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Evaluation and Assessment of Communication in Infants and Toddlers: Birth to Two, presented in partnership with Cincinnati Children's

Presenter: Gina Blume M.A., CCC-S

Moderated by:
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Evaluation and Assessment of Communication in Infants and Toddlers: Birth to Two

Gina Blume M.A., CCC-S

SpeechPathology.com

Cincinnati Children's

Learner Outcomes

After this course, participants will be able to…

1. describe the process of assessing a child between the ages of birth to two.
2. describe normal sound acquisition versus delayed/disordered sound acquisition in infants.
3. identify red flags for co-existing conditions and conduct an appropriate referral

ASHA's Guiding Principles for SLPS in Early Intervention (ASHA, 2008)

- Services are family centered and culturally and linguistically responsive.
- Services are developmentally supportive and promote children's participation in their natural environments.
- Services are comprehensive, coordinated, and team based.
- Services are based on the highest quality evidence that is available.

VALUE AND FUNCTION OF ASSESSMENT

- Function of Assessment
- Function of Evaluation
- Cultural and Linguistic Diversity
- Multi-Factored Assessment Process

FUNCTION OF ASSESSMENT

- Assessment is an ongoing process of observing, measuring , documenting and communicating the child's level and needs (ASHA, 2008)
  - **Understand the family's** concerns, resources, and goals in order to achieve the best outcomes for the child
  - **Identify specific areas of deficit** in order to direct intervention approaches as well as strengths which can be used as a vehicle to enhance deficit areas
  - **Assess parent skills and areas for coaching** that will lead to successful development of new skills for their child
  - Determine the **need for further diagnostic testing** by other specialists

FUNCTION OF EVALUATION

- Evaluation is different than assessment, occurring as part of the assessment process. (Crais, 2011)
- Can be used to determine eligibility for services
- **Evaluation identifies the child's level of functioning** in all or a specific domain: cognitive, physical, **communication, social emotional** and adaptive development.
- Speech-Language pathologists can evaluate independently or as part of a team.
- If evaluating independently, consultation with other providers is important and necessary for treatment, parent coaching and further assessment

CULTURAL AND LINGQUISTIC DIVERSITY

- Assessment
  - Children whose dominant language is not English require at least partial evaluation in their native language
  - SLPs who are fluent in that language, or an interpreter assisting the SLP, must conduct the evaluation. (Carter, J. et al)
  - SLP determines if there is a speech difference or speech disorder
  - Test modifications can assist in determining a diagnosis and developing a treatment plan (Carter et al.,2015)

CULTURAL AND LINGQUISTIC DIVERSITY

- When using an interpreter:
  - Provide training to the interpreter on the purposes, procedures and goals of the tests and therapy methods.
  - Teach to avoid the use of gestures, vocal intonation, and other cues that could inadvertently influence the child's response
  - Pre-plan for an individual's services to insure the interpreter understands the clinical process
  - Attempt to use the same interpreter(s) with a given minority language client rather than using assistants on a random basis
  - Use patient observation or other nonlinguistic measures as supplements to the translated measures

  (ASHA, 2008)

EVALUATION: A MULTI – PROCESS APPROACH

"*The end purpose of an assessment in speech-language pathology is to draw a conclusion about an individuals' communication abilities. The paths to that end are varied.*" (Shipley, 2009)

- Using a single formal test measure will not provide an adequate overall representation of the child's skills.
- *Observation and qualitative analysis of the child's performance supplement objective test results and are essential for making a diagnosis and devising a treatment plan. (Carter et al., 2015)*
- Knowledge of normal speech and language development is critical for evaluation , diagnosis and devising an appropriate treatment plan

EVALUATION: A MULTI – PROCESS APPROACH

- A thorough evaluation will include a combination of these methods (IDEA, 2004, ASHA, 2008, 2010):
  - **Formal Tests**: also referred to as 'standardized' tests –
    - use a 'standard' procedure for administration and scoring
    - norm referenced tests compare scores to a 'norm group'
      - PLS-5
    - criterion referenced tests compare performance to an expected set of criteria
      - Rossetti Infant Toddler Language Test
  - **Parent Interview and Sharing** : obtain history, goals, barriers

EVALUATION: A MULTI – PROCESS APPROACH

- **Parent Questionnaires** -strong evidence that parents provide accurate information about their child's development (Crais, 2011) and want to be a part of the evaluation (Fenson et al.,2007)
- **Informal Observation and Assessment**
  - Interactions with the child and interactions initiated by the child
  - Observations of the child in natural contexts (i.e. with caretaker, with familiar toys)
- **Clinical Opinion**

CHOOSING PROTOCOLS FOR ASSESSMENT

Options for Birth to Two Testing

- Speech and Language Tests
- Developmental Tests with a speech/language component

FORMAL SPEECH AND LANGUAGE TESTS: BIRTH TO TWO

http://www.health.ny.gov/community/infants_children/early_intervention/disorders/appendix_d.htm#rits
http://www.esc-cc.org/Downloads/Catalog_Screen_assessment2.pdf

- These tests include parent questionnaire or report and are commonly used as part of an evaluation:
  - Preschool Language Scale- 5 (norm referenced)
  - Rossetti Infant – Toddler Language Scales (criterion referenced)
  - Receptive Expressive Emergent Language (REEL)-(norm referenced)
  - Communication and Symbolic Language Scales (CSBS)-(norm referenced)
  - Language Development Survey (LDS) (norm referenced)
  - Reynell Developmental Language Scales (RDLS) (norm referenced)
  - Evaluating Acquired Skills in Communication – Revised (EASIC) (norm referenced)

DEVELOPMENTAL SCREENING TESTS

Containing a Communication Section

Agency for Healthcare Research and Quality (US); 2015 Jul.

- These developmental screenings include speech/language/social subareas and are commonly used as part of an evaluation:
  - MacArthur Bates Communication Development Inventories (CDI) (norm referenced)
  - Ages and Stages Questionnaire (ASQ) - norm referenced
  - Language Development Survey (LDS) - norm referenced
  - Bayley Scales of Infant Development – (SCID) (norm referenced)
- Consider using a combination of norm and criterion referenced or interview based evaluation protocol.

DEVELOPMENTAL SCREENING TESTS

Containing a Communication Section

- Research about effectiveness of developmental screenings (Berkman et al, 2015):
  - MacArthur Bates Communication Development Inventory (CDI) and Language Development Survey out performed the Ages and Stages Questionnaire- Communication Domain (ASQ) related to specificity: (CDI) 82%, (LDS)91% accurate vs (ASQ) 58%
  - CDI outperformed ASQ on sensitivity and specificity measures in two and under
  - Language Development Survey (LDS) out performed ASQ and CDI in specificity: 91% vs 82% (CDI), and 58% (ASQ)
- Review potential tests and screening tools for, content, sensitivity and specificity. Excellent resource:

  http://www.health.ny.gov/community/infants_children/early_intervention/disorders/appendix_d.htm#rits

Caregiver Interview and Pre-Assessment Information

'*The term family-centered refers to a set of beliefs, values, principles, and practices that support and strengthen the family's capacity to enhance the child's development and learning'* (ASHA Guidelines, 2008)

The initial caretaker/parent interview is important in identifying the family's concerns and goals for their child and how the family currently deals with the reported concerns.

Caregiver Interview and Pre-Assessment Information

Overview:

- Verbally conduct an information sharing discussion with the caregiver; document pertinent information
- Caregiver Interview and Discussion
  - Medical History
  - Parent Concern and Related family factors
  - Related Areas
- While talking with the caregiver, provide toys for the child and observe the child's social and communicative skills

Caregiver Interview and Pre -Assessment Information

Overview continued…..

- Share the 'next steps' of the evaluation with the caregiver; assure them they can ask questions, make comments anytime during the evaluation (with the exception of the formal testing segment).

Example of what you may share with caregivers as ' next steps':

- ✓ Informal observation and assessment while clinician plays with the child
- ✓ Informal observation and assessment while caregiver plays with the child
- ✓ Formal assessment of language (describe comprehension and expression) and speech (describe difference between speech and language)
- ✓ Share findings and make recommendations
- ✓ Discuss the parent's concerns and questions
- ✓ Provide written recommendations and information

Caregiver Interview and Discussion

- **Medical History**:

(if this is available in the chart/file- review with the parent and check for changes or additions). Include the following:

- Medications that are pertinent to communication
- Allergies
- Conditions that may impact communication (i.e. motor delays, syndromes)
- Past evaluations or treatment
- Hearing: previous testing results, ear infections and treatment
- Defects in organs (may be indicator of a syndrome)

Caregiver Interview and Discussion

- **Other related topics**:
  - Social interaction with peers, family, daycare
  - Eating Skills: textures, food groups, quality, swallowing, sensory
    - If there is a noted problem when eating (i.e. vomiting, choking, frequent respiratory issues with low tone) - probe further; this could signal swallowing difficulties and potential medical disorders
  - Family History: communication, learning disabilities, mental health
  - Behavioral Concerns: be aware of behaviors that can indicate possible autism, sensory integration
  - Developmental milestones: communication and motor
    - If the basic milestones in motor have occurred, no need to probe further

Caregiver Interview and Discussion

- **Caregiver Concern** (reason for the visit)

  - Why is the family there? Was this a concern of theirs or the pediatricians; listen carefully to their reasons for wanting the evaluation
  - Current method of communication; this may include a variety of open ended questions to avoid leading the parent's response
  - Living situation: who lives in the home, who helps with caregiving, feelings of those who help with caregiving about the potential communication problem
  - Family related issues and concerns; how does the child's difficulty impact the family, community outings , daycare etc.

INFORMAL ASSESSMENT

Performing the Assessment

- Environment and Materials
- Documentation
- Observation
- Selecting Informal Assessment Procedures
- Special Considerations

Environment and Materials

- Environment
  - Comfortable seating for caregivers
  - Clean and sterile surface for babies and toddlers
    - Sheet or mat on the floor
    - Appropriate seating: riftin chair, boppy chair, high chair etc.
  - Limit visual and auditory distraction
  - Safety (outlets, cords, sharp corners)
  - Appealing and comfortable for the babies

Environment and Materials

- Materials
  - Toys that are appropriate for a range of within one year of the child's age (rotate)
  - Choose toys that provide a look at cognitive processes (i.e. cause/effect), visual (tracking), motor planning/strength (physical manipulation), toys noted in evaluation protocols.
  - Snack and drink (from parent, or ask permission)
  - Test protocols, note pad

Joshua Video (1)

- Seating: Riftin Chair, enticed with snack
- Feeding: snack and drink
- Parent Interview: discussing behavior, family situation- newborn arrived
- Prepare for formal testing

Observation

- **Parent- Child Interaction**
- **Child- Toy Interaction**
- **Child- Food Interaction and Eating skills**
- **Motor Skill- is there an impact on exploration and communication?**

Joshua Video (2)

- Demonstrate strategies during the assessment: give visual facial cues, pause
- Determine what strategies are effective
- This type of information should be noted in the report so other providers, SLP will be successful
- Strategies that work should be provided to the caregivers in writing at the end of the session.

Selecting Informal Assessment Procedures

(Shipley, McAfee-2009)

Based on the verbal level of the child:

- Non Verbal Child
  - Play behaviors (functional, appropriate?)
  - Use of gestures, signs
    - Gestures: (reaching, pointing): Children produce their first gestures before their first words and first gesture+ word before their first two word utterances . Gestures predict language milestones (Golding-Medal et al, 2007
  - Vocalizations (intentionality, quality, type)
  - Response to verbal stimuli
  - Behavioral responses and calming strategies

Selecting Informal Assessment Procedures

(Shipley, McAfee-2009)

- Non-Verbal processes cont.…
  - Eye contact

    Eye contact: at 4 months of age, infants are following their parent's eye gaze to direct their attention (Hogue, S. 2008
  - Imitation of actions, mouth movements , sounds, words, phrases
  - Spontaneous verbal productions
  - Communicative Intent
    - Checklist of Communicative Function and Means (Wetherby, 1995)
    - Checklist is particularly helpful if autism is suspected

Selecting Informal Assessment Procedures

(Shipley, McAfee-2009)

Base on the verbal level of the child:

- Verbal Child
  - Processes noted in 'non-verbal'
  - Naming familiar objects
  - Type of words
  - Mean length of utterance
  - Comprehension of words and phrases
  - Sound analysis (phonation, syllable structure, sounds)

Joshua Video-(3)

- PLS-5 administration
- Play and keep it light and fun

Documentation

- Documentation
  - Have protocols handy for catching up on documentation during breaks
  - Take notes
  - Give the parent the chosen 'test' questionnaire to complete while you are engaging with the child
  - Complete protocols with 'notepad' information at the end of the session or after the session

Joshua Video (4)

- SLP completing documentation
- Observing parent- child interaction
- Parent is using strategies that were discussed during evaluation
- Parent coaching to reward immediately when she hears a word

Special Considerations

- Behavior :
  - Child can not focus for more than a few seconds; active
    - What, if any, toys or activities obtain more 'sustained' attention?
    - Observe parent style and interaction; ask for ideas on how to gain attention and engagement
    - Note the actions of the child-are they exploring how things work, seeking out sensory input, avoiding interaction, anxious
- Medical Deficit: impacts how child feels and thus how they respond
- Sensory Deficit :
  - Visual deficit: requires different presentation of materials and face to face contact
  - Auditory: note localization, reactions, anticipation, response to varying volume
- Motor Delays/Deficit: tone, planning, mobility, exploration, imitation

Special Considerations

- Are there signs of Autism?
  - **Red Flags:**
    - Does not point to show objects
    - Does not follow a point
    - No response to name (over 18 mo)
    - Unusual hand or arm movements
  - Research based screening tool: **Modified Checklist for Autism in Toddlers - Revised (M-CHAT-R)** (Robins, et al, 2009)
    - Meant to be a parent questionnaire- can be completed online
    - PCP will use these on occasion
    - SLP can use to ask questions/observe or give to parent
    - Use to support referral for further assessment (ASD)

Special Considerations: **Autism**

- **Motor Skills/Imitation Correlates with Autism**
  - Infant and toddler oral –motor and manual-motor skills inter correlated significantly, and distinguished autistic children from typically developing children and predicted -minimally, moderately and highly fluent autistic children (Gernsbacher, 2008)
  - Children with autism were significantly more impaired in overall imitation abilities, oral-facial imitation and imitations of actions on objects than children in all of the other groups (fragile X, other DD, typical development). (Rogers, SJ., (2003)

Effects of Otitis Media on Speech Production

- The most serious impact of hearing deficits is the lack of speech acquisition (Kopf ,1982)
  - Two year olds acquire less initial position consonants and produce words with less accuracy than children without otitis media (Abraham SS, Wallace IF, Gravel JS, 1996)
  - Two year olds have delayed development of final position back sounds (/k/, /g/, /ng/) than age matched children without otitis media (Abraham SS, Wallace IF, Gravel JS, 1996)
  - May not produce quiet (voiceless) sounds: /s/, /sh/, /f/,/t/, /k/,/p/ (Audiology Knowing Notes)
  - May speak too loudly or too softly or sound as if they are mumbling. Pitch may be off. (Audiology Knowing Notes)

Recommendation and Referral

- **Giving the Diagnosis and Recommendations**
- **Referring to other providers- red flags**
- **Process with PCP**
- **Who, What, Why**
- **Referral to Early Intervention Program**
- **Addressing Parent Concerns**

Giving the Diagnosis and Recommendations

- First- Take the parent's perspective; be empathetic
- Share the child's strengths and challenges and diagnosis (if known); avoid numbers unless the parent wants this information
- If there are concerns about other domains of development, share your concerns (red flags) and discuss the next step in the process (referral)
  - Allow the caregiver time to ask questions; ask permission to give them 'written information' and contact their PCP.
  - If parents are not ready for the next step, assure them they can speak with their PCP and follow up when they are ready

REFERRAL CHART (Handout)

Domain	Red Flags	Specialist
Hearing	Quiet Infant Poor localization Limited startle to loud noises Frequent ear infections	Audiologist ENT
Vision	Poor tracking Improved alertness and engagement when faces/objects are closer Bumps into things, misses grasp Limited mobility	Ophthalmologist that specializes in pediatrics
Motor	Limited mobility for age, late milestones Minimal movement of one side of body Limited ability to use utensils or play with age appropriate toys Poor quality of movement (gestures, chewing, grasping)	Occupational and/or Physical Therapist
Sensory Integration	Poor ability to regulate emotions Over or under sensitivity in any of the sensory areas Seeks out sensory input (atypical): example- jumping from high places continuously with limited interest in other toys	Occupational Therapy- specializing in Sensory Integration Dysfunction Diagnostic Center
Cognition	Significantly delayed language and play skills for age History of abusive, neglect, addiction at birth Prematurity	Team Assessment including developmental pediatrician (if possible) Diagnostic Center
Behavior	Significant tantrums – long in duration, unable to self-calm, physical (aggression, destructive, self-abusive) Poor sleeper- up several times a night History of mental health difficulties in family Family Dynamic and response to child's behavior (caregiver attends to negative behavior only, caregiver seems threatening , sense 'end of rope', safety of others in question)	Discuss with PCP Psychologist with pediatric specialty Diagnostic Center Occupational Therapy (sensory integration disorder)
Medical Concerns	Multiple organ involvement (i.e. cardio, hearing)- could be genetic etiology Constipation (chronic), Respiration (chronic)- could be feeding issue Ear Infections (chronic) Large tonsils/adenoids- poor sleeper, mouth breather, sleep apnea, drooling	Discuss with PCP Genetics ENT Feeding Team (if available) Gastroenterologist

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Giving the Diagnosis and Recommendations

- Understand that parents may 'tune out' as soon as they hear their child has a delay, disorder or any concern
  - Be careful not to overload them with information- they will receive a report and can always call later with questions
  - Have written information about home suggestions, the disorder and possible referral sources available **if** the family would like them
- Review 2-3 basic things they can do at home (this can also be done during the evaluation process); give these in writing if possible

Process with PCP

- It is our practice at CCH to contact the child's primary care physician (PCP) as they are the 'case manager' and need to be aware of concerns and evaluations
  - Discuss referral with the family , ask permission to contact the PCP
  - Prepare concise list of reasons prior to contacting the PCP
  - PCP's nurse may take the information and make the referral
  - Include referral recommendation on report
  - See the Referral Chart which lists domain, red flags and service providers

Early Intervention Programs

(US Department of Education, 2016)

- EI programs provided by the state or county :
  - are available in all 50 states
  - are at no cost to the family
  - provide services in the home; providing the most naturalistic environment for coaching, intervention and observation
  - include speech-language pathologists, occupational and physical therapists, and early interventionist educators
- According to the US Department of Education, children qualify (evaluation required) for these services who:
  - are experiencing developmental delays in one or more of the following five areas: cognitive development, physical development, communication development, social or emotional development, or adaptive development; or
  - have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay

Recommendations

- Recommendations can be quite varied depending age, caregiver goals, education and values and other medical issues
- Common Recommendations for language and speech deficits:
  - Parent coaching sessions: group or individual
  - Consultative Therapy: one, three, six month intervals
  - Early Intervention services (alone or in combination with private)
  - Recommendations for dysphagia can vary widely depending on the problem and severity
- Research (O'Connor et al, 2007) regarding successful self management of families related to therapy, shows that 'decision aids' are helpful in empowering caregivers to make realistic choices and commitments (see Decision Aid handout)

Speech and Language Development

DEVELOPMENT

- In order to successfully determine whether a child needs intervention, one must understand development
- Speech Acquisition chart (birth – 24mo)
- Pre-Linguistic Skills chart (birth – 12mo)
- Language acquisition chart (birth – 30mo)

Sound Acquisition Chart – Handout

https://youtu.be/ywAu8RZ_Gdw
Henry phonating at 1 month

https://youtu.be/VnbzVgqYcNs
Henry vocalizing at 2 months

https://youtu.be/ZRST7s3Sq60-
Henry imitates /b/- 5 months

https://youtu.be/I8RSdL2JNdA
Henry does flashcards at 18 mo.

11 Domains of Pre-Intentional Communication

- Early Communication and Behavior Scales (ECBS) prototype testing (Cress, 2010)
- Extracted infant behaviors 0-12 months from 28 early assessments related to communication
- Clustered skills into eleven domains
- Pre- Intentional communication skills expected by 12 months of age
- This is not a promotion of the test, but nice breakdown of communication domains in infants

EARLY COMMUNICATION BEHAVIOR SCALES (ECBS): 11 DOMAINS OF PRE INTENTIONAL COMMUNICATION (CRESS, 2010)

Intentionality	**Getting message across to people e.g. Deliberately indicates desire toward objects or events**
Engagement	connecting with people personally e.g. Makes a social smile when adult interacts
Anticipation	Anticipation(27): expecting the ways things happen e.g. Increases activity when sees toy, object, adult
Reciprocity(21):	taking turns doing things together e.g. Repeats an action when it gets adult response
Affect(19):	showing & sharing emotions or reactions e.g. Shows pleasure at physical/social play
Attention(19):	noticing & focusing on important info e.g. Searches for source of sound
Exploration(23):	figuring out how people/toys work Tries variety of actions on same object or person in play
Mastery(16):	persisting & getting around problems e.g.Tries different behavior when actions do not get reactions
Self-Regulation(14):	handling own emotions/reaction e.g.Can return to starting activity without distress or avoidance
Speech(15x3):	making sounds to self, others, imitate i.e.Changes pitch or loudness noticeably in same utterance
Emergent Literacy:(19)	relating to reading/writing Follows adult pointing to items on book pages

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Birth to 30 Months – Speech and Language Development

BIRTH TO 3 MONTHS	
TYPICAL	AT RISK
SMILES OR MOVES WHEN SOMEONE SPEAKS	QUIET BABY
BEGINS TO 'COO' (RANDOM VOWELS)	LIMITED OR NO EYE CONTACT OR INTERACTION
MAKES 'HAPPY SOUNDS; SCREECH, LAUGH	NO COOING OR LAUGHING
CALMS IN RESPONSE TO PARENT'S VOICE RATHER THAN STRANGER'S	DOES NOT CRY FOR ATTENTION
LOOKS AT CAREGIVER'S FACE	DOES NOT REACT TO LOUD NOISES

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Birth to 30 Months – Speech and Language Development

3 TO 6 MONTHS	
TYPICAL	AT RISK
RECOGNIZES OWN NAME AND SOME WORDS	NO COOING OR GURGLING SOUNDS
LOOKS TOWARD A VOICE OR SOUND	DOES NOT REACT TO VOICE OR SOUNDS – MOVE HEAD TO LOCATE SOUND SOURCE
MAKES COOING OR GURGLING SOUNDS: CHANGING PITCH AND LOUDNESS	NO IMITATION OR INTEREST IN FACES
TAKES TURNS MAKING SOUNDS WITH CAREGIVER; MAY MOVE MOUTH WITH NO SOUND	LIMITED OR NO EYE CONTACT AND VOCALIZATIONS
SMILES AT FACES OF FAMILY MEMBERS OR CAREGIVERS PAIRS EYE GAZE AND VOCALIZATIONS TO INTERACT	
PLAY: INTERESTED IN TOYS THAT MAKE SOUNDS MUSIC: PAYS ATTENTION	

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Birth to 30 Months – Speech and Language Development

6 TO 9 MONTHS	
TYPICAL	AT RISK
MAKES PLAYFUL SOUNDS WITH SYLLABLES SUCH AS 'BA', 'DA', 'KA'; BABBLES (REPEAT SYLLABLES I.E. MAMAMAMA, DADADADADA	NO SOUNDS OR LIMITED SOUNDS IN RESPONSE TO GAMES, TOYS OR MUSIC
ATTEMPTS TO TAKE TURNS MAKING SOUNDS WITH CAREGIVER	NO BABBLING OR JARGON BY 12 MONTHS
BEGINS TO ASK FOR OBJECTS BY REACHING AND MAKING SOUNDS PAIRS EYE GAZE WITH GESTURE AND/OR VOCALIZATION TO COMMUNICATE (COMBINES TWO OR MORE MEANS)	LIMITED INTEREST OR ATTEMPT TO IMITATE FACIAL EXPRESSIONS OR SOUNDS
RESPONDS TO NAME AND RECOGNIZES NAMES OF FAMILY MEMBERS	LIMITED EYE CONTACT OR INTEREST IN OTHERS
LOOKS AT PICTURES	NOT REACHING TO REQUEST SOMETHING
PLAY: IMITATES SOCIAL GAMES LIKE PEEK-A-BOO AND PAT- A- CAKE; LIKES TOYS THAT MAKE SOUNDS	LIMITED INTEREST IN TOYS OR SOCIAL GAMES

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Birth to 30 Months – Speech and Language Development

9 TO 12 MONTHS	
TYPICAL	AT RISK
BEGINS JARGON – PUTS SOUNDS TOGETHER AS IF 'TALKING'- LIMITED 'REAL' WORDS	DOES NOT LOOK WHEN YOU CALL HIS/HER NAME
IMITATES NEW SOUNDS AND SYLLABLES WORD APPROXIMATIONS BEGIN	NO BABBLING OR JARGON BY 12 MONTHS
UNDERSTANDING WORDS FOR BODY PARTS AND COMMON OBJECTS; FOLLOWS SIMPLE COMMANDS (EX. GIVE ME YOUR SHOE)	LIMITED INTEREST OR ATTEMPT TO IMITATE
POINTS TO OBJECTS SO THEY CAN BE NAMED AND FOLLOWS YOUR POINT	LIMITED EYE CONTACT OR INTEREST IN OBJECTS OR PEOPLE
PLAY: BANGING TOYS, TOYS IN/OUT OF OBJECTS, SOCIAL GAMES AND SONGS, TOYS THAT MAKE SOUNDS, SIMPLE CAUSE AND EFFECT TOYS (PUSH BUTTON TO MAKE SOUND)	NOT REACHING OR POINTING; NOT FOLLOWING A POINT

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Birth to 30 Months – Speech and Language Development

12 TO 18 MONTHS	
TYPICAL	AT RISK
POINTS AND GESTURES TO SHOW WANTS – CONSISTENT COMMUNICATIVE GESTURES GIVES OBJECTS WHEN ASKED	SOCIAL INTERACTION: SUSTAINED ATTENTION TO A SOCIAL ROUTINE, SHOWING OFF REGULATE THE BEHAVIOR OF OTHERS: GET PERSON TO OBTAIN AN OBJECT, CARRY OUT AN ACTION, STOP AN ACTION JOINT ATTENTION: DIRECT ANOTHER'S ATTENTION –(POINT TO SHOW), COMMENT ON SOMETHING WITH SHARED ATTENTION (HOLD UP ITEM TO SHOW AND LABEL) DOES NOT POINT OR FOLLOW A POINT
USES SOME WORDS (I.E. MAMA, DADA) IMITATING SIMPLE SOUNDS AND WORDS	NOT USING WORDS OR ATTEMPT TO IMITATE
SAYS 'NO' AND SHAKES HEAD 'NO'	PRIMARILY USES GESTURES- NOT SOUNDS OR WORDS TO COMMUNICATE
POINTS TO PICTURES IN A BOOK OR BODY PARTS WHEN NAMED	DOES NOT RESPOND TO QUESTIONS LIKE "WHERE'S MOMMY?"

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Birth to 30 Months – Speech and Language Development

12-18 Months continued….	
PLAY: PLALY FOCUSES ON ROUTINES OF DAILY LIVING AND ENVIRONMENT. EXPLORING OBJECTS: COLOR, SIZE, FUNCTION PLAY: ATTENDS TO TOY OR BOOK FOR 2 MINUTES; SINGLE PLAY SCHEMES (I.E. HUGS DOLLS/ ANIMALS; PRETENDS TO FEED SELF ENJOYS RHYMES AND FINGER PLAY GAMES	SHOWS LITTLE INTEREST IN TOYS OR CAN NOT ATTEND TO PLAY FOR MORE THAN A FEW SECONDS

Birth to 30 Months – Speech and Language Development

18 TO 24 MONTHS	
TYPICAL	AT RISK
UNDERSTANDS THE NAMES OF MOST FAMILIAR EVERYDAY OBJECTS	CAN NOT FOLLOW COMMANDS RELATED TO ROUTINE ACTIVITIES (GET YOUR SHOES) DOES NOT 'UNDERSTAND' WORDS FOR OBJECTS
UNDERSTANDS THAT OBJECTS ARE IN CATEGORIES (DOG IS AN ANIMAL)	NOT USING WORDS TO COMMUNICATE OR IMITATING WORDS (PHRASES);
UNDERSTANDS ADJECTIVES (BIG/LITTLE)	< 50 WORDS
ACTION WORDS (EAT/PLAY), PRONOUNS (I , ME, YOU, HIM, HER)	LIMITED OR NO USE OF CONSONANT SOUNDS (ALL- P,B,N,W,M,H)
USES MOSTLY TRUE WORDS MUCH LESS JARGON; AT LEAST 50 WORDS	NOT POINTING OR FOLLOWING A POINT
USES INTONATION TO ASK QUESTIONS AND MAKE STATEMENTS	LIMITED USE OF EYE CONTACT; SHOULD LOOK AT YOU THEN OBJECT THEN BACK TO YOU WHEN REQUESTING
BEGINS COMBINING WORDS TOGETHER; IMITATES 2-3 WORD PHRASES	LIMITED INTEREST IN 'PRETEND' PLAY WITH DOLLS/ANIMALS (FEEDING, COVERING ETC)
PLAY: Focus listed in 12-18 month COMBINES ACTIONS IN PRETEND PLAY ROUTINES (I.E. FEEDS SELF AND THEN DRINKS) Playing with baby dolls, kitchen, Little people toys, Writing on Magna doodle or with chalk, puzzles with knobs.	LINING TOYS UP PRIMARILY OR FOCUS ON THE DETAILS OF A TOY RATHER THAN THE TRUE FUNCTION 64

Birth to 30 Months – Speech and Language Development

24 TO 30 MONTHS	
TYPICAL	AT RISK
UNDERSTANDS SIMPLE QUESTIONS AND COMMANDS (NOVEL AND ROUTINE)	NOT COMBINING WORDS NOT COMBINING WORDS AND VOCABULARY IS 100 WORDS LIMITED VOCABULARY< 50 WORDS; PREFERS TO GESTURE RATHER THAN USE WORDS
NAMES PICTURES AND ACTIONS IN PICTURES NAMES BODY PARTS (SIX OR MORE)	NOT FOLLOWING SIMPLE COMMANDS; LIMITED UNDERSTANDING OF WORD LABELS; DOES NOT POINT TO PICTURES IN A BOOK WHEN ASKED NO VERBS (24 MO.), < 20 VERBS (27 MO),
USES 2-3 WORDS PHRASES ROUTINELY AND BEGINNING TO USE NEGATIVE PHRASES ("NO WANT")	SHORT ATTENTION SPAN MOST OF THE TIME < 5 MINUTES ABSENCE OF GRAMMATICAL STRUCTURES: 3RD PERSON SINGULAR (DOG EATS), COPULAR (IS HOT),
IMITATES ACTIONS OBSERVED: HOUSEWORK, OTHER KIDS, SONG MOVEMENTS, GAMES	REGRESSION IN ANY SKILL; "HAD IT THEN LOST IT" FEELINGS
PLAY-(24-28 MONTHS)> BEGINNING OF SYMBOLISM AND SIMPLE CONSTRUCTION THEMATIC PLAY SCHEMES (I.E. FEEDS BABY, CHANGES DIAPER, PUTS TO SLEEP) PLAY: PLAYS ALONGSIDE OTHERS; LIMITED 'TALKING'; IMAGINATIVE PLAY; Using more than one action with an object (dumping blocks from a truck), simple puzzles, play dough, Reasoning…. If..then. SHOWS OBJECTS OR CREATIONS	MOST WORDS ARE DIFFICULT TO UNDERSTAND NOT USING P, M, B, N, H, W , D SOUNDS (ALL) DOES NOT PLAY WITH TOYS IN THE MANNER EXPECTED (FUNCTIONAL PLAY) THROWS, LINES UP, SPINS TOYS MOST OF THE TIME

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In Summary,

- Assessment is a multi- modality process
- Involve parents throughout the process; welcome dialogue and questions
- Know development to be a discerning and accurate diagnostician
- Referral and intervention are necessary for the best outcomes
- Empathy and perspective taking will improve the communication process and intervention outcomes
- Have fun; play, laugh and be silly

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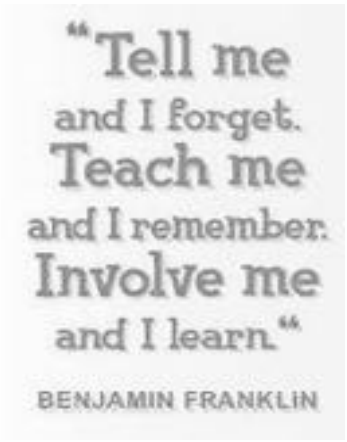
Cincinnati Children's



Questions- contact me at gina.blume@cchmc.org

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Resource

Link: https://viablesynergy.wufoo.com/forms/s3q62e1k51n5v/

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Helpful Websites

Review of potential tests and screening tools for, content, sensitivity and specificity. Excellent resource (2002):

http://www.health.ny.gov/community/infants_children/early_intervention/disorders/appendix_d.htm#crits

http://www.esc-cc.org/Downloads/Catalog_Screen_assessment2.pdf

www.mchatscreen.com

http://connectability.ca/2011/10/19/how-to-use-the-%e2%80%9cchecklist-of-communicative-functions-and-means%e2%80%9d/

Speech and Articulation Chart (beginning at age two)

C:\Users\BLU1AG\Desktop\Speechpath.com course.2016\Handouts\Talking Child articulation dev chart.ASHA.htm