used with the signs of the Makaton Vocabulary. The songs are graded to complement the stages. Even as early as Stage 1 there are simple songs to provide practice and reinforcement of the signs learnt in this pleasurable way.

The Makaton is still new and there is much to be discovered. We wish anyone using it every success.

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Further reading (references in text)

Pilot Study for Makaton Vocabulary
Walker, M. (1973): *An experimental evaluation of the success of a system of communication for the deaf mentally handicapped* (Unpublished MSc thesis, available for reference from author or from following libraries: RNID, Gower Street, London; The Hilliard Collection, John Ryland's Library, Manchester University)

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Sheridan, M. D. (1975) *Children's Developmental Progress: From Birth to Five Years* (NFER Publishing Co. Ltd., Windsor)

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