Healthy child, healthy future

Speech and language therapy for children

Information and referral guidance

HSC Public Health Agency

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Healthy child, healthy future: health visiting and pre-school sub group

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Contents

Page

Introduction

This training and information resource supports and reinforces a collaborative approach between speech and language therapists, referrers and parents in the identification and management of children with developmental speech and language and communication needs (and includes children with feeding/swallowing difficulties).

There is huge variability in normal speech and language development in the early years. Making the decision on whether a child requires referral to speech and language therapy (SLT) needs to be a collaborative process. In line with recommendations, "professionals can do this by drawing on parental concerns, using structured questions that tap into parents' knowledge of their child, supported by the insights of relatives, child care staff, playgroup leaders etc...". Also, the process should include the "facilitation of key learning skills, including language development, to inform parents about normal and abnormal language acquisition". (Hall and Elliman, 2003)

Referrers should continue to exercise professional judgement, in addition to the application of this guidance, and should liaise with a speech and language therapist as appropriate, especially at the pre-referral stage.

This resource has been written predominantly with the health visitor in mind. However, it will equally serve the needs of other referral agents.

Aim

To revise and enhance referrers' skills in identifying children's speech, language and communication needs (in line with current guidance detailed in *Healthy child, healthy future*, May 2010).

Objectives

- To provide referrers with additional information to enhance their management options for the child.
- To provide referrers with information to deliver health promotion messages regarding speech, language and communication development.
- To present referral guidance for children presenting with speech, language and communication difficulties.

(Male pronouns will be used in the text to denote either gender.)

Section 1: Information on speech and language and communication development

Key communication skills in speech and language development – management options

This section outlines the key communication skills in speech and language development, and includes guidelines for referral.

The key communication skills and guidelines allow professionals to look at what an individual child can do in the context of a range of communication-related skills he should have developed at that age. This should help clarify whether the child has a significant problem. If immediate referral is not felt to be necessary, advice handouts can be given and a follow-up visit planned, or parents can be encouraged to contact the SLT department in the future, if appropriate.

The **key skills** information includes the following areas of development:

- attention;
- communicative intent;
- understanding of language;
- play;
- expressive language;
- development of sounds.

These areas are interdependent and therefore will not be separated at each age level. **There is a wide range of normal development.**

It is important to look for patterns of skills in all language-related areas to create a more complete picture of the child's ability. For example, if a child has every skill at a particular level except one, it is likely that he will develop that skill also. Obviously, each age level builds on the skills of the previous level.

Key skills: 3 months

Key skills: developmental guide	Cause for concern	Management options for consideration
• Shows he is interested in your face • Smiles at you and may be beginning to chuckle and laugh • Sticks out his tongue and moves his lips when you are speaking to him • Responds to loud household noises • Occasionally makes cooing sounds back to you when you are talking to him • Cries to express how he feels	• He does not smile • He is not soothed and quietened by voices or being picked up • He does not turn towards a light or the sound of a rattle • He has feeding problems • He does not coo using vowel sounds	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 0–3 months* – *What your baby says about learning to talk* • Hearing assessment according to local referral pathway • Review • Onward referral, eg to: – community paediatrician – Sure Start – child development clinic/ centre (CDC) • Referral to specialist SLT paediatric dysphagia service

Key skills: 6 months

Key skills: developmental guide	Cause for concern	Management options for consideration
• Makes noises to get your attention • Begins to play with sounds for fun, eg 'bababa' • Appears to know what 'no' means • Takes turns making sounds • Recognises very familiar voices • Recognises very familiar words that are used with actions, eg 'up you come'	• He doesn't look around to see who is speaking • He seldom makes noises back to you when you talk to him • He makes very few noises apart from crying • He rarely follows a moving object with his eyes • He has feeding problems	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 3–6 months* – *What your baby says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – community paediatrician – Sure Start – CDC • Referral to specialist SLT paediatric dysphagia service

Key skills: 9 months

Key skills	Cause for concern	Management options for consideration
• Pays fleeting attention but may still be highly distractible • Notices everyday sounds • Makes eye contact readily • Tries to maintain interaction with carer through eye contact and cooing/babbling • Babbles using a variety of sounds • Responds to his own name • Demonstrates a range of emotions appropriately • Initiates communication	• He does not seem to recognise his name or those of close family members • He seldom makes sounds to people as if he wants to talk to them • He does not produce strings of babble sounds like 'mamamama' or 'bababa' • He does not enjoy interactive games such as 'peek-a-boo' • He does not show any interest in noise-making toys • He has feeding problems	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 6–12 months* – *What your baby says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – community paediatrician – Sure Start – CDC • Referral to specialist SLT paediatric dysphagia service

Key skills: 12 months

Key skills	Cause for concern	Management options for consideration
• Can follow simple commands associated with gesture, eg 'wave bye-bye' • Understands familiar single words, eg 'no', 'bye-bye' • Will vocalise to attract attention or get something he wants • Beginning to use gesture to convey message, eg points, holds arms up	• He never looks around for familiar objects such as his shoes when he hears you talking about them • He does not turn towards a speaker when his name is called • He does not produce a lot of tuneful babble • He never tries to start little games like 'round and round the garden' • He does not follow your direction when you point to an object • He has feeding problems	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 6–12 months* – *What your baby says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – community paediatrician – Sure Start – CDC • Referral to specialist SLT paediatric dysphagia service

Key skills: 15 months

Key skills	Cause for concern	Management options for consideration
• Indicates exactly what he wants or sees using gesture (or may use a few words) • Looks with interest at books and points to items • Uses gesture to communicate, eg pointing, 'all done' • Is very persistent when communicating – really wants you to share his idea • Looks at familiar objects or people when he hears them named	• He never takes his turn when you are making sounds to him • He doesn't respond by looking in the right direction to simple questions, eg 'where's your teddy?' • He doesn't look in the right direction when you are pointing and saying 'look' • He doesn't babble with lots of different sounds. This should sound almost as if he is talking • He is not interested in starting lots of games with you, like 'round and round the garden' • He never concentrates on anything for more than a few seconds • He is not interested in simple play materials • He has feeding problems	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 12–18 months* – *What your tot says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – community paediatrician – Sure Start – CDC • Referral to specialist SLT paediatric dysphagia service

Key skills: 18 months

Key skills	Cause for concern	Management options for consideration
• Will concentrate on task of own choosing for short periods of time • Is able to communicate successfully, either verbally and/or by gesture and/or by behavioural means • Can understand simple directions that include nouns and verbs, eg 'make dolly sit' • Points to a few body parts • Uses knowledge of situation and routine to understand much of what is said to him • Plays with many toys meaningfully, ie knows how to play appropriately with a variety of toys • Has simple pretend play with large-sized toys, eg brushing teddy's hair • Recognises miniature toys, ie can select a bed, chair, etc • Enjoys looking at books • Can identify familiar objects in pictures not seen before • May have 6-10 words. These may only be understood by parents at this stage • Communication is continually progressing from non-verbal to verbal	• He is not interested in toy material • He does not often look around to see where sounds are coming from • He does not use any meaningful words • He does not understand simple everyday vocabulary • He does not want lots of attention from you, ie lack of social interest • He does not show shared attention/joint referencing • He shows very little intention to communicate • He has feeding problems	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 18–24 months* – *What your tot says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – community paediatrician – Sure Start – CDC • Referral to community SLT • Referral to specialist SLT paediatric dysphagia service

Key skills: 24 months

Key skills	Cause for concern	Management options for consideration
• Can concentrate for a short time on a toy and not flit from one activity to another • Is very communicative – becoming more verbal and less behavioural • Continual increase in his new words being understood by parents • Responds to in/on in simple directions, eg 'put it on the chair' • Is interested in playing with small toys, eg farm set, small doll • Will carry out simple make believe activities with toys, eg tea party • Has an expanding single word vocabulary • At this stage, he is frequently using two words together, eg 'daddy gone' • Speech should be getting clearer and should be intelligible to family • Enjoys nursery rhymes and action songs	• He does not seem to understand the names of lots of everyday objects • He has less than 25 words (refer to Appendix 1'Late talkers – risk factors') • He never links two words together • He never pays sustained attention to an activity of his own choice • He does not want to help you in your activities • He does not show any pretend play • He lacks social interest	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 2–3 years* – *What your tot says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – CDC – community paediatrician – Sure Start • Referral to SLT services

Key skills: 30 months

Key skills	Cause for concern	Management options for consideration
• Is very communicative • Can have a two-way conversation • Can select an object according to its function, eg 'which one do you sleep in?' • Understands simple size words, ie big and small (little) • Can follow more complex commands, including position words 'in' and 'on', eg 'put teddy's shoe on the chair' • Will play alongside another child • Play will include short sequences of imaginative play, eg with Duplo, dolls etc • Some of what he says is understood by health visitor/ others • Many speech sound immaturities may be evident • Most of what he says is understood by parents/ others familiar with him • Uses 200 or more recognisable words	• He is not showing an increase in the number of words he is using • He is still mainly using single words rather than two together • Parents often cannot understand what he has said • He does not seem to want you to play with him • He does not show any pretend or imaginative play • He does not seem to understand what you say to him unless you make it very simple • His attention span is still very short most of the time • He stumbles, repeats sounds at the beginning of words or gets stuck on words (dysfluency/stammer) • He has a habitually hoarse voice	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 2–3 years* – *What your toddler says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – CDC – community paediatrician – ear, nose and throat (ENT) – Sure Start • Referral to SLT services

Key skills: 36 months

Key skills	Cause for concern	Management options for consideration
• Is eager to give and receive information verbally • Is interested in peers/friends and beginning to play with them • Is using language to share experiences with others rather than simply to give directions, ie wants to have conversations • Can understand more position words, eg under • Understands common action words (verbs) and some describing words (adjectives), eg big, sad • Is beginning to carry out commands containing up to three different types of concepts, eg size, action, position – 'kick the big ball under the table' • Can sort colours • Plays imaginatively with make believe objects and will role-play • Should be using his spoken language to fulfil a variety of functions, eg seeking information, answering questions, describing objects and actions, attempting to relate experiences, protesting etc • Talks in sentences most of the time and asks questions, eg what, where, who? • Should be understood most of the time by health visitor/ others not familiar with him • Knows several nursery rhymes/songs to repeat and sometimes sings them	• He frequently does not seem to understand what you have said • He only uses two word combinations • He has a very restricted vocabulary • He never asks questions • He shows no interest in stories • He shows no interest in playing with other children • Most of the time, his speech is not understood by unfamiliar people • Attention span is very short • He stumbles, repeats words or the beginning of words, or gets stuck on words (dysfluency/stammer) • He has a habitually hoarse voice	• Provision of SLT health promotion information leaflets: – *Tips for talking: children aged 3–4 years* – *What your toddler says about learning to talk* • Hearing assessment • Review • Onward referral, eg to: – CDC – community paediatrician – ENT • Referral to SLT services

Key skills: 42 months (3½years)

Key skills	Cause for concern	Management options for consideration
• Can control his own attention and can sustain this for play or listening • Has made friends within his peer group • Can understand questions that do not relate to the here and now, eg 'what did you eat at playschool?' • Can respond to commands that include established concepts such as size, colour and position, eg 'give me the big teddy' • Understands sequences of events, eg what happened next in the story • Can name a few colours • Make believe play with toys is quite elaborate and accompanied by verbal commentary • Grammar is becoming more adult, eg use of plurals and tenses, but grammatical immaturities are still evident • Speech is understood by strangers, but many sound immaturities remain	• He does not concentrate on anything for more than a few minutes • He does not understand what you have asked him • He is using very short or jumbled sentences and not linking sentences together • He does not show interest in playing with other children • Speech is not understood by unfamiliar people (see also **Sound chart** on page 22) • He is very verbal but conversation is unusual and centres around topics of interest to himself • He stumbles, repeats words or the beginning of words, or gets stuck on words (dysfluency/stammer) • He has a habitually hoarse voice	• Provision of SLT health promotion information leaflet: – *Tips for talking: children aged 3–4 years* • Hearing assessment • Link in with nursery/ playgroup • Onward referral, eg to: – CDC – community paediatrician – ENT • Referral to SLT services

Key skills: 4 years

Key skills	Cause for concern	Management options for consideration
• Speech is creative and is now an effective means of communication • Can carry out three step instructions, eg 'close the door, then get the ball and put it on the table' • Understands more colour, position and size words • Is beginning to enjoy elaborate make believe play, eg dressing up, role-play • Enjoys playing with friends and understands sharing and taking turns • Can tell long stories, relate events and describe pictures quite accurately • Some grammatical immaturities are noticeable • Some sound immaturities still present but speech should be largely intelligible	• He does not understand what you have asked him • He does not concentrate on anything for more than a few minutes • Very poor use of grammar • Speech is very unclear • He cannot relate events that occurred when you were not present • He does not show interest in playing with other children • He stumbles, repeats words or the beginning of words, or gets stuck on words (dysfluency/stammer) • He has a habitually hoarse voice	• Provision of SLT health promotion information leaflet: – *Tips for talking: children aged 3–4 years* • Hearing assessment • Link in with nursery/ playgroup • Onward referral, eg to: – CDC – community paediatrician – ENT • Referral to SLT services

Key skills: 4 to 5 years

Key skills	Cause for concern	Management options for consideration
By this time, he will be having an even wider range of experiences, especially in early years settings or school. His speech and language development will continue, as will the demands on him to use his language skills. He needs to listen and understand more and to share his ideas within the classroom. He will also use his language skills to build on as he learns to read and write. Children will develop language skills at different rates, but at this stage, typically, he will be: • able to understand spoken instructions related to an activity without stopping what he is doing to look at the speaker • choosing his own friends and playmates • taking turns in much longer conversations • understanding more complicated language (eg 'first', 'last', 'might', 'may be', 'above' and 'in between') • using sentences that are well formed, although he may still have some difficulties with grammar (eg some plurals, like saying 'sheeps' instead of 'sheep', or more complicated tenses, like using 'goed' instead of 'went') • thinking more about the meanings of words – perhaps describing what simple words mean or asking what a new word means when he first hears it • using most sounds effectively – may have some difficulties with words with lots of syllables or consonant sounds together, eg 'scribble' or 'elephant'	• Speech sound development is immature (refer to **Sound chart** on page 22) • Sentence structure is immature or ungrammatical • Vocabulary is weak and impacting upon progress in the classroom • He is not able to communicate appropriately with teachers/peers, eg in relating relevant information, taking turns to speak, keeping to the topic of conversation, initiating interaction • He engages in his own rigid choice of activity and/or topic of conversation • He is not able to sustain attention for classroom activities • He stumbles, repeats words or the beginning of words, or gets stuck on words (dysfluency/stammer) • He has a habitually hoarse voice	• Provision of SLT health promotion information leaflet: – *Tips for talking: children aged 4–5 years* • Link with teaching staff/ special educational needs coordinator (SENCO): – Has a referral been made to educational psychology? – Has the child been given individual learning targets/been placed on the SEN code of practice by the teacher/school? • Hearing assessment • Onward referral, eg to: – CDC – community paediatrician – ENT • Referral to SLT services

Key skills: 5 years onwards

Key skills	Cause for concern	Management options for consideration
This covers a huge period of development for any child. Often by five or six years old, he will have well-developed language with a wide vocabulary, well-formed sentences and good use of speech sounds. He will usually have developed attention skills so that he can understand instructions while carrying on with another activity at the same time. He should also be able to understand much more information. As he grows up, he gains a wider understanding of how to use his language in different situations – for example to discuss ideas or give opinions. Speech and language development is a gradual process and builds on skills he has already learnt. He will: • remain focused on one activity for increasing lengths of time without being reminded to do so • continue to learn new words – his vocabulary will increase enormously, especially with words learnt in school (as he gets older, he will rely less on pictures and objects to learn new language, and be able to learn simply through hearing and reading new words; however, using visual materials helps older children and even adults to learn new words)	• See **4 to 5 years** section on page 17 • Consider how the child's speech and language skills fit with his general learning progress and ability	• See **4 to 5 years** section on page 17 • Link with teaching staff/ SENCO: – Has referral been made to educational psychology? – Has the child been given individual learning targets/been placed on the SEN code of practice by the teacher/school? • Hearing assessment • Onward referral, eg to: – CDC – community paediatrician – ENT • Referral to SLT services

Key skills: 5 years onwards (cont.)

Key skills	Cause for concern	Management options for consideration
• use his language skills in learning to read, write and spell • learn that the same word can mean two things (eg 'orange' the fruit and 'orange' the colour) • learn that different words can mean the same thing (eg 'minus' and 'take away') • understand concepts and ideas that are abstract - like feelings and descriptive words, eg 'carefully', 'slowly' or 'clever' • use language for different purposes, eg to persuade, negotiate or question • share and discuss more complex and abstract ideas, like relationships with others • use language to predict and draw conclusions • use language effectively in a range of different social situations • understand more complicated humour and figurative language (like sarcasm)		

Additional guidance

1. Play and communication

Play allows a child to learn skills that are essential to language development, eg listening, observing, imitating, symbolic understanding, concept formation and social skills, such as taking turns and cooperation.

Play provides an opportunity for experimenting with and developing new skills, and practising those already learned.

If a child's play is delayed, it is often an indicator of difficulty in some other aspect of development, or in the environment.

Below are certain types of play behaviours, which are expected around the given ages.

9 months

Looks for a dropped toy.

Enjoys peek-a-boo and rhymes, eg 'round and round the garden'.

12–15 months

Plays with an object according to its function, eg brushes own hair.

Can give adult a toy if requested.

Enjoys action songs.

18 months

Simple pretend play with large toys, eg brushing teddy's hair.

Pretends to do real life activities, eg dusting/cleaning.

Is interested in looking at books.

24 months

Interested in playing with small toys.

Will carry out simple make believe activities with toys.

Will play with a toy for longer periods, eg five minutes.

Will play alongside other children.

36 months

Has sequences of activity in make believe play.

Can take on simple roles within play, eg shopkeeper.

Play may involve miniature figures, eg Duplo/Playmobil.

Will join in play with other children.

Enjoys listening to stories.

48 months

Enjoys dressing up/elaborate make believe play.

Enjoys playing with friends.

Understands sharing and taking turns.

Can play games with rules.

Stages of play

Exploratory play

From birth, eg with toys/objects, mouthing, shaking, feeling. Initially, child plays with only one object.

Relational (constructional) play

From 9 months.

Child uses two hands, eg bangs two objects together, takes rings off stacking ring.

Pretend play

From 12 months approximately.

Self, 12 months – eg feeds self with cup.
Doll, 16 months – eg feeds doll with cup.
Other, 18 months – eg feeds doll/self/adult.

Social play

Social play follows a developmental sequence:

- solitary play – may be silent;
- parallel play – not sharing;
- looking-on play – 2½ years;
- simple cooperative play – 3½–4 years;
- games with rules – 4 years onwards.

2. Phonology/speech sound development

Speech sound development begins with babbling and can continue until a child is around seven or eight years of age. The most rapid period of change is usually between two and four years of age. It ties in closely with a child's language, motor, auditory and cognitive development (see **Sound chart** on following page).

Children need time to develop their sound system. This may need to be explained to the parent, with advice not to directly correct or train the child's speech. If they do so, they will be breaking down the child's communication attempts and increasing the child's awareness and anxiety. The child may then avoid speaking because of lack of confidence.

Discuss with a speech and language therapist if:

- a child's speech sounds are clear, but the quality of their voice is hoarse or nasal;
- a child has air escaping through their nose when talking;
- a child's speech sound development is markedly delayed or deviant.

Lisps

A lisp is a hissy 's' sound where you can see the tongue protruding between the teeth.

Children presenting with a lisp as their only difficulty may be referred after 4½ years of age.

Clinical practice indicates that changing this speech pattern is often not possible until second upper and lower front teeth are in place. This should be explained to parents at the time of referral. A lisp does not interfere with a child's educational progress. It is important that negative attention is not drawn to it.

Tongue-tie

In the majority of cases, tongue-tie will not affect the development of speech sounds. Referrals for babies with tongue-tie will only be accepted if the baby presents with eating and drinking difficulties. The baby should be referred to the specialist SLT paediatric dysphagia service.

Community referrals for young children with tongue-tie will only be accepted if there are presenting speech difficulties, which may or may not be attributed to the tongue-tie.

For further information for parents and carers, see the *Does my child speak clearly?* handout

Sound chart

The following chart gives an overview of speech sound development.

The early sounds made by babies and toddlers include a variety of speech and non-speech sounds. Over time, children develop their ability to use the speech sounds of their first language, in words.

There is variation in the rates at which different children develop speech sounds; however, based on research and clinical practice, the following table shows when sounds are used spontaneously, or when their use can be encouraged. Sounds are usually treated at the upper level of normal age acquisition, or six months later. Research shows that boys are slower to develop speech sounds.

Age	Sounds
6-12 months	Babble (varied consonants and vowels)
1-2 years	p, b, t, d, m, n, w – as in 'Mama', 'bye', 'ta ta'
3 years	h – as in 'home' ng – as in 'sing'
3 years 6 months	s, f – as in 'sun', 'four', 'phone'
4 years	c,k – as in 'car', 'bake' g – as in 'goose', 'pig' l – as in 'look', 'lady'
4 years 6 months	Double consonants are being used In English these are double consonants with 'l', eg bl – as in 'blue'; pl – as in 'plate'; fl – as in 'fly'; cl/kl – as in 'cloud'; gl – as in 'glass' Also double consonants with 's', eg sp – as in 'spoon'; st – as in 'star'; sk – as in 'skip'; sl – as in 'slip'; sm – as in 'smoke'; sn – as in 'snap'; sw – as in 'sweet' Final clusters, eg mp – as in 'stamp' y – as in 'yes'
5 years	sh – as in 'shop', 'push' ch – as in 'witch', 'chip' j – as in 'jug' ʒ – as in 'measure' Many children outgrow a lisp in their fifth year.
5 years 6 months	v – as in 'van' z – as in 'zip'
7 years	r – as in 'rabbit', 'parrot' th – as in 'thumb', 'birthday'

3. Dummies: advantages and disadvantages

Despite their popularity and long history, the use of dummies is a controversial topic among professionals and parents/carers.

Advantages

For parents and carers, the most important advantage of dummies is their role in soothing babies or helping them settle down to sleep. Some studies show that dummies can help establish good sucking patterns in very young babies, especially those born prematurely.

Disadvantages

There are a number of disadvantages associated with the use of dummies, some of which impact upon the child's speech and language development. Some critics say that dummy use may encourage the child and mother to stop breastfeeding earlier than is in the best interests of the child. Other concerns raised by various professional groups include an increased risk of the following:

- Stomach and mouth infections.
- Middle ear infections (otitis media). This is due to the fact that sucking opens the Eustachian tube, which links the nose and middle ear, and this can allow bacteria into the middle ear from the nasal area.
- Dental problems such as open bite and cross bite.
- Overdevelopment of the muscles at the front of the mouth compared to those at the back of the mouth, which may lead to a persistent tongue thrust and further affect placement of the teeth.
- Reduced babbling and experimentation with sounds. When a baby or young child has a dummy in his mouth, he is less likely to copy sounds adults make or to attempt to babble and play with sounds himself. This is important in the development of speech skills.

Advice for parents and carers

There is a lot of confusing advice available about the use of dummies and it is important to be aware of the range of arguments. Dummies may be useful in settling young babies and encouraging strong sucking patterns, but their specific usefulness declines after a developmental age of about six months. The increased risk of ear infections, dental problems and reduced babbling and use of sounds (both of which are essential in the development of speech and language skills) are all very good reasons for not giving dummies to infants after about **one year of age**, especially during the day and when they are interacting with other children and adults.

For further information for parents and carers, see the *Dummies and talking* handout

4. Stammering/fluency

What is stammering?

- Stammering or stuttering is characterised by unusually frequent repeating or prolonging of sounds or words. The child may struggle to speak, which can lead to anxiety, distress or reluctance to speak.
- Stammering can occur at any time in childhood, but more commonly between the ages of two and five years. Approximately 1 child in 20 will have difficulties speaking fluently at this stage. The majority will grow out of it with little or no help, but one in three will require more help.
- Boys are four times more likely to stammer than girls.
- Stammering may come and go. Speech may be fluent for several days, weeks, or even months, and then speaking may become difficult again. Fluency may also change according to the situation the child is in, who the child is talking to, what he wants to say, and also how the child is feeling (tired, excited, confident etc).
- The cause is unknown, but family history of persistent stammering is a risk factor.

The child will appear to have noticeable difficulties speaking smoothly and freely, characterised by:

- partial word repetition, "mi-milk";
- single syllable word repetition, "I-I want that";
- multi-syllabic word repetition, "Superman... Superman comic please";
- phrase repetition, "I want a.....I want an ice cream cone";
- prolongation, "I'm Tiiiiiiimmy Thompson";
- tense pause, "can I have some more (lips together, no sound coming out) milk?"

Some factors have been shown to be characteristic of those children at greater risk of developing a persistent stammer. The British Stammering Association (BSA) reports the following risk factors:

- a family history of stammering or speech/language problems;
- the child is finding learning to talk difficult in any way;
- the child shows signs of being frustrated or is in any way upset by his speaking;
- the child is struggling when talking;
- parental concern or uneasiness.

When to refer?

Early referral is essential because:

- research tells us that intervention as close as possible to onset has the best chance of success;
- effective therapy depends on a detailed assessment and a treatment programme that meets the needs of the individual.

For further information for parents, see:

- ***Helping your young non-fluent child* handout**
- **BSA information leaflets available from www.stammering.org**
  - ***Information for parents of children under five***
  - ***Information for parents of school-age children***

5. Voice/dysphonia

Paediatric dysphonia

A child's voice is similar to an adult's in that it reflects many aspects of his physical, environmental, cultural, social and psychological development. There are many variations within normal voice production but a useful indicator of an abnormal voice is if the listener 'turns their head' to locate a speaker because of unusual voice production.

Common symptoms of voice problems include:

- quality (eg hoarse, rough voices);
- loudness (eg too loud or too quiet);
- inappropriate pitch (eg too high or too low).

Causes may include:

- physical factors (eg excessive shouting, prolonged crying, persistent coughing);
- noisy activities (eg team sports, playground games);
- behaviour (eg aggression, immaturity);
- family dynamics (eg sibling rivalry, amount of attention).

Vocal nodules or swollen vocal cords are by far the most common cause of hoarseness in children, although other conditions such as papilloma or vocal fold weakness can occasionally occur.

Assessment by an ENT surgeon is necessary before speech and language therapy assessment can be initiated.

However, referrers should feel free to discuss any concerns about a child's voice with the SLT department prior to making a decision regarding referral.

Partnership with parents is critical to the success of therapy.

Voice therapy is a treatment that needs to be taught and then carried over into the child's daily life. Concepts taught in voice therapy can be supplemented and reinforced by the parents, but for long-term benefit to be attained, the child must be capable of controlling some of the situations in which the voice is being used. Thus, assessing the maturity of the child is essential when deciding whether direct voice therapy is appropriate.

For further information for parents and carers, see the *Does my child have a voice problem?* handout

6. The bilingual child

Definitions

Monolingual: A person who knows and/or uses one language.

Bilingual: A person who knows and/or uses two languages.

Multilingual: A person who knows and/or uses three or more languages.

Simultaneous bilingualism is when a child (usually younger than three years of age) learns two languages at the same time. The 'one person, one language' approach has been found to help the child separate and learn the two languages.

Sequential bilingualism is when a child (usually after the age of three) learns a second language after the basic acquisition of the first language.

Research shows that bilingualism in a child or adult is an advantage. Learning two (or more) languages can be beneficial to a child's overall language and learning abilities. Research shows that children who understand more than one language are able to think more flexibly and creatively.

Many children who are second language learners are thought to be language delayed, when in fact they are demonstrating normal features of learning a second language. Common characteristics are as follows:

- A silent period is common in the sequentially bilingual child, where the child may say very little for up to seven months. This happens soon after the second language is introduced.
- Code mixing. Children often use words from both languages in one sentence.
- Loss of the first language. If the child has learned a first language but doesn't use it much, he will lose his skills in that language. This means that while English is still being learned, the child's ability in both languages will be below age level. When a child is acquiring a new language and not continually using the first language acquired, he can lose proficiency.
- Most children who learn English as a second language will be using two and three word phrases in English after 18 months of exposure, and will be able hold a conversation after about two years of exposure.

Criteria for referral

Bilingualism is not a cause of language delay and is not in itself a reason to refer to speech and language therapy.

A child should be referred if he is having difficulty acquiring his first language. For example, a three year old who can communicate competently in Cantonese would not be considered to have a language problem, even though his English skills may not yet be comparable with his Cantonese.

Referral of a child should be based on the same developmental criteria and decision-making process outlined in the key skills section, and other information about normal development outlined in this information pack.

If a referral is appropriate, it is important to specify which languages are spoken at home and whether an interpreter is required.

For further information for parents and carers, see the *Talk to your child in your own language* handout

7. Feeding and swallowing difficulties in children

Community SLT services do not assess and treat eating and drinking difficulties (dysphagia) in children. Referral should be directed to a specialist speech and language therapist, who will have completed postgraduate training in paediatric dysphagia.

Specialist speech and language therapists are trained in assessing feeding and swallowing skills. They have an understanding of the:

- developmental stages involved in the progression from fluids to solid foods;
- oral skills required for sucking, biting and chewing;
- pharyngeal skills required for swallowing.

The causes of feeding difficulties (dysphagia) are many and varied and may include:

- neurological disorders;
- prematurity;
- gastroesophageal reflux;
- developmental disorders;
- behavioural/sensory issues;
- craniofacial abnormalities.

The child with feeding/swallowing difficulties may present with some of the following symptoms. It is important to note that these symptoms may relate to other medical conditions and a wider team involving a GP, paediatrician, dietician etc may be required to assess the problem fully.

Symptoms may include:

- breathing difficulties, including a history of chest infections;
- coughing or choking during or after feeds;
- eye watering;
- wet or gurgly voice quality;
- poor oral control;
- multiple swallows required for one spoonful;
- food refusal and lengthy feeding times;
- faltering weight.

The specialist speech and language therapist will assess the child's skills at a number of levels, including the range of oral movements, effectiveness of these movements to control food and liquids, coordination of the swallow and the nature of the foods/liquids taken.

Following assessment, recommendations may be made, which may include:

- further investigations and onward referral, eg videofluoroscopy assessment (a specialist swallow assessment involving x-ray equipment);
- changes in feeding techniques (ie positioning, equipment, food consistencies and the method and pacing of food presentation);
- sensory/behavioural strategies;
- alternative feeding methods.

The management of feeding and swallowing difficulties in children is always taken with the parents' or carers' involvement and with consideration of the:

- child's age and general health;
- family support and circumstances;
- developmental considerations;
- nature of the feeding/swallowing difficulty.

It is important to remember that there is a wide variation in development through weaning milestones. Primary healthcare providers can often effectively support parents through these milestones. It is only when this support is not enough, or when parents are highly concerned, that children with weaning difficulties should be referred.

If you have concerns regarding a child's ability to feed and swallow correctly, please contact the appropriate speech and language service to discuss or refer.

Section 2: Referral to speech and language therapy

1. General points

Using the developmental guidelines provided, refer children who are delayed in relation to the normal range but remember the following:

- Look at the child as a whole rather than isolating speech.
- Look for progression in development rather than how a child performs on a specific day. Ask:
  - "would this be typical?";
  - "have you noticed any changes?";
  - "are there things he does this month that are different to last month?".
- Consider the broader developmental picture when deciding if referral is necessary; for example, desire to communicate, play skills, behaviour etc. In children under three years, it is the desire to communicate and the quantity of verbalisation, rather than the quality, that is important.
- In the normal child, language development continues into middle primary years – it is not complete for P1 entry.
- Liaise with the speech and language therapist at any stage of the identification process if you are unsure whether to refer or not.
- Give advice when appropriate, using relevant leaflets/websites provided.
- If the child has a mild speech and/or language delay at the time of your assessment, advise the parents to contact you again if these have not been resolved within a reasonable period, or to contact the speech and language therapist directly.
- Referral information must be detailed enough to ensure appropriate and timely triage by the SLT service. Incomplete referrals will be returned.

2. Criteria for referral to community speech and language therapy

1. 18 months –18 years of age.
2. Parental consent must be obtained.
3. Child presents with communication difficulties that impact on his social, emotional or educational development. This includes children with:
   - receptive language difficulties;
   - expressive language difficulties;
   - delayed/disordered speech development;
   - a stammer/non-fluent speech;
   - a voice disorder, eg hoarse voice.

Exclusion criteria

- Referrals of children where there is no evidence of reason for concern.
- Referrals of babies/toddlers with tongue-tie where there is no history of feeding or speech difficulties.
- Referrals that indicate inappropriate expectations relative to a child's age (see **Key skills**, pages 5-19, and **Sound chart**, page 22).
- Lisps in children younger than 4½ years.
- Referrals of selective mutism where there is evidence that speech and language development is age appropriate.
- Referrals of children with general learning difficulties where there is evidence that speech and language skills are commensurate with general ability.
- Referrals of children with specific literacy problems where there is evidence that verbal communication is normal.
- Re-referral of school-age children within six months of being discharged by HSCT staff because no therapy was required, and presenting with no new/additional difficulties.

3. Procedures

SLT services work to the Integrated Elective Access Protocols (IEAP) as set by the DHSSPS.

Referral

The SLT service has an open referral system. All referrals require consent from the person with parental responsibility. For details on the referral process in your area, contact the SLT department of your local HSCT.

Triage

Referrals are triaged to consider whether assessment is appropriate.

Initial appointment

Following acceptance of referral, the patient will be offered an initial appointment for assessment within nine weeks. If the patient fails to attend without notification, he will be discharged.

The initial appointment may be used for:

- discussions with patients/carers;
- observation;
- taking case history;
- initiating assessment.

Assessment may not be completed at the initial interview.

Following an assessment, a management decision will be made in discussion with the patient/carer.

Intervention options

Assessment and intervention options include:

- one to one;
- groups;
- telephone contact;
- liaison with other professionals;
- report writing;
- case conference/annual review;
- training parent/other;
- consultative model;
- school based options.

A management decision on the type and frequency of intervention will be made, based on the age of the child and his presenting difficulties, and the impact on the child.

4. Discharge

The patient may be discharged at any point following referral, after a case management decision to do so.

Failure to contact the service or attend a booked appointment will result in discharge.

Section 3: Health promotion information for parents and carers

These leaflets can be downloaded from the website www.talkingpoint.org.uk under the section entitled 'The Basics':

- Tips for talking: 0-3 months
- Tips for talking: 3-6 months
- Tips for talking: 6-12 months
- Tips for talking: 12-18 months
- Tips for talking: 18-24 months
- Tips for talking: 2-3 years
- Tips for talking: 3-4 years

The following leaflets and handouts, which support the information in this resource, will be available.

Leaflets

- Tips for talking: 4-5 years
- What your baby says about learning to talk
- What your tot says about learning to talk
- What your toddler says about learning to talk

Handouts

- Does my child speak clearly?
- Dummies and talking
- Helping your young non-fluent child
- Does my child have a voice problem?
- Talking to your child in your own language

Additional information on stammering/ non-fluency can be found on the British Stammering Association's website www.stammering.org

- BSA information for parents of children under 5
- BSA information for parents of school-age children

Websites for parents/carers:

www.talkingpoint.org.uk

www.literacytrust.org.uk

www.talktoyourbaby.org.uk

www.stammering.org

www.ican.org.uk

www.afasic.org.uk

Section 4: Bibliography and websites

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Magill S, McKee A, Devon C, Bell M. Improving speech and language therapy services for children through collaboration. Journal of the Association for Quality in Healthcare 1996; 3(4): 127–133.

Van der Gaag A, McCartan P, McDade A, Reid D, Roulstone S. The early communication audit manual: a talking toolkit. London: Royal College of Speech and Language Therapists, 1999.

Ward S. Babytalk: strengthening your child's ability to listen, understand and communicate. London: Arrow, 2004.

Websites

www.talkingpoint.org.uk

www.stammering.org

www.afasic.org.uk

www.rcslt.org

www.talktoyourbaby.org.uk

www.ican.org.uk

www.hanen.org

www.elklan.co.uk

www.literacytrust.org.uk

Section 5: Appendices

Appendix 1

Late talkers – risk factors

Risk factors to be considered include:

- family history of speech, language and/or communication difficulties/literacy difficulties/learning difficulties;
- history of upper respiratory tract infections;
- limited babbling – a quiet baby;
- difficulty understanding spoken language and following simple instructions;
- limited range of symbolic noises (eg animal sounds/car noises);
- limited imitation and copying of actions;
- limited use of gesture;
- limited pretend play;
- limited spontaneous imitation of single words;
- limited range of words used (ie using only names for objects or people and no action words);
- lack of engagement with adults or children/poor eye contact.

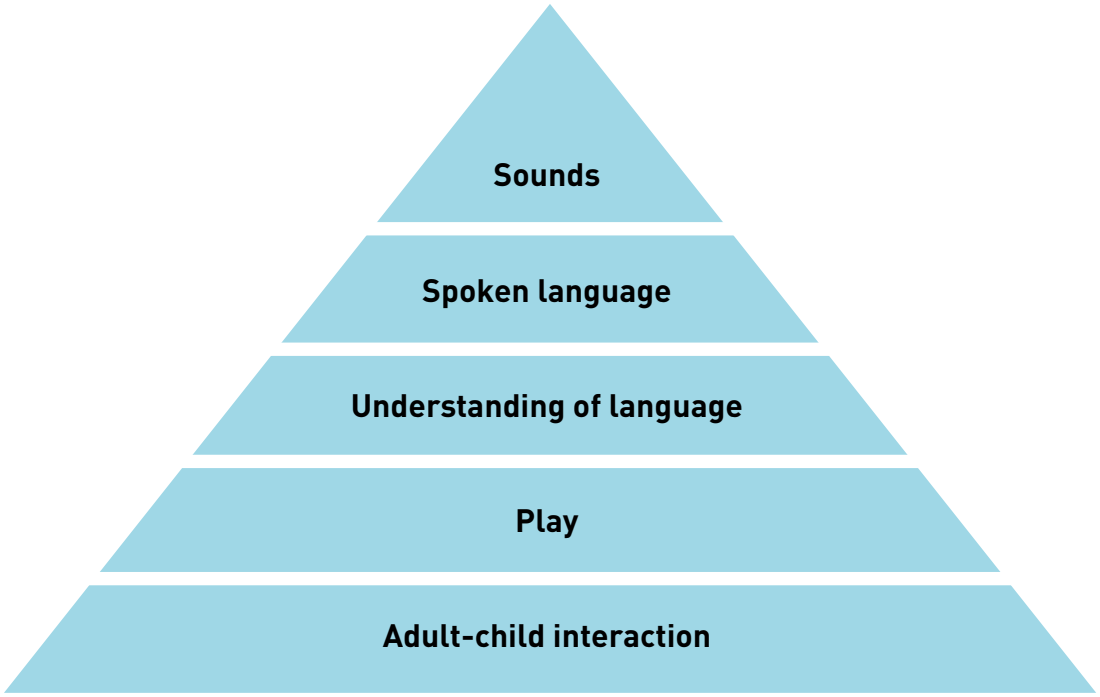
Appendix 2

Suggested toys for observation of speech, language and communication skills in children aged 24–30 months

- Objects – eg car, cup, miniature animals, toy phone, ball, key, bricks, dolls, teddy, toy food, spoons and boxes of varying sizes.
- Simple picture books (one picture on each page).
- Six object picture cards (use prompts such as 'show me the...' /'give me the... '/'what's this?'/'which one do you drive?' etc).
- Six action picture cards (use prompts such as 'show me who is running'/'tell me what is happening').

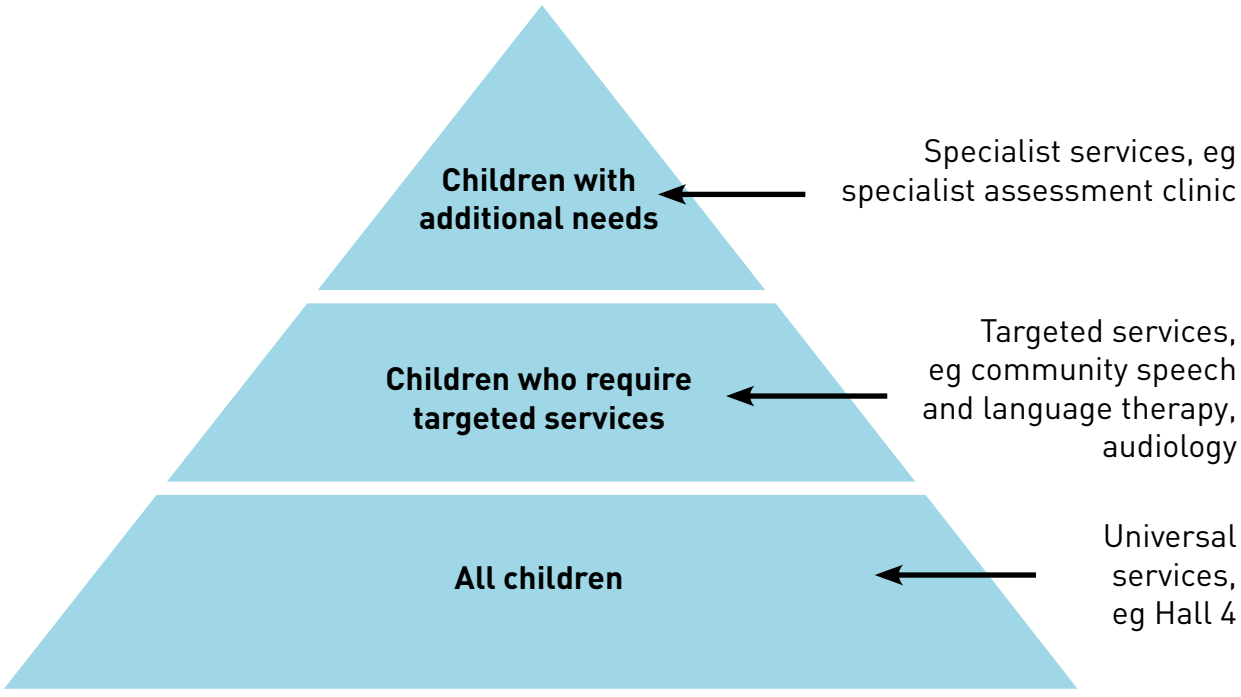
Appendix 3

Language development pyramid



Appendix 4

Population of children and services provided



Public Health Agency

DHSSPS

Department of Health, Social Services and Public Safety

www.dhsspsni.gov.uk

Public Health Agency, Ormeau Avenue Unit, 18 Ormeau Avenue, Belfast, BT2 8HS.
Tel: 028 9031 1611. Textphone/Text Relay: 18001 028 9031 1611.
www.publichealth.hscni.net

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