



# Communication Delays

## Service Delivery Guidelines

Intervention guidance for service providers and families of young children with communication delays



State of Alaska • Department of Health & Social Services • Office of Children's Services  
Alaska Early Intervention • Infant Learning Program



ALASKA EARLY INTERVENTION / INFANT LEARNING PROGRAM

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# COMMUNICATION DELAYS

EARLY INTERVENTION GUIDANCE FOR SERVICE PROVIDERS AND FAMILIES  
OF YOUNG CHILDREN WITH COMMUNICATION DELAYS

**JUNE 2011**



## MISSION

To promote positive development and improved outcomes for Alaska's families by creating a culturally responsive, comprehensive and accessible service delivery system that links service providers, empowers families and engages communities

–Alaska Early Intervention/ Infant Learning Program

# COMMUNICATION DELAYS

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# INTRODUCTION

One of the most common reasons families contact the Alaska Early Intervention/Infant Learning Program (EI/ILP) is when a child’s ability to communicate is delayed. Speech and language deficits comprise the most common childhood disabilities and affect about one in 12 children, or 5 to 8 percent of American children under the age of five, according to the American Speech-Language-Hearing Association (ASHA). A wide variety of conditions can impact communication, including both receptive language (what the child is able to understand), as well as expressive language (what the child is able to tell us). It takes a skilled practitioner to distinguish between a child whose “late talking” is normal and does not require intervention and one whose language development is a cause for concern.

When evaluating communication delays in Alaska, we must also keep in mind the rich diversity of languages spoken throughout the state. Not only are there indigenous languages that are spoken by 13,000 Alaska Natives, but Alaska also has a large immigrant population whose children may be bilingual or live in families with limited English proficiency. Children should be assessed in their primary language before determining a communication delay exists, and the services of a speech language pathologist (SLP) or an interpreter may be required.

Providing early intervention services within the natural environment in which the child lives will provide the best circumstances for learning. By continuing to listen to the family throughout the process, the intervention techniques can be modified on a continued basis to meet the child’s and family’s needs.

## PURPOSE OF THE GUIDELINES

The purpose of these service delivery guidelines is to provide parents and EI/ILP service providers with an overview of the best practices for early identification and intervention for young children with communication delays in Alaska. These include those approaches that have been shown to result in the best outcomes for children from birth to three.

While the guidelines primarily focus on communication problems related to speech and language, other conditions often encountered when identifying and assessing communication delays are covered as well. The guidelines also include suggestions for evaluation and support of children experiencing communication delays in homes where English is not the primary language spoken.

While most of the recommended practices in the guidelines do not carry the force of regulation, they are intended to guide parents and early intervention providers in making informed decisions about the most appropriate assessment procedures and intervention practices that will enhance the child’s language development.

Not all practices will be appropriate in all cases. The guidelines are intended to be flexible, not prescriptive or limiting, and to set the tone for the family to be an instrumental part of early intervention. An Individualized Family Service Plan (IFSP) should be developed for each child based on the child’s particular needs, the resources available, and input from the family and the early intervention provider or team.

## EARLY INTERVENTION SERVICES IN ALASKA

Early intervention services are federally mandated under Part C of the Individuals with Disabilities Education Act (IDEA), a federal law passed in 1986. IDEA requires states to ensure that young children who may have disabilities or developmental delays receive an evaluation to identify the potential need for early intervention.

Alaska’s early intervention services are administered by the Department of Health and Social Services, Office of Children’s Services, through its EI/ILP office. They include a flexible array of services for children birth to 3 years of age who experience disabilities or developmental delays, or who are at risk for developmental delays.

EI/ILP partners with grantees to provide services directly to families at a local and regional level. In 2010, services were provided to children throughout the state by approximately 115 highly qualified staff employed within 17 regional grantee agencies. Programs vary widely by staff and region size. Service may include:

- Developmental screening and evaluation
- Individualized Family Service Plans to outline goals for the family and child
- Child development information
- Home visits
- Infant mental health services
- Physical, occupational or speech therapy
- Specialized equipment
- Referrals to other needed services

### EI/ILP APPROACH TO SERVICE DELIVERY

Because no single professional can meet all the needs of a child with developmental delays, EI/ILP encourages the use of a *transdisciplinary* approach, with a primary service provider assigned to each child and a team of professionals from different disciplines who share their expertise with the parents and other team members as

needed to support the child’s progress and participation in daily activities in the family’s home and community.

In addition to taking a team approach to service delivery, the core values of the EI/ILP support services that are *evidence-based* and *family-centered*. By listening to the family throughout the process, intervention techniques can be modified on a continual basis to match the child’s and family’s unique needs and strengths.

### **MORE INFORMATION**

More information and resources for early intervention services in Alaska are available at the EI/ILP website. The site includes a statewide directory of EI/ILP programs that cover all regions of Alaska.



[www.earlyintervention.alaska.gov](http://www.earlyintervention.alaska.gov)

# UNDERSTANDING COMMUNICATION DELAYS

## WHAT IS COMMUNICATION?

Communication is what happens when we exchange information with others. It includes the transmission of all types of information, including verbal and nonverbal messages related to needs, feelings, desires, perception, ideas and knowledge. The process of communication requires both the ability to produce and understand messages.

- **Nonverbal** messages can include gestures, body posture, facial expression, eye contact, head and body movement, and physical distance.
- **Verbal** communication uses words, whether we are speaking them, writing them, or using sign language.

Although language and speech are sometimes thought of as the same thing, they are different. The American Speech-Language-Hearing Association provides a useful distinction (1):

- **Language** is made up of socially shared rules about what words mean (e.g., "star" can refer to a bright object in the night sky or a celebrity), how to make new words (e.g., friend, friendly, unfriendly), how to put words together (e.g., "Peg walked to the new store" rather than "Peg walk store new"), and what word combinations are best in what situations ("Would you mind moving your foot?" could quickly change to "Get off my foot, please!" if the first request did not produce results).
- **Speech** is the verbal means of communicating. It consists of *articulation* (how speech sounds are made), *voice* (the use of the vocal folds and breathing to produce sound (e.g., the voice can be abused from overuse or misuse and can lead to hoarseness or loss of voice), and *fluency* (the rhythm of speech).

## WHAT IS TYPICAL IN COMMUNICATION DEVELOPMENT?

Communication is important for all aspects of a child's development, and the quality of the child's communication development has long-term impacts on learning and on the child's ability to interact with others. The give and take interaction of communication is essential to building strong and supportive relationships with others.

The way in which a child communicates varies with the child's age and developmental status. Communicative behaviors begin at birth and evolve over time. Children enter the world with a limited but meaningful set of behaviors that serve as communication signals to parents and caregivers.

Young children demonstrate many kinds of nonverbal gestures and social routines before the onset of first words. Typically in young children, the ability to understand language (*receptive skills*) develops before the ability to speak or produce language (*expressive skills*).

During the second year of life, a child's understanding of language and ability to communicate expand rapidly. By 3 years of age, most children have acquired the basics of language.

## WHAT IS A COMMUNICATION DELAY?

The American Speech-Language-Hearing Association estimates that 42 million Americans have some type of communication disorder. Communication delays represent the most common developmental problem in young children (2).

ASHA groups communication delays or disorders into three categories:

- **Language Delays/Disorders.** When a person has trouble understanding others (*receptive language*), or sharing thoughts, ideas, and feelings completely (*expressive language*), then he or she has a language delay or disorder. Young children with cognitive delays, autism spectrum disorders (ASD), and other general developmental disabilities, almost always experience general delays in language development.
- **Speech Delays/Disorders.** When a person is unable to produce speech sounds correctly or fluently, or has problems with his or her voice, then he or she has a speech delay or disorder.
- **Hearing Loss.** A hearing loss is the result of impaired sensitivity of the physiological auditory system.

## WHAT CAUSES COMMUNICATION DELAYS?

Communication delays can occur in isolation (not associated with any other identifiable cause), or they may coexist with other conditions such as hearing loss or developmental disorders such as intellectual impairment or ASD. The specific cause of a communication delay is often unknown. The focus of these guidelines is on primary communication delays that are not the result of hearing loss or other specific developmental problems. Other guidelines in this series provide more details on early identification and intervention practices for young children with ASD, mental health issues, or those who are hard of hearing or deaf.

## WILL CHILDREN OUTGROW A COMMUNICATION DELAY?

While some children with communication delays may catch up to their peers without early intervention, it is difficult to predict *who* will outgrow a communication delay. Young children who have speech and language delays as a result of hearing loss, developmental disorders, or other specific medical conditions do not typically outgrow their communication disorder. Appropriate treatment for these children may help them improve their communication skills, but it will probably not completely eliminate the disorder. When a communication delay is present or suspected, an assessment will help to identify the need for intervention.

## LANGUAGE AND CULTURAL CONSIDERATIONS

A regional, social, cultural, or ethnic variation of a language system is not considered a disorder of speech or language. *Bilingualism* (two languages) or *multilingualism* (more than two languages) within a child's home or other care environment may affect the way in which the child learns each language. As a result, the child's early expression of language may vary somewhat from that of children raised in an environment where only one language is spoken. This is a difference in learning language, not a language disorder. A true communication disorder will be present in all languages a child is acquiring. Children cannot have a communication disorder in one language alone.

## EARLY IDENTIFICATION

It is important to identify potential communication delays as early as possible. In truth, however, it is very challenging to correctly differentiate young children who are late to begin talking, but who will eventually speak without intervention, from those who will experience longer-term communication problems.

Early identification of children with communication delays can occur in a variety of ways. In some cases, certain behaviors or lack of progress in the child's development may cause parents or other caregivers to become concerned that the child may have a communication problem. In other instances, a health care provider seeing the child for a routine visit may become concerned based on information from the parents or from direct observation of the child. Clinical clues to a possible communication disorder may be provided by risk factors the child has or by delays in achieving typical speech and language milestones.

## TYPICAL DEVELOPMENTAL MILESTONES

Most young children vary somewhat in the timing of their communication development. Typical developmental milestones can be used as a reference to monitor a child's speech and language development. The typical language milestones presented in Table 1 are specific communication behaviors grouped according to the age range when they first appear in most children.

Although there is some normal variation in the rate at which children develop, these milestones are usually first seen sometime during the age range specified. The age when a behavior or absence of a behavior starts to become a cause for concern corresponds to the upper limit of the age range when this behavior usually first appears in most children.

For example, babbling usually develops between 6 and 9 months of age. A child not babbling or babbling with few or no consonants by the end of 9 months is a clinical clue to a possible communication problem.

Some clinical clues to a possible communication delay can be identified at a very early age; others may not be recognized until parents, caregivers, or health care providers notice the child’s use of language seems to be delayed compared to other children within the same age range.

Table 1 describes typical developmental milestones for speech and language acquisition and indicates age from birth to 36 months at which a behavior or absence of a behavior warrants concern.

**Table 1: Typical Speech-Language Milestones and Causes for Concern**

Typical Milestones	Cause for Concern at 3 Months
<b>First 3 Months</b>	
Looks at caregivers and others	Lack of awareness of environment
Becomes quiet in response to sound (speech)	Lack of awareness of sound
Cries differently when tired, hungry, or in pain	Cry is no different if tired, hungry or in pain
Smiles or coos in response to another person’s smile or voice	Lack of responsiveness
	Problem sucking, swallowing
Typical Milestones	Cause for Concern at 6 Months
<b>3 to 6 Months</b>	
Fixes gaze on face	Cannot focus, easily over stimulated
Responds to name by looking for voice	Lack of awareness of sound, no localizing toward the source of sound or speaker
Regularly localizes sound source or speaker	Lack of awareness of people and objects in the environment
Cooing, gurgling, chuckling, laughing	Problem sucking, swallowing

Typical Milestones	Cause for Concern at 9 Months
<b>6 to 9 Months</b>	
Imitates vocalizing to another	Does not appear to understand or enjoy the social rewards of interaction
Enjoys reciprocal social games structured by adult (such as peek-a-boo, pat-a-cake); Recognizes familiar people. Cries when a parent leaves the room (at 9 months)	Lack of connection with adult (such as lack of eye contact, reciprocal eye gaze, vocal turn taking, reciprocal social games)
Has different vocalizations for different states (tired, hungry, in pain)	Cry is no different if tired, hungry or in pain
Reduplicative babbling ("bababa," "mama-mama"), vocal play with intonational patterns, lots of sounds that take on the sounds of words; Imitates familiar sounds and actions	No babbling or babbling with few or no consonants
Responds consistently to soft speech and environmental sounds	Does not respond to soft speech and environmental sounds
Reaches to request object	Does not clearly indicate request for object while focusing on object
	Problem sucking, swallowing

Typical Milestones	Cause for Concern at 12 Months
<b>9 to 12 Months</b>	
Imitates new sounds and actions	Is easily upset by sounds that would not be upsetting to others
Indicates requests clearly; directs others' behavior (shows objects); gives objects to adults; pats, pulls, tugs on adult; points to desired object	Does not clearly indicate request for object while focusing on object
Coordinates actions between objects and adults (looks back and forth between adult and desired object)	Does not coordinate action between objects and adults
Shows consistent patterns of reduplicative babbling, produces vocalizations that sound like first words ("mama," "dada")	Lacks consistent patterns of reduplicative babbling
Uses communicative gestures: shakes head "no," pushes undesired objects away; Waves "bye"	Lack of communicative gestures
Attracts attention (such as vocalizing, coughing); Cries when a parent leaves the room (9 months)	Lacks responses indicating comprehension of words or communicative gestures

Typical Milestones	Cause for Concern at 18 Months
<b>12 to 18 Months</b>	
Begin single-word productions	Does not attempt to imitate or spontaneously produce single words to convey meaning
Uses ritual words such as "bye," "hi," "thank you," and "please"	Limited expressive vocabulary (speaks fewer than 10 words); Lack of growth in expressive vocabulary over 6 month period from 12 to 18 months
<b>Requests objects:</b> points, vocalizes, may use word approximations; Understands that an adult can do things for him/her (such as activate a wind-up toy); <b>Comments:</b> points to an object, vocalizes, or uses word approximation; <b>Protests:</b> says "no," shakes head, moves away, pushes objects away; <b>Gets attention:</b> vocally, physically, maybe by using words (such as "mommy"); <b>Acknowledges:</b> eye contact, vocal response, repetition of words	Lack of communicative gestures; Does not persist in communication (such as may hand object to adult for help, but then gives up if adult does not respond immediately)
	Limited comprehension vocabulary (understands fewer than 50 words or phrases without gesture or context clues)

Typical Milestones	Cause for Concern at 24 Months
<b>18 to 24 Months</b>	
Uses mostly words to communicate	Reliance on gestures without verbalization
Begins to use two-word combinations; First combinations are usually memorized forms and used in one or two contexts.	Does not use any two-word combinations
By 24 months, has at least 50 words, which can be approximations of adult form	Limited production vocabulary (speaks fewer than 50 words)
By 24 months, uses combinations with relational meanings (such as "more cookie," "daddy shoe"); More flexibility in use of words	Compulsively labels objects in place of commenting or requesting
	Regression in language development: stops talking or begins echoing phrases he or she hears, often inappropriately
	Largely unintelligible speech with limited consonant production

Typical Milestones	Cause for Concern at 36 Months
<b>24 to 36 Months</b>	
Engages in short dialogues and expresses emotion	Words limited to single syllables with no final consonants
Begins providing descriptive details to facilitate listener's comprehension	Echoing or "parroting" of speech without communicative intent
Uses attention-getting devices (such as "hey")	Does not demand a response from listeners; Asks no questions
Able to link unrelated ideas and story elements; Begins using language in imaginative ways	Few or no multiword utterances
Begins to include articles (such as a, the); Word endings (such as -ing added to verbs); Regular plurals (-s); "is" + adjective (ball is red); And regular past tense (-ed)	Poor speech intelligibility; Frequent tantrums when not understood

Source: *Clinical Practice Guideline: Quick Reference Guide*. Communication Disorders, Assessment and Intervention for Young Children (Age 0-3 Years). 1999, Reprinted 2008, Publication No. 4219. Accessed online at: [www.nyhealth.gov/community/infants\\_children/early\\_intervention/](http://www.nyhealth.gov/community/infants_children/early_intervention/)

## RISK FACTORS FOR COMMUNICATION DELAYS

There are a number of risk factors that increase the concern that a child has or may develop a communication delay or disorder. These risk factors may be genetic, medical or environmental in nature. For example, a history of chronic ear infections is considered a risk factor for communication delays.

Table 2 presents some conditions that suggest that a child is at increased risk for communication delays. These risk factors may be recognized by parents or others caring for the child or by a professional evaluating the child.

### Normal Fluency Development & Stuttering

- Young children learning language demonstrate normal developmental *disfluencies* early on (interruptions to the flow of talking such as hesitations, interjections and work and phrase repetitions), which disappear as their expressive language skills mature. This characteristic of speech and language development is typical in young children and does not require intervention, except to allay the parents' fears and concerns. Stuttering is not generally a concern in children under three.

**Table 2: Risk factors for speech/language problems in young children**

Genetic/Congenital	Medical Conditions	Family/Environmental
Prenatal Complications	Ear and Hearing Problems	Family History of Hearing Loss
Prematurity	Oral motor/Feeding Problems	Family History of Speech Language Problems
Microcephaly	Cleft Lip or Cleft Palate	Parents with Hearing Impairment
Genetic Disorders	Tracheotomy	Parents with Cognitive Limitation
Fetal Alcohol Syndrome	Autism/ASD	Children in Foster Care
Exposure to a Teratogen	Neurological Disorders	Family History of Abuse or Neglect
Positive Toxicology Screen at Birth	Long-term Medical Problems, Illness, or Hospitalizations	
Child with Dysmorphic Features	History of Intubation	
	Lead Poisoning	
	Failure to Thrive	

### ELEVATED RISKS IN ALASKA

Alaska has elevated risks for several conditions associated with communication delays. These include higher incidences of ear infection, cleft lip and cleft palate among Alaska Native populations, as well as higher rates of indoor air pollution among all populations, which have been correlated with increased ear infections in children.

- **Ear Infections.** Ear infections or *otitis media* is the inflammation of the middle ear, usually with fluid, which may or may not be infected. The condition is very common in young children, particularly in Alaska, and is a common reason for visits to the pediatrician. Otitis media often occurs in repeated bouts, causing

periods of hearing loss that can affect children during the critical time for language and speech acquisition. Some evidence exists that Alaska Native children (especially Eskimo groups) suffer ear infections at higher rates than other ethnic groups (3). Poor indoor air quality from wood smoke, space heaters and tobacco use in many Alaskan homes may contribute to increased rates of ear infections (4).

- **Cleft Lip and Cleft Palate.** Cleft lip and cleft palate are among the most common birth defects in the United States and the world. The conditions can, understandably, cause delays to a child's ability to communicate but may also occur with other congenital disorders including hearing loss that interfere with communication. American Indians, Alaska Natives, and Asians have higher rates of cleft lip and cleft palate, due to both genetic and environmental factors (5).

# ASSESSING COMMUNICATION DELAYS

## UNDERSTANDING THE ASSESSMENT PROCESS

Not all children with an elevated risk for communication delays or who fail to meet developmental milestones have a communication disorder. The presence of risk factors or clinical clues merely provides an indication that further assessment may be warranted. If parents have concerns about a child's speech and language development, they should talk with their health care provider or other professional experienced in evaluating young children with developmental delays. Depending on the level of parental concern and the presence of other developmental problems or risk factors, assessment might begin with a formal or informal checklist or a direct referral for formal evaluation.

If the family is referred to EI/ILP for a suspected communication delay, an initial evaluation will be done to determine whether the child meets requirements for receiving early intervention services. To be eligible, a child must be determined to have, or to be at risk for, a significant developmental delay. The intent of the evaluation is not to arrive at a formal diagnosis, but to identify children for whom there is an increased likelihood of a communication delays and who, therefore, need further in-depth assessment.

### SCREENING FOR HEARING LOSS

Even though all newborns in Alaska have their hearing screened at birth, it is possible for children to develop what is called "late onset" hearing loss due to otitis media, other diseases, or medications. Any hearing loss in young children, even a temporary loss due to chronic ear infection, can cause significant communication and developmental delays, and intervention may be in order. A child who is delayed in speech and language development needs to have hearing loss ruled out as a cause of the delay.

Screening for possible hearing problems is particularly important for infants and young children when:

- There are known risk factors for hearing loss.
- Clinical clues for communication delays are identified.

- Parents express concerns about the possibility of a communication delay or hearing loss.
- There are abnormal findings on a speech-language screening test.

## ASSESSMENT PROTOCOL

Many screening instruments are readily available to detect possible communication delays. Appendix 1 lists specific assessment instruments and procedures recommended for different circumstances. They may include the use of open-ended questions, informal or formal checklists, formal screening instruments, and observation of parent-child interactions in a setting that is familiar to the child. However, even screening instruments that are easy to administer usually require the experience of a qualified professional who is knowledgeable about communication delays in young children to interpret results and counsel parents.

### Initial Phone Call or Visit

Prior to the evaluation the following topics should be discussed with the family:

- Discuss what the child understands and how the child is understood.
- Determine whether the child has had an audiological assessment.
- Explore whether communication is the only area of concern.

### Components of an Assessment

It is not expected that all elements of the assessment protocol can be completed during an initial evaluation; however, attention should be paid to each area, especially when communication is the only area of concern.

If the child's delay is in expressive language only, a family history and assessment of phonology/oral motor skills may provide the information needed to determine eligibility. If the child is determined eligible, all areas can be explored in greater detail during the ongoing assessments that are a part of EI/ILP service delivery.

The following steps should serve as reminders for speech language pathologists and prompts for other disciplines for conducting an evaluation or assessment when a communication delay is suspected:

- **Audiological exam.** Recommend a hearing assessment to rule out hearing loss, if one hasn't been done. EI/ILP can arrange for an audiological exam if needed and serve as payer of last resort.
- **Family history.** Note history of language delays and disorders including fluency.
- **Medical history.** Note any significant birth history or history of otitis media
- **Presence of pre-linguistic skills**

- **Standard communication skills.** Note use of vocabulary, syntax and semantics.
- **Other ways of communicating.** Note use of gestures, sounds, and facial expressions used to communicate.
- **Oral motor skills, including imitation.** Note any struggle in feeding (taste, texture, temperature) and patterns of speech production (typical or atypical error patterns, degree of intelligibility, child's apparent frustration).
- **Phonological skills.** Note pattern of phonological processes, degree of intelligibility, stimulability (need for auditory cues, visual cues, tactile cues), child's age, and child's apparent frustration.
- **Pragmatics** (how the child uses language). Note reasons why child communicates (e.g., requesting, protesting, commenting, establishing joint attention and reference), means by which child communicates (e.g., pointing, vocalizing), frequency of initiating communication compared with typical milestones (1 act/minute at 12 months; 2 acts/minute at 18 months; 5-7 acts/minute at 24 months)
- **Symbolic Play.** Observe symbolic, or dramatic, play which usually begins between 18 and 24 months of age when children begin to substitute one object for another (e.g., using a hairbrush to represent a microphone). The child may pretend to do something (with or without the object present or with an object representing another object) or be someone. They may also pretend through other inanimate objects (e.g., has a doll pretend to feed another doll).
- **Fluency.** Note type and frequency of disfluent speech, child's awareness of speaking difficulties, any secondary behaviors, and parental response to disfluent speech.

## CULTURAL AND LANGUAGE CONSIDERATIONS

When working with children and their families, it is important to consider and respect cultural and language differences. A child's language skills should be evaluated in a setting familiar to the child (a natural language sample). Whenever possible, the evaluator should use tools that have been tested for accuracy in the child's language and cultural group. It is also recommended that a parent or other family member be included who can interact with the child during the assessment.

### ASSESSING CHILDREN WITH LIMITED ENGLISH PROFICIENCY

When assessing young children from homes in which English is not the primary language, best practices tell us (6):

- The child with limited proficiency in English cannot be compared to a monolingual English speaker in the social-emotional, academic, cognitive, or communication domains. He or she can, however, be compared to his or her

culturally and linguistically matched peers (e.g., in the rate of acquisition of English).

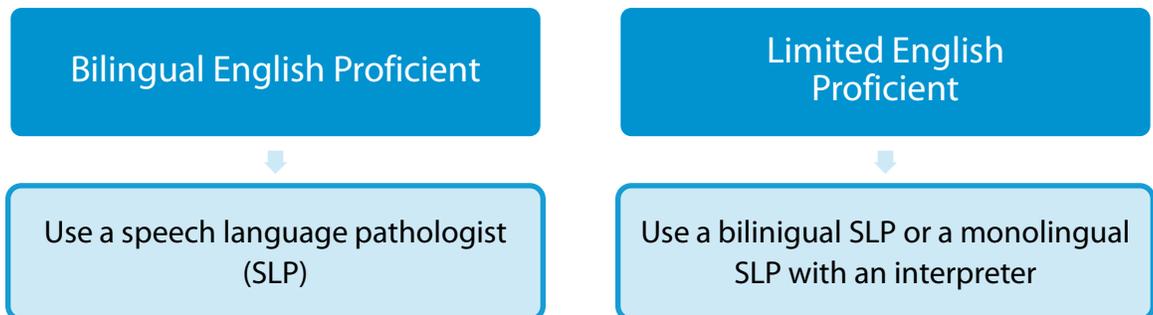
- Children may appear hyperactive, or shy and withdrawn in an unfamiliar situation, depending on the child’s culture. This is not clearly indicative of a disorder.
- The personality of the child and his or her adaptability may determine the way he or she reacts to a new situation, such as an unfamiliar, English-speaking classroom, play group or child care center.
- Learning the child’s experiential background is essential in adapting a test that appropriately measures the child’s skills. For example, a picture of a helicopter might be an appropriate replacement for a picture of an ambulance in some areas of Alaska not served by roads.

### Guidelines for Using an Interpreter

It is strongly recommended that the evaluator be fluent in the child’s primary language and be familiar with the child’s cultural background. If no evaluators are fluent in the child’s primary language, a trained interpreter should participate in the evaluation process. It may also be helpful to include a cultural informant.

**Figure 1: When to Use a Bilingual SLP or Interpreter**

#### If the parent or primary caregiver is:



When working with a parent or primary caregiver with limited English proficiency, all reports, correspondence and the IFSP may need to be translated. Remember that skilled verbal interpreters are not necessarily also skilled written translators. Appendix 3 includes a list of interpretation and translation services.

When using an interpreter, consider the following best practices (6):

- An interpreter is under the supervision of the speech language pathologist at all times. An interpreter’s activities should be reviewed and assigned by the SLP.

- The interpreter should receive training in interpreting during assessments (the role of the interpreter, functions of the SLP and interpreter, testing protocols), intervention, and conferencing.
- In assessment, the interpreter should have an understanding of the rationale, procedures, and information that is obtained from tests.
- The interpreter should have a high degree of proficiency in both English and the family's primary language.
- The interpreter should understand both mainstream culture and the culture of the child and family.
- The interpreter should not be a family member or family's friend if it raises issues of confidentiality. Children should never be used to interpret.

Appendix 2 includes additional guidelines for using an interpreter.

### **Assessing International Adoptees**

Children from non-English speaking countries who are adopted by families in Alaska should be evaluated in the language they currently hear daily. However, when communication is the only area of concern, it is prudent to allow time for the child to adjust to his or her new culture and language before making a referral to an early intervention provider. If the delay is in English speech only, children adopted from non-English speaking countries will not be eligible until the child has been living with his or her adopted family for at least 6 months. Even then, the evaluator must use clinical opinion to assess whether the child is a typical English language learner or has a true language disorder.

### **WORKING WITH BILINGUAL CHILDREN**

Learning a second language is easier for children if they have a good language base in their first language (7). It is the responsibility of the EI/ILP team to raise families' level of awareness about second language acquisition and bilingual issues and how they can best support their child's development. The parents should be supported and encouraged to communicate with the child in their native language in order to enhance the child's intellectual, cognitive, and linguistic development (6).

### **ASSESSING HEARING CHILDREN OF DEAF PARENTS**

Research has shown that a hearing child of deaf parents may have sign language as a first language and that oral language skills typically will develop normally (8). There are several systems of signing used in the United States, including *American Sign Language* (ASL) and *Signing Exact English* (SEE). It is important for early interventionists to have a working knowledge of beginning sign.

As with other languages, EI/ILP providers should be encouraged to use a speech language pathologist fluent in the family's primary sign language for the assessment of a hearing child of deaf parents; if none is available, a monolingual SLP with a sign

language interpreter for the parents can be used. The Alaska's Governor's Council on Disabilities and Special Education may be of assistance. Appendix 3 includes a list of interpretation and translation services.

Eligibility for these children is the same as for other children. However, as with international adoptees, the evaluator must distinguish between normal English-language-learning and a language disorder.

### **Childhood Apraxia of Speech (CAS)**

Childhood Apraxia of Speech (CAS) is one of the most challenging diagnoses to make when children are very young, requiring considerable clinical skill and judgment. The core impairment in CAS is neurological: the child knows what he or she wants to say but the brain is not sending the correct instructions to move the body parts needed for speech (21). There is disagreement about whether CAS can even be diagnosed in children under three, and it is unusual to have children referred to the Alaska EI-ILP with a CAS diagnosis. The American Speech-Language-Hearing Association has not yet issued clinical recommendations and guidelines on the youngest age at which CAS can be diagnosed.

# APPROACHES TO INTERVENTION

Speech and language interventions for young children include a variety of methods and approaches. No one type of intervention is best for all young children. Interventions should focus directly on the child and on teaching intervention skills to family members or caregivers who interact with the child. When communication is the primary concern, the focus of intervention is to enhance the child's overall language development and promote better long-term functional outcomes, such as expressing basic needs, establishing functional use of language, interacting socially, and acquiring knowledge.

Once a child is determined eligible for services, an EI/ILP family service coordinator can help the family put together a transdisciplinary team of providers to develop an IFSP, based on the child's unique needs, and strengths, consider assistive technology options, and help look for funding if necessary, while also providing support for the child and family.

Further assessment of the child and of the family's priorities, concerns, and resources may be done after eligibility is determined to help identify the outcomes that will be addressed in the IFSP and the supports necessary to achieve the outcomes. The IFSP also includes a plan for transitioning the child to school- and community-based services after age three.

## PRINCIPLES OF EARLY INTERVENTION

The following basic principles should guide families and service providers in developing an effective intervention plan for young children experiencing communication delays.

### **INTERVENTION REQUIRES A TEAM APPROACH**

A team approach is taken to developing the IFSP, with the child's family as integral members. Other team members typically include the EI/ILP family service coordinator and a speech language pathologist or SLP assistant. Depending on the child's needs, other specialists may also be involved, such as an audiologist, occupational therapist, or early childhood or special educator.

Because there is a wide range of individual skills, experience, and areas of specialization among health care professionals and other service providers, individual providers who work with Alaska's young children should engage only in

those aspects of their profession that are within the scope of their competence, considering their level of education, training, and experience. Licensed practitioners should follow the high-quality, evidence-based standards of their professions as determined by their state and national credentialing and professional associations.

The early intervention team will meet to establish goals and objectives as part of the development of the IFSP. The team will then discuss the services and supports essential to achieving the child and family outcomes, and will determine the frequency, intensity, and method of service delivery.

### **A CHILD'S UNIQUE STRENGTHS AND NEEDS GUIDE THE PLANNING**

Parents may come to EI/ILP services with preconceived notions of the type of specialist or service delivery method that will best meet their child's needs. The family may have been told by a neighbor or friend that because their child isn't talking, they need to work with a speech language pathologist. Or a health care provider may have written a prescription for a specific type and amount of therapy. However, research supports the use of a variety of service delivery methods as both appropriate and effective for speech and language intervention with young children.

When developing the IFSP, the team should review the child's current skills and consider what may make one type of provider or method more appropriate than another when selecting service providers and a service delivery model.

When selecting the method of service delivery, the team should consider:

- What are the unique strengths and needs of the child, family, caregiver and other communication partners?
- What is the optimal learning environment for the child? For example, consider the benefits of peer modeling and interaction and which environments best support generalization of learning to other contexts.
- Is the service delivery model flexible and dynamic enough to allow for change as the child's and family's concerns and priorities evolve? Using a service delivery model that can evolve with the child is important given the rapid developmental changes in young children.

### **FAMILY INVOLVEMENT IS CRITICAL TO THE CHILD'S PROGRESS**

Family involvement in intervention is critical to the child's progress. To understand the child's communication delays, family members or other primary caregivers need to be involved in the assessment. They should be actively involved in determining intervention options, goals, methods, and be able to identify daily routines that may help promote their child's progress.

Family involvement in intervention can be facilitated and enhanced by assuring that the intervention team plans adequate time for family training and provides ongoing direction and support to family members or caregivers. Best practice research

suggests that SLPs and other service providers see their role as more of an advisor or coach to families, rather than as a hands-on provider working directly with child.

## **A NATURALISTIC APPROACH IS PREFERRED**

Because interventions in the child's natural environment are more successful in increasing spontaneous language and generalization than intervention provided in clinic settings, a naturalistic approach to intervention is preferred. Naturalistic interventions create opportunities for the child to learn by using specific techniques and aspects of adult-child interaction to promote language learning in the child's many natural environments.

This approach differs from a direct approach where the focus is on the structural aspects of language and speech. Naturalistic approaches typically include:

- Providing learning opportunities in the day-to-day environment of the child rather than structured learning sessions
- Following the child's focus of attention or interest
- Using an incentive and a reinforcer that are naturally associated with a particular communication response

Deciding which techniques to use for an individual require the early intervention provider to draw upon knowledge about normal language learning and to be aware of the needs of the particular child. Intervention may be a mix of both techniques and depend on the child's needs, individual characteristics and stage of language development.

## **LANGUAGE AND CULTURAL CONSIDERATIONS**

It is essential to consider and respect the culture and primary language of the family when providing interventions for children with communication delays. While it is important to consider the family's preference in determining the language used in the intervention, it is strongly recommended that intervention be conducted in the primary language used in the home. Family education and counseling, including written materials, should be in the family's primary language and should be delivered by the method preferred by the family.

It is a best practice that an early intervention provider who is fluent in the primary language of the child and the family be included in the team providing services. If no providers fluent in the language are available, an interpreter may be used who can participate in the specific intervention program. Interpreters should be trained by the early intervention provider to ensure that interpretations of the child's behaviors are culturally and linguistically accurate. (See Appendix 2 for guidelines on working with an interpreter.)

Because family involvement is such an integral part of the development of speech and language, it is also important for service providers to be familiar with the family's culture. If this is not the case, best practices recommended that a cultural

informant be brought in to advise the team on issues that may cause misunderstanding during the course of intervention. A person familiar with the culture and language of the family needs to review intervention techniques and materials to determine if they are culturally sensitive and appropriate.

## SERVICE DELIVERY MODELS

Collaborative models of service delivery focus on functional communication during the child and family's natural, daily activities and routines. Team members work together to determine the most appropriate locations for services (e.g., home, child care, preschool) and collectively select intervention goals and strategies. The team collaborates to identify the many opportunities for intervention activities and strategies that occur daily within the child's normal routines in the natural environment, recognizing that embedding interventions in community activities will help promote generalization of the child's language skill to other settings important to the family.

### CONSULTATIVE SERVICES

Consultative services are designed to enable non-professionals to work with the child to meet his or her communication goals. In consultative models, the SLP or other clinician or therapist provides information and supports to the *communication partners* (the child, family, other caregivers and teachers) to teach them how to use specific or general intervention strategies with the child to increase frequency, accuracy, or sophistication of communicative interactions.

In consultation, the speech language pathologist uses a specialist's knowledge and experience to enable another person to interact with the child or group of children more successfully. Consultation may include, but is not limited to:

- Supports to embed intervention into daily routines
- Supports such as pictures or assistive technology
- Suggestions for activities that promote the acquisition of functional skills
- Modifications to an existing program and environmental arrangements

Consultation may also involve the speech language pathologist in hands-on work with the child, but is likely to include demonstration, coaching, joint practice, and feedback by the SLP. To be an effective consultant, the SLP may need to serve as a central point of contact for information sharing among team members or communication partners.

### DIRECT SERVICE

Direct service may be appropriate when specialized approaches and techniques are needed that are individualized to the child and that require the skills of a trained

therapist to administer. Direct service can occur in natural settings, such as the child's home and community, and may consist of one or more of the following:

- Education (teaching, demonstrating, promoting the use of a skill which the child has the understanding and physical capacity to perform but is not doing consistently)
- Remediation (work on improving the child's capacity to do a component of the skill through use of therapeutic techniques)
- Expert alteration of the task
- Provision of services and supports by two early intervention providers of differing disciplines during the same time period

Even when direct, hands-on services from a speech language pathologist are provided, the SLP is still part of a team and will need to collaborate and communicate with the family, caregivers and other professionals working with the child.

Regardless of whether the services and supports are direct or consultative, services should be provided by the SLP as part of daily activities in the home, community or preschool setting. Ongoing communication among all team members is essential to identify the child's needs and strengths and to monitor progress.

## EARLY INTERVENTION TECHNIQUES

Many specific intervention techniques have been shown to be effective in improving speech and language skills in children with communication deficits. The specific techniques that will be most effective for an individual child will depend upon many factors, including the type of communication need, the child's personality, and whether or not the child has other areas of developmental delay.

The following best practice guidelines apply to all intervention approaches and techniques:

1. Goals for each individual child are clearly identified and defined with measurable results and clear markers for mastery. Goals should be clearly linked to the priorities of the family.
2. For most young children with communication delays, intervention should focus first on increasing the amount, variety, and success of verbal and nonverbal communication and then, if necessary, on intelligibility or articulation.
3. The long-term goals for all communication interventions include better functional outcomes, such as expressing basic needs, establishing functional use of language, interacting socially, and acquiring knowledge.
4. A child's progress is facilitated by focusing on communication skills that are appropriate to the child's particular age or developmental level.

5. Interventions in the child's natural environment are more useful in increasing spontaneous language and generalization than intervention that is provided in clinic settings.
6. The choice of setting for intervention activities will depend on a variety of factors relating to the individual child's needs and family situation (age and developmental level, type and severity of communication delay, other developmental concerns or medical problems, the family's interest in and ability to participate in the intervention, the culture of the child and family, and the language used by the child and family).
7. Ongoing assessment of the child's progress is used to modify intervention strategies as needed.
8. The intervention approach is modified when any of the following occur:
  - Goals have been achieved
  - Progress is not evident
  - Regression is noted
  - An unexpected change in the child's behavior or health status
  - A change in the intervention setting or the child's environment.
9. A comprehensive evaluation, including appropriate standardized tests, should be performed at least yearly to compare the child's individual progress to age-expected development.

## **FAMILY EDUCATION PROGRAMS**

Training and education of the family is an intervention that can result in improvement in the child's communication because families (or the child's primary communication partners) are key to creating learning opportunities in day-to-day involvement. The purpose of the training is to teach families ways to help improve a child's communication. The training includes demonstrations and discussion of various strategies and techniques designed to facilitate children's emerging communication and language skills. Families learn to interact and communicate with their child during everyday activities and routines in ways that promote social communication and language learning. Programs such as these are appropriate for a wide range of ages, including infants, toddlers, and preschool children.

## **MONITORING PROGRESS**

It is important to evaluate the effectiveness of interventions on a regular basis. Whatever techniques and service delivery model are chosen, objectives for the child should be identified and defined with clear criteria for success. When a child is receiving speech language therapy, it is important to assess behaviors and communication skills at the beginning of intervention and to document progress at the end of each intervention session.

When intervention is integrated within the child's daily activities (rather than in separate sessions), it is still important to periodically monitor and document the child's progress and to assess the extent to which the communication skills acquired are being generalized to other settings.

The team should use information gathered regularly about the child's progress to assist in choosing and modifying intervention strategies as well as the intensity, frequency and duration of the intervention.



# PLANNING FOR TRANSITION

As a child approaches 3 years of age, the family's service coordinator and IFSP team, including parents, will work together to plan for a smooth transition from early intervention services to services designed for preschoolers.

Most children progress rapidly in their communication skill development between the ages of two and three. Sometimes a child who has been enrolled in EI/ILP due to a communication delay will make enough progress through early intervention so as not to qualify for preschool special education services at age three. In other cases, the school district evaluation team will determine that the child is eligible only for limited speech therapy services.

If the team believes the child will continue to benefit from intervention but may not qualify for special education preschool programs, the EI/ILP family service coordinator will help the family locate community-based services and supports. The service coordinator can make sure parents receive information on the various program options that may be available for their child, including the services of community partners such as Parents as Teachers, Early Head Start and the family's primary care provider.

Whatever their child's particular case, families need to plan for this transition. Starting at the initial IFSP meeting, the service coordinator will talk with the family about what will happen when the child turns three or no longer needs services. At least 6 months prior to the child's third birthday, the team will develop a detailed transition plan that will outline the steps, services, and supports for the child's transition to the appropriate setting. Parents participate in all meetings to ensure a smooth transition for their child.

## Transition Planning Tools

### **EI/ILP Transition Planning Handbook**

A detailed, step-by-step guide for parents going through the transition process with a timeline of steps as a child gets older and an overview of the process to create an Individual Education Plan (IEP). Available at:  
[hss.state.ak.us/ocs/InfantLearning/afterage3/afterage3/ilp\\_StepAhead.pdf](https://hss.state.ak.us/ocs/InfantLearning/afterage3/afterage3/ilp_StepAhead.pdf)

### **Alaska Transition Training Initiative**

A consortium of early childhood programs and providers in Alaska, ATTI helps address transition issues for special needs children moving from Part C to Part B at age three. Learn more at:  
[www.alaskaearlytransitions.org/trainers.html](http://www.alaskaearlytransitions.org/trainers.html)

### **Stone Soup Group: Transitions**

Information and resources for parents and caregivers transitioning someone with special needs from one phase of care to the next, including medical and legal issues, guardianship, Medicaid, and transitions into postsecondary programs. Links to parent groups, behavioral supports and assistance programs specifically for kids transitioning from an early intervention to early education can be found at:  
[www.stonesoupgroup.org/transitions.html](http://www.stonesoupgroup.org/transitions.html)

**The Paper Trail Notebook** can assist the family in identifying and organizing the information that will be needed for transition from EI/ILP to preschool. See page **Error! Bookmark not defined.** for more information. Request a copy at:

[www.stonesoupgroup.org/papertrail.html](http://www.stonesoupgroup.org/papertrail.html)

**Emergency Information Form for Children with Special Needs.** Provided in Appendix **Error! Reference source not found.**, this tool can be used to transfer critical information about a child's medical history and needs.

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**Delaware Birth to Three System.** *Communication Guidelines.* July 2004.

**New York State Department of Health Early Intervention Program.** *Clinical Practice Guideline: Quick Reference Guide. Communication Disorders, Assessment and Intervention for Young Children (Age 0-3 Years).* 1999, Reprinted 2008, Publication No. 4219.

— . *Clinical Practice Guideline: Report of the Recommendations. Communication Disorders, Assessment and Intervention for Young Children (Age 0-3 Years).* 1999, Publication No. 4218

# APPENDICES

1. Assessment Instruments & Procedures
2. Working with Limited English-Proficient Children
3. Resources

## ASSESSMENT INSTRUMENTS & PROCEDURES

The following is a listing of suggested instruments and techniques which will assist the team in determining the presence or absence of delayed communication, as well as further assessing the underlying causal or influencing factors. For the purpose of eligibility evaluation, instruments or parts of instruments, as well as more informal measures supported in the literature, provide the basis for most effectively determining the presence of a significant delay or disorder in a timely fashion. This is the purpose of the eligibility evaluation.

Once determined eligible, part of the IFSP process will most likely include a plan for more in-depth assessment of the child's skills to form the basis of an effective treatment plan. This list is not meant to be complete or exhaustive, but provides an overview of many current tests and procedures.

### EXPRESSIVE LANGUAGE DELAYS

#### Suggested Instruments

**Preschool Language Scale-(4th. Ed.)** . Assessment of speech and language development (auditory comprehension and expressive communication), articulation screening and other supplemental areas, for children 2 weeks to 6-11 months. Responses obtained via testing and parental report. Provides standard scores, percentiles and age equivalency. Spanish edition available (see below). Source: Harcourt Assessment/Psychological Corporation.

**The Rossetti Infant-Toddler Language Scale.** Assesses pre-verbal and verbal areas, within specific areas: Interaction-Attachment, Pragmatics, Gesture, Play, Language Comprehension and Language Expression. Responses are observed, elicited, and/or reported. Criterion-referenced, with basal and ceiling levels for children age birth to 36 months. Also available in Spanish (Latin American dialect). Source: LinguSystems.

**Early Language Milestone Scale (2nd. Ed.)**. Assesses language development for children birth to 36 months and speech intelligibility for children 18 to 48 months. Responses obtained by history, testing and incidental observation. Provides standard scores, percentiles and age equivalency. Source: Pro-Ed.

**MacArthur-Bates Communicative Development Inventories Second Edition.** An inventory completed by parents/caregivers to assess language development in children to 37 months of age. CDI scores are converted to percentile ranks. Spanish adaptation available (see below). Source: Brookes Publishing.

**Receptive-Expressive Emergent Language Scale (2nd. Ed.).** Assesses language development (Receptive Language and Expressive Language) for children birth to 36 months, via parent/caregiver interview. Yields receptive and expressive language ages. Source: Pro-Ed.

**Sequenced Inventory of Communication Development-Revised (SICD-R).**

Assesses receptive and expressive language for children 4 months to 4 years. Responses are obtained via testing and parent report. Scoring is a record of successes and failures, with comparison of the percentage of successes at each age range with normative data to determine receptive and expressive communication ages. Spanish version available (see below). Source: Slosson.

**Transdisciplinary Play Based Assessment-Second Edition.** Assessment of a child's developmental skills and influencing factors in a transdisciplinary play approach for children from infancy to 6 years of age. Source: Brookes Publishing.

**Communication and Symbolic Behavior Scales.** Assesses communicative and symbolic skills of children 8 to 24 months via a norm-referenced rating scale. Videotaping recommended. Source: Brookes Publishing.

### Suggested Procedures

**Spontaneous Language Sampling:** Obtain a spontaneous language sample during play. Record and transcribe the sample. From this sample, information can be obtained regarding the child's syntactic skills, semantic development, pragmatic use of language and speech intelligibility. For children 18 months or older, a mean length of utterance (MLU) may be calculated to further evaluate the child's syntactic and morphologic development (Miller & Chapman, 1981, JSHR, 24).

## PHONOLOGY/ORAL MOTOR SKILLS

### Suggested Instruments

**Goldman-Fristoe Test of Articulation 2.** Assesses articulation skills in picture naming and story retelling format for children 2 years and older. Scoring is converted to percentile ranks. Source: Pearson Assessments.

**Khan-Lewis Phonological Analysis, Second Edition.** Assessment of 15 common phonological processes for children 2 years and older. Information is transferred from the Goldman-Fristoe Test of Articulation and analyzed. Norms are provided for comparison, with percentile ranks and age equivalencies. Source: Pearson Assessments.

**Oral Motor/Feeding Rating Scale.** Rating scale to evaluate oral motor/feeding dysfunction. One year through adult. Source: Harcourt Assessments.

## APPENDIX 1

**Apraxia Profile** (Source: Harcourt Assessment) Profile of apraxic characteristics in children 2 years and older.

### Suggested Procedures

**Percentage of Consonants Correct (PCC).** Obtain and transcribe a 5-minute continuous speech sample to analyze the child's phonological system. Shriberg & Kwiatowski, 1982

**Scale developed by Preisser, Hodson and Paden.** Method of phonological assessment which provides means and standard deviations for children 18 months to 29 months. JSHD, 1988

**Assessment of Speech Intelligibility.** Based on informal sample, determine percentage of intelligibility with familiar and unfamiliar listeners, in known and unknown context.

**Assessment of the presence or absence of typical and idiosyncratic phonological processes.** Characteristics of phonological development of children as reviewed in the literature.

**Pre-Feeding Skills Second Edition: A Comprehensive Resource for Mealtime Development.** A comprehensive resource guide for feeding development. Source: Harcourt Assessment. Suzanne Evans-Morris & Marsha Dunn Klein

## CHILDREN WHO ARE ENGLISH LANGUAGE LEARNERS

### Suggested Instruments

**Assessment of Asian Language Performance** information about Vietnamese, Cantonese, Mandarin, Japanese, Khmer, Korean, and other languages. Source: Academic Communication Associates.

**Bilingual Language Proficiency Questionnaire.** Means to gain information about speech and language developmental milestones and skills, functional use of Spanish and English and parental concerns. Questions provided in Spanish and English. English/Vietnamese Edition also available. Source: Academic Communication Associates.

**BRIGANCE Assessment of Basic Skills – Revised Spanish Edition.** Criterion referenced measure that can be used as part of a play based assessment. Spanish adaptation of the *Comprehensive Inventory of Basic Skills*. Source: Curriculum Associates, Inc.

**Fundacion MacArthur-Bates Inventario del Desarrollo de Habilidades Comunicativas.** Spanish adaptation of MacArthur Communicative Development Inventory (see above). Does not yield a standard score. Source: Brookes Publishing.

**Preschool Language Scale-4th. Edition.-Spanish.** This is a direct translation of the English version (see preceding pages). No normative information for native Spanish speakers. Source: Harcourt Assessment.

**Sequenced Inventory of Communication Development.** Cuban-Spanish translation of the English version. Assesses receptive and expressive language for children 4 months to 4 years of age. Direct translation of the English version (see above). Source: Slosson.

## SOURCES OF ASSESSMENT INSTRUMENTS

### **Academic Communication Associates**

PO Box 4279, Oceanside, CA 92052  
888-755-9558 | [www.acadcom.com](http://www.acadcom.com)

### **Curriculum Associates, Inc.**

P. O. Box 2001, North Billerica, MA 01862  
1-800-225-0248 | [www.curriculumassociates.com](http://www.curriculumassociates.com)

### **Pearson Assessment/ Psychcorp**

Inbound Sales & Customer Support  
P.O. Box 599700, San Antonio, Texas 78259  
1-800- 627-7271 | [psychcorp.pearsonassessments.com](http://psychcorp.pearsonassessments.com)

### **LinguiSystems Inc.**

3100 4th Avenue, East Moline, IL 61244  
1-800-776-4332 | [www.linguisystems.com](http://www.linguisystems.com)

### **Paul H. Brookes Publishing Co.**

PO Box 10624, Baltimore, MD 21285  
1-800-638-3775 | [www.brookespublishing.com](http://www.brookespublishing.com)

### **Pro-Ed**

8700 Shoal Creek Boulevard, Austin, Texas 78757  
1-800-897-3202 | [www.proedinc.com](http://www.proedinc.com)

### **Slosson Educational Publications**

PO Box 544, East Aurora, NY 14052  
1-888-756-7766 | [www.slosson.com](http://www.slosson.com)

### **The Speech Bin**

P. O. Box 922668, Norcross, GA 30010  
1-800-850-8602 | [www.speechbin.com](http://www.speechbin.com)

## WORKING WITH LIMITED ENGLISH-PROFICIENT CHILDREN

### ASHA GUIDELINES FOR BILINGUAL SPEECH LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

To be defined as a multilingual speech-language pathologist or audiologist and provide assessment and intervention services in the client's home language, it is mandated that the speech-language pathologist and audiologist possess the following competencies:

- **Language proficiency** - Native or near native fluency in both the client's language and in English
- **Normative processes** - Ability to describe the process of normal speech and language acquisition for both bilingual and monolingual individuals and how these processes are manifested in oral and written language
- **Assessment** - Ability to administer and interpret formal and informal assessment
- Procedures to distinguish between communication differences and communication delays
- **Intervention** - Ability to apply intervention strategies for communication delays in the client's home language
- **Cultural sensitivity** - Ability to recognize cultural factors which affect the delivery of speech-language pathology and audiology services to non-English speakers

### ASHA GUIDELINES FOR MONOLINGUAL SPEECH LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

Practitioners who do not speak the language of the client should be able to:

- Describe the process of normal speech and language acquisition for both multilingual and monolingual individuals by using a trained interpreter/cultural mediator to gather information and data from the client/family/caregiver and being familiar with behaviors that reflect the typical acquisition process of monolingual and multilingual individuals
- Conduct culturally and linguistically appropriate assessments by knowing the limitations and possible cultural and linguistic biases of standardized test
- Know the types of and need for alternative forms of assessment
- Identify individuals who need to be referred to multilingual clinicians
- Distinguish behaviors that are attributed to cultural or linguistic differences

- Use interpreters, translators, cultural mediators, and multilingual professionals to involve the family in the assessments process and to share results of the assessment

### GUIDELINES FOR WORKING WITH AN INTERPRETER

When working with an interpreter, practitioners should follow the following guidelines, which have been adapted from *Developing Cross-cultural Competence: A guide for working with young children and their families* (9).

10. Learn proper protocols and forms of address (including a few greeting and social phrases) in the family's primary language, the name they wish to be called, and the correct pronunciation.
11. Introduce yourself and the interpreter, describe your respective roles, and clarify mutual expectations and the purpose of the encounter.
12. Learn basic words and sentences in the family's language and become familiar with special terminology they may use so you can selectively attend to them during interpreter-family exchanges.
13. Meet regularly with the interpreter in order to keep communications open and facilitate an understanding of the purpose of the interview, meeting, or home visit. At a minimum, meet with the interpreter before meeting with the parent(s).
14. During the interaction, address your remarks and questions directly to the family (not the interpreter); look at and listen to family members as they speak and observe their nonverbal communication.
15. Avoid body language or gestures that may be offensive or misunderstood.
16. Use a positive tone of voice and facial expressions that sincerely convey respect and your interest in the family, and address them in a calm, unhurried manner.
17. Speak clearly and somewhat slowly, but not more loudly. Limit your remarks and questions to a few sentences between translations and avoid giving too much information or long complex discussions of several topics in a single session.
18. Avoid technical jargon, colloquialisms, idioms, slang, metaphors, similes, and abstractions.
19. Avoid oversimplification and condensing important explanations. Repeat important information more than once.
20. Give instructions in a clear, logical sequence; emphasize key words or points, and offer reasons for specific recommendations.
21. Periodically check on the family's understanding and the accuracy of the translation, by asking the family member to repeat instructions or whatever has been communicated in their own words, with the interpreter's facilitation, but avoid literally asking: "Do you understand?"

## APPENDIX 2

22. When possible, reinforce verbal information with materials written in the family's language and visual aids or behavioral modeling if appropriate. Before introducing written materials, tactfully determine the client's literacy through the interpreter.
23. Be patient and prepared for the additional time that will inevitably be required for careful interpretation.

### Who can interpret?

- Professionals from a language bank
- Bilingual professionals from a health or education background
- Someone who can read, write and use the two languages fluently
- Except in an emergency, do not use relatives or friends for interpreting because it may breach confidentiality or make the parent reluctant to share important personal information. In addition, family and friends usually are not competent to act as interpreters, since they are often insufficiently proficient in both languages, emotionally biased, lack interpretation skills, and are unfamiliar with specialized terminology. It is never acceptable to use a child to interpret for adults, since it undermines family authority; making a parent dependent on the child

### Interpreters must:

- Demonstrate proficiency in both English and the second language
- Understand their role and why they are being used
- Follow the ethics of interpreting and have particular competence in maintaining confidentiality
- Have a fundamental knowledge, in both languages, of any specialized terms or concepts
- Show a sensitivity to the culture of the person with limited English proficiency
- Demonstrate the ability to accurately convey information in both languages
- Use the interpretation mode that best enhances comprehension and encourages direct communication between the parent(s) and the provider
- Reflect the style and vocabulary of the speaker, including level of formality and use of slang as well as the emphasis and degree of emotion of the speaker
- Ensures that the interpreter understands the message by asking for clarification or repetition if unclear
- Remains neutral where there is conflict between the parent(s) and the provider
- Does not project his or her own values onto the parent(s) and identifies and separates personal beliefs
- Identifies and correct his or her own mistakes

- Addresses cultural based miscommunication by identifying instances in which cultural differences between the parent(s) and provider have the potential to seriously impair communication

## RESOURCES

### ALASKA RESOURCES

**Alaska Early Intervention/Infant Learning Program (EI/ILP)** is a division of the Alaska Department of Health and Social Services, Office of Child Services that partners with grantees around the state to provide services directly to children with special needs and their families at a local level.

P.O. Box 240249, 323 East 4th Avenue, Anchorage, AK 99501

Toll-free (877) HSS-FMLY (477-3659). Local (907) 269-8442

Fax (907) 269-3497

[www.earlyintervention.alaska.gov](http://www.earlyintervention.alaska.gov)

Find a complete list of EI/ILP providers in Alaska at:

[www.hss.state.ak.us/ocs/InfantLearning/program/program\\_dir.htm](http://www.hss.state.ak.us/ocs/InfantLearning/program/program_dir.htm)

**Alaska Governor’s Council on Disabilities and Special Education (GCDSE)** is one of four governor-appointed advisory boards to the Alaska Mental Health Trust. The Council plans, evaluates, and promotes programs for people with disabilities in the state of Alaska.

3601 C Street, Suite 740, P.O. Box 240249, Anchorage, AK 99524-0249

Toll-free (888) 269-8990. Local (907) 269-8990, Fax (907) 269-8995

[www.hss.state.ak.us/gcdse](http://www.hss.state.ak.us/gcdse)

**Assistive Technology of Alaska (ATLA).** As the state’s Tech Act Project, ATLA provides Alaska’s most comprehensive assistive technology resources, including assessments, training, webinars, demonstrations, education and AT device loans, including technology for deaf and hard of hearing.

3330 Arctic Blvd., Ste.101, Anchorage, AK 99503

Toll-free (800) 723-2852(ATLA). Local (907) 563-2599. TTY (907) 561-2592.

Fax (907) 563-0699 | Email [atla@atlaak.org](mailto:atla@atlaak.org)

[www.atlaak.org](http://www.atlaak.org)

### Interpretation and Translation Services

**Alaska Deaf Council** is recognized as a statewide information clearinghouse and services referral center. Their resources page lists all forms of agencies available for deaf or hard of hearing individuals in Alaska. Included are interpreting services, education resources, assistance services, accommodations, as well as job training and organizations that also provide services for deaf or hard of hearing.

P.O. Box 90129, Anchorage, AK 99509

Email [anchoragedeafcenter@gmail.com](mailto:anchoragedeafcenter@gmail.com)

[www.alaskadeafcouncil.org](http://www.alaskadeafcouncil.org)

**Deaf Community Services** in Fairbanks provides TTY relay services, Braille services, hearing devices and digital hearing aids and accessories, disability education, vocational rehabilitation and training, as well as narcotic/addiction rehabilitation services.

475 Hall Street, Fairbanks, AK 99701

Phone (907) 451-4889

**The Language Interpreter Center, Alaska Immigration Justice Project** offers both ends of the spectrum for interpretation, both providing interpretation to those needing it and offering jobs to qualified interpreters or training individuals to become qualified interpreters and translators. With their registry of interpreters for Alaska they are able to match qualified interpreters with businesses requiring their services.

431 West 7th Avenue, Suite 208, Anchorage, AK 99501

Phone (907) 279-2457

[www.akijp.org/interpreter.html](http://www.akijp.org/interpreter.html)

**Alaska Registry of Interpreters for the Deaf (RID)** supports professional interpreters and aspiring interpreters by providing information, training, and support on a national and state level.

P.O. Box 202010, Anchorage, AK 99520-2010 | Email [board@akrid.org](mailto:board@akrid.org)

[www.akrid.org](http://www.akrid.org) | [www.rid.org](http://www.rid.org)

**Juneau Services for the Deaf** are offered through **Southeast Alaska Independent Living (SAIL)**, which provides oral and sign language interpreter services to individuals who are deaf/hearing impaired. Deaf Services also provides interpreter training, community education, and recreation opportunities.

3225 Hospital Drive, Suite 300, Juneau, AK 99801

Toll-free (800) 478-SAIL (7245). Local (907) 586-4920. Fax (907) 586-4980

ORCA (907) 586-0104. TTY (907) 523-5285

Afterhours/weekend interpreter requests (907) 463-7490

Email [info@sailinc.org](mailto:info@sailinc.org)

[www.sailinc.org/services.php](http://www.sailinc.org/services.php)

## NATIONAL AND ONLINE RESOURCES

**American Speech-Language-Hearing Association** is the professional association for speech-language pathologists and audiologists.

[www.asha.org](http://www.asha.org)

**Childhood Apraxia of Speech Association of North America (CASANA)** provides information on childhood apraxia of speech for families and SLP professionals, including articles, workshops, and online community links.

[www.apraxia-kids.org](http://www.apraxia-kids.org)

## APPENDIX 3

### **Early Childhood Research Institute on Culturally and Linguistically**

**Appropriate Services (CLAS)** identifies, evaluates, and promotes effective and appropriate early intervention practices and preschool practices that are sensitive and respectful to children and families from culturally and linguistically diverse backgrounds..

[www.clas.uiuc.edu](http://www.clas.uiuc.edu)

**The Hanen Centre** is a Canadian charitable organization with information on family-focused early intervention programs and resources to help to develop language and literacy skills in preschool children.

[www.hanen.org](http://www.hanen.org)

**If Your Child Learns in Two Languages.** A parent's guide for improving educational opportunities for children acquiring English, published by the National Clearinghouse for English Language Acquisition. Also available in Armenian, Chinese, Haitian, Korean, Spanish, and Vietnamese. These publications are in the public domain and can be reproduced freely.

[www.ncela.gwu.edu/files/uploads/9/IfYourChildLearnsInTwoLangs\\_English.pdf](http://www.ncela.gwu.edu/files/uploads/9/IfYourChildLearnsInTwoLangs_English.pdf)

**National Early Childhood Technical Assistance Center** serves IDEA Part C-Infant and Toddlers with Disabilities Programs and Part B-Section 619 Preschool Programs for Children with Disabilities to improve service systems and outcomes for children and families.

[www.nectac.org](http://www.nectac.org)

**Prompts for Restructuring Oral Muscular Targets** is a program to treat childhood apraxia of speech.

[www.promptinstitute.com](http://www.promptinstitute.com)

**Speechpathology.com** contains links to a large number of related sites.

[www.speechpathology.com](http://www.speechpathology.com)

### ***Additional Copies or Services***

*These guidelines are available online at [earlyintervention.alaska.gov](http://earlyintervention.alaska.gov)*

*To request additional copies or auxiliary aids and services, please contact:*

Alaska Early Intervention/Infant Learning Program

P.O. Box 240249

323 East 4th Avenue

Anchorage, Alaska 99501

Toll-free (877) HSS-FMLY (477-3659)

Anchorage (907) 269-8442

TT Relay (800) 770-TYPE (8973)





# *Alaska Infant Learning Program*

This report, historical data and other publications available at [www.earlyintervention.alaska.gov](http://www.earlyintervention.alaska.gov)

Call toll free in Alaska: 1 (877) HSS-FMLY (477-3659); In Anchorage 269-8442

INFANT LEARNING PROGRAMS THROUGHOUT ALASKA



The Alaska Infant Learning Program offers developmental services to families of children birth to 3. If you have concerns about your child's development make a referral to your local Infant Learning Program. Our Mission is to promote positive development and improved outcomes for Alaska's children birth to 3 by creating a culturally responsive, comprehensive and accessible service delivery system that links service providers, empowers families and engages communities.

