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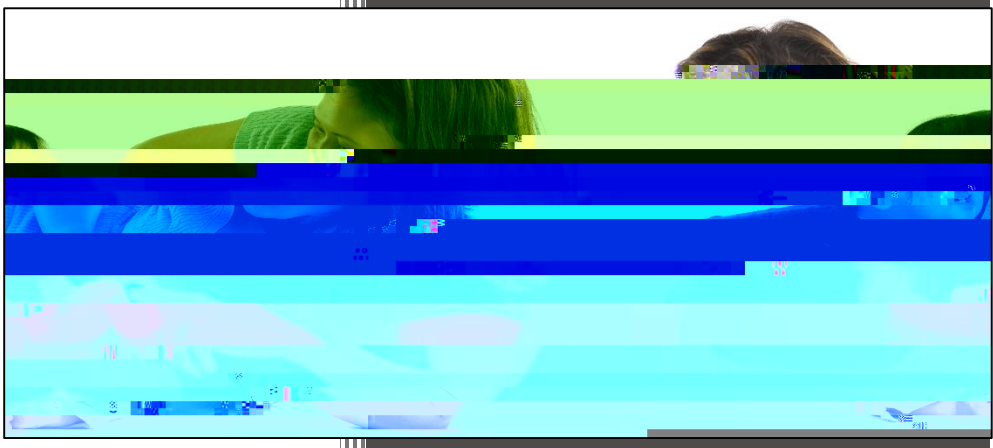
Language Development Services Guidelines Ontario Infant Hearing Program



Ministry of Children and Youth Services

April 2018

ACKNOWLEDGEMENTS

The Ontario Infant Hearing Program -

CONTENTS

ACRONYMS IN THIS DOCUMENT

INTRODUCTION

PURPOSE AND APPLICATION

The purpose of the Language Development Services Guidelines is to describe and provide operational guidance for the delivery of language development services within the Ontario Infant Hearing Program (IHP), in order to support proactive and timely services for participating families. This document is for all professionals supporting language development services through the IHP. It is intended to formalize multidisciplinary teamwork, enable family-centred services, and facilitate knowledge of roles and responsibilities.

These Guidelines set out MCYSôexpectations for the delivery of language development services across the province and aim to improve consistency of implementation across program regions. These Guidelines replace the Guidelines for Communication Development Services (2012) and the Framework for Language Development Services (2009).

Additional resources provided in this document include:

A Glossary of

HEALTHY CHILD DEVELOPMENT

Literature on developmental health trajectories demonstrates that early detection of risks and challenges, and timely support of children, youth and families, lay a critical foundation for healthy development and improve long-term outcomes across the lifespan (Halfon et al., 2014; Hertzman, 2010). These studies recognize the need for early identification, service delivery, and provision of resources and support for children showing signs of developmental concerns to eliminate or reduce the likelihood of poor developmental outcomes or minimize adverse childhood experiences. Optimizing development in this period can be accomplished by ensuring the child is exposed to developmentally enriching and enhancing environments (Baker, 2010). A delay in one or more domains of development (e.g., cognitive functions, speech functions, mobility) can have significant long-term effects on childrenôs functional behaviour and skills (World Health Organization,

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Prior to school entry, if assessment indicates that a child is achieving age-appropriate (i.e. actual age) language development milestones, the child should be discharged from active language development services (e.g., ongoing language development services from a Speech-Language Pathologist or ASL/LSQ Consultant, regular team meetings). The IHP is moving toward monitoring all children using new outcome measurement tools, until school entry. See the IHP Language Development Services Guidelines Questions & Answers for more information.

Audiology services (e.g., hearing assessments, hearing aid management) are provided to children, through the IHP, until they are six years of age. In most IHP regions, Family Support Worker services are available

LANGUAGE DEVELOPMENT PATHWAY VISION AND GUIDING PRINCIPLES

The following Vision and Guiding Principles have been developed to establish a common understanding among IHP professionals of the expectations and goals for language development service delivery.

VISION

Children are supported to develop language to the best of their ability by the time they enter school, so that they are ready to learn.

All children identified with PHL will have timely access to quality and evidence-based intervention that will support language development.

Children and their families will receive services that are family-centred and reflect their unique needs and strengths. Services will be adapted based on changing circumstances and priorities of the child and family.

Family members are key partners in contributing towards their childôs success in developing language. Family members are actively engaged throughout the decision-making process, as members of the parent-professional partnership team. They identify their childôs goals, participate in team meetings, and provide opportunities for their child to learn to use language at every opportunity within their natural family environment.

Multidisciplinary service providers will collaborate to best support the needs of the child and family.

Families will be supported in preparing for their childôs transition to school (and other transitions, such as child care services) so they can make informed decisions about supports and services available to their child. The transition to school process will be coordinated and seamless, supported by a collaborative team of professionals.

THE LANGUAGE DEVELOPMENT PATHWAY

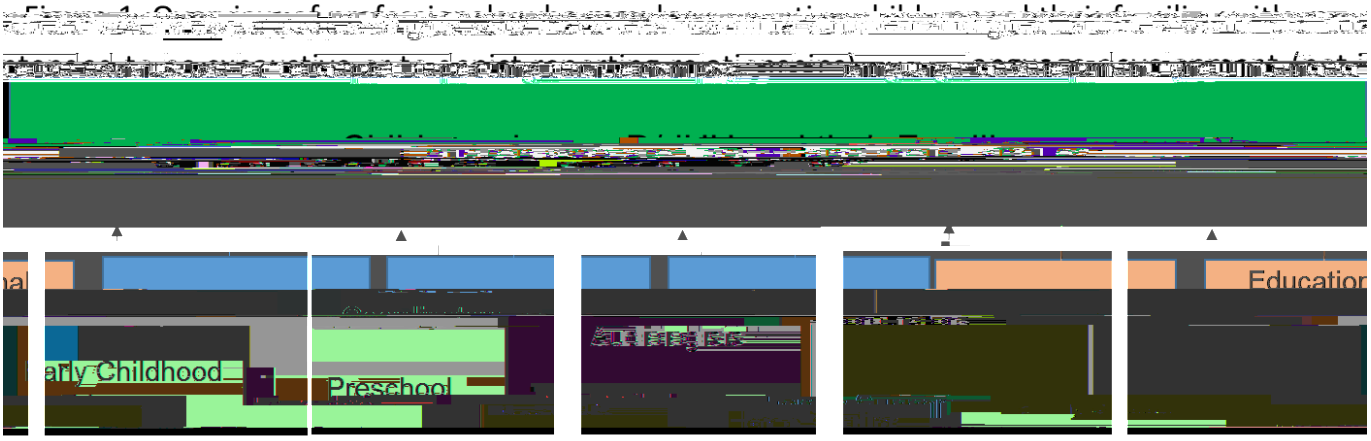
OVERVIEW

The IHP Language Development Pathway (LDP) is comprised of the nine steps summarized in the table below (Coutu et al., 2015). While the pathway intends to capture the process for providing language development services, the sequence of steps may not occur exactly as outlined below (e.g., some steps may be initiated or occur at the same time). The steps may not be sequential and are not intended to describe separate and/or different appointments. The table provides an overview of the service providers who may be supporting a child who is D/HH and their family, during each step in the process. It is not intended to be exhaustive of all professionals who may be working with a child and/or their family. IHP service providers may not be involved exactly as outlined below.

#	**Step** *Some steps may be initiated or occur at the same time*	**Key IHP Professionals Who May Be Involved**
P1	Confirm permanent hearing loss of the child	Audiologist
P2	Initiate medical consultations and community referrals as necessary	Audiologist Family Support Worker
P3	Gather and share information about language development	ASL/LSQ Consultant Audiologist Family Support Worker Speech-Language Pathologist
P4	Identify the language development pathway	Audiologist Family Support Worker ASL/LSQ Consultant
P5	Identify the childôs language development team	

INTERPROFESSIONAL COLLABORATION

A number of multidisciplinary professionals collaborate with the family


arly Childhood
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SIBILITIES OF IHP PROFESSIONALS

nes the roles and responsibilities of professionals who may have either an ry role in the IHP. This is not an exhaustive list of all professionals who may or their family

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INFANT HEARING PROGRAM COORDINATOR (Affiliation: MCYS- Infant Hearing Program)

AMERICAN SIGN LANGUAGE (ASL)/ LANGUE DES SIGNES QUÉBÉCOISE (LSQ) CONSULTANT (Affiliation: MCYS- Infant Hearing Program)

ASL/LSQ Consultants are trained to support and provide sign language development services for children in the IHP. While ASL/LSQ Consultants do not teach ASL/LSQ to families, they support families with strategies for providing a language-rich environment for their child to develop ASL/LSQ. ASL/LSQ Consultants assess ASL/LSQ language functions, language development milestones, and help prevent language delays.

When a family chooses sign language development services for their child, the role of the ASL/LSQ Consultant is to:

- Conduct an initial assessment and develop a plan for services, based on the child and family's needs;
- Employ a variety of strategies to encourage language-rich environments through ASL/LSQ language development (e.g., language instruction, connect to resources in the local community, language/early literacy development through play, or others as appropriate);
- Assess the child's language development progress every six months, using at a minimum, MCYS-mandated outcome measurement tools;
- Coordinate CDP meetings (if identified by the team as the person to do so), in collaboration with other team members; and
- Participate in CDP meetings.

If there are concerns about a child's language development progress:

- Coordinate a team meeting to discuss the child's progress and a revised plan; and
- Coordinate with team members to implement the revised plan and continue to monitor the child's progress.

If there continue to be concerns about a child's language development progress after the child's team has made reasonable efforts to meet and implement coordinated strategies to try and address the concerns:

- Notify the Director of IHP ASL Services of the family's case so that he/she is aware of the concerns and can identify if there are other steps that the Director of IHP ASL Services can take to facilitate progress; and
- Ensure that the Director of IHP ASL Services is kept informed of the child's progress.

AUDIOLOGIST (Affiliation: MCYS-

FAMILY SUPPORT WORKER (Affiliation: MCYS- Infant Hearing Program)

Family Support Workers (FSW) who provide services to children

SPEECH-LANGUAGE PATHOLOGIST (Affiliation: MCYS- Preschool Speech and Language Program)

Speech-Language Pathologists (SLP) that provide services for children in the IHP are regulated health care professionals under the RHPA. SLPs are trained to support development of spoken language through listening and development of communication skills. SLPs assess audition, language (receptive and expressive), speech, cognitive-communication, behaviour, and communication. They maintain, rehabilitate or augment oral motor or communicative functions. SLP services are funded through the PSL Program and therefore, SLPs may report to PSL Coordinators.

When a family chooses spoken language development services for their child, the role of the SLP is to:

- Conduct an initial assessment and develop a plan for services, based on the child and familyôs needs;
- Employ a variety of strategies to encourage communication skills through different therapy approaches (e.g., auditory verbal therapy (avt) approach, speech and language therapy, or others as appropriate);
- Assess the childôs language development progress every six months, using at a minimum, MCYS-mandated outcome measurement tools;
- Coordinate CDP meetings (if identified by the team as the person to do so), in collaboration with other team members; and
- Participate in CDP meetings.

If there are concerns about a childôs language development progress:

- Coordinate a meeting with the family and other team members to discuss the childôs progress and a revised plan; and
- Coordinate with team members to implement the revised plan and continue to monitor the childôs progress.

If there continue to be concerns about a childôs language development progress after the childôs team has made reasonable efforts to meet and implement coordinated strategies to try and address the concerns:

- Ensure the IHP Coordinator is notified of the familyôs case so that he/she is aware of the

OPERATIONALIZING THE LANGUAGE DEVELOPMENT PATHWAY

LANGUAGE DEVELOPMENT PATHWAY IMPLEMENTATION

The following section describes MCYSôexpectations for how each step in the LDP is intended to be operationalized. These Guidelines promote consistent implementation of the LDP and provision of service across the province.

IDENTIFYING A TEAM LEAD

Within each step of the LDP, team members must work together to identify a ñleadò who will be responsible for coordinating and communicating with other team members to provide family-centred service. The name and contact information for the team lead should be documented (e.g., in a childôs CDP). Lead team members may change over time, depending on the stage of the child and family within the LDP and the respective roles of team members. Families may take on a leadership role depending on their capacity, readiness, and desire to do so. As team member roles evolve throughout the process, the team must discuss changes in lead roles during points of transition so that accountability for coordination and communication among team members is maintained.

P1: CONFIRM PERMANENT HEARING LOSS

The first step in the language development pathway is confirmation of PHL, which is identified and confirmed by an IHP Audiologist. Protocols for the hearing assessment of infants and young children

P3: GATHER AND SHARE INFORMATION ABOUT LANGUAGE DEVELOPMENT

The IHP Audiologist provides language development information to parents in a timely manner after confirmation of PHL, based on the familyôs stage of readiness. The IHP Audiologist should offer the involvement of other service providers (e.g., SLPs, ASL/LSQ Consultants) to support information sharing on language development and informed decision-making by families. These may or may not be the same service providers who will later support the family with language development services. Service providers are expected to collaborate to ensure that consistent messaging is provided to the family. To help provide family-centred service, families should be asked if there are other individuals supporting the child/family who they feel should be included in these discussions (e.g., family member, other professionals).

INFORMATION AND TOPICS TO DISCUSS WITH FAMILIES

The service providerôs role at this stage is to offer information on the importance of language acquisition and development in the early years within a language-rich context (Bagatto &637.teM

Spoken and Signed Language Development

- **Signed language** is achieved by combining hand shapes, face movements, body movements, and other grammatical features to form signs and sentences (Valli, Lucas & Mulrooney, 2005). Therefore, sign languages use the visual system for receptive language and manual articulators (e.g., hands, face, and body) for expressive language). **ASL/LSQ** are the signed languages slanguages

decision-making about a language pathway that will be supported by the IHP. Providing families with the relevant, objective and evidence-based information they need to make the best decisions for their children and their families is a process, not a one-time event (Beckley, 2016). The Decision Aid is also a tool that service providers and families can revisit if there is a need to reconsider a childôs language pathway through the IHP.

In addition to supporting information-sharing and shared decision-making with families, another objective of the Decision Aid and support material is to ensure consistent messaging from all service providers about signed and spoken language. For example, the Decision Aid and supplementary Frequently Asked Questions, include common questions from families about spoken and signed language development with corresponding, evidence-based responses that can support service providers in these discussions.

As initiated in step P3, families may benefit from continued access to consultations with other team members, in addition to the Audiologist and FSW, so that families feel supported in making informed decisions.

DECIDING WHICH LANGUAGE DEVELOPMENT SERVICES WILL BE PROVIDED TO THE CHILD THROUGH THE IHP

At this point in the language development pathway, the family is supported to make a decision about the language development service that they would like for their child to receive through the IHP. Parents will be made aware that their childôs progress will be assessed over time. Changes will be made if language development expectations are not being achieved, or if the family revises their goals for their child.

A trial period of both signed and spoken language development services may be considered for 0 0 1 413.11

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knowledge of the childôs needs and strengths and the professionals possess the knowledge, training, and expertise in their scopes of practice to support the language development goals for the child.

The CDP could include the following components (not an exhaustive list):

current date;

P7: IMPLEMENT LANGUAGE DEVELOPMENT SERVICES

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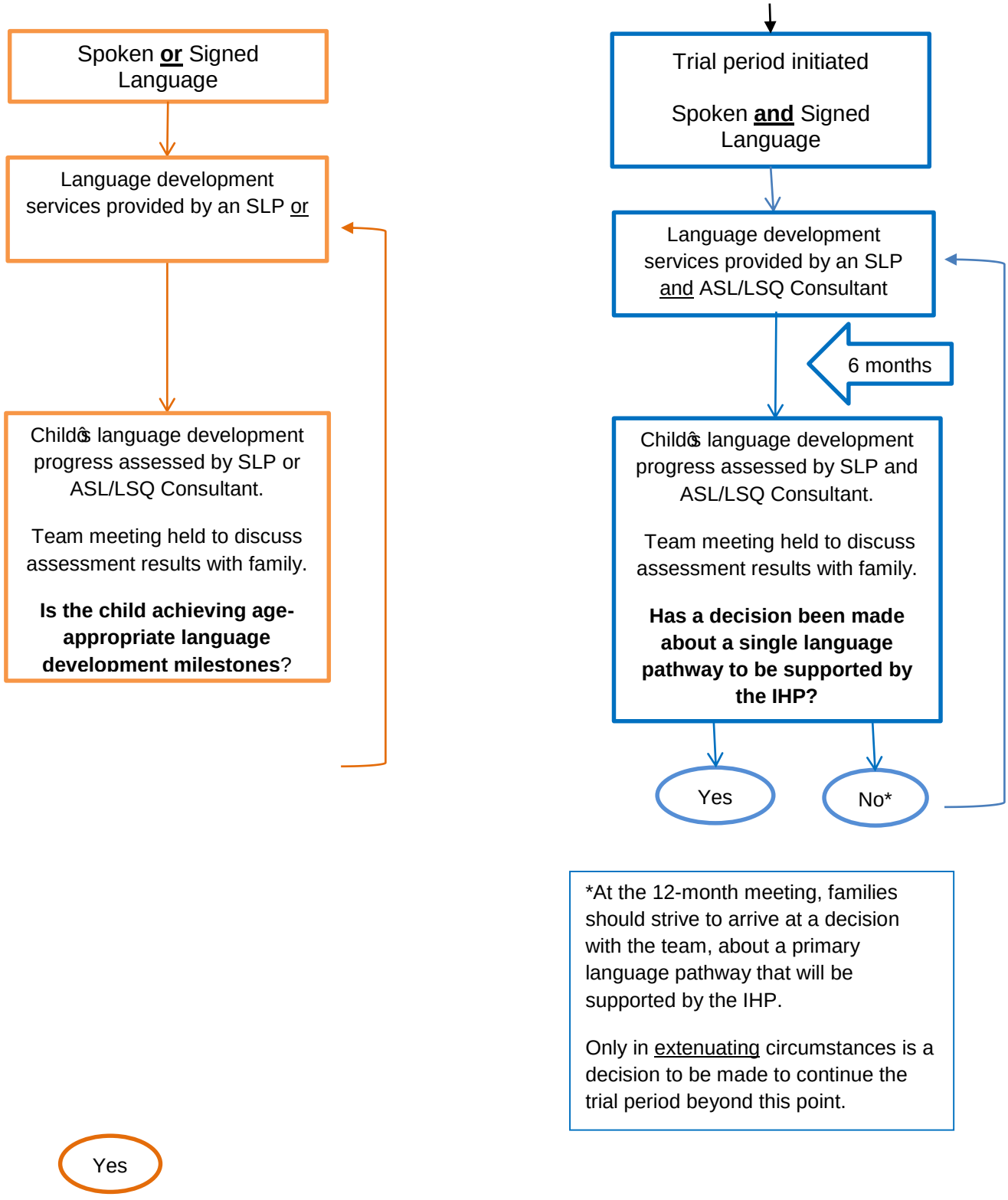
TRIAL PERIOD ASSESSMENT TIMELINES

If in step P4, the

Figure 2: Language Development Services – Delivery & Assessment Timelines



P9: RE-ASSESS, RE-EVALUATE, AND RE-ESTABLISH GOALS AND

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Communication

Communication is a two-way process of reaching mutual understanding, in which participants not only exchange information, news, ideas, and feelings but also create and shared meaning (http://businessdictionary.com/definition/communication.html). Communication includes auditory, visual, gestural, written, receptive and expressive language. (Moeller et al, 2013)

Individual Education Plan (IEP)

The Individual Education Plan (IEP) is ña written plan describing the special education program and/or services required by a particular student, based on a thorough assessment of the studentôs strengths and needs ï that is, the strengths and needs that affect the studentôs ability to learn and to demonstrate learning.òIt is a working document that identifies learning expectations that are modified from the expectations for the age-appropriate grade level in a particular subject or course, helps teachers monitor the studentôs progress, and provides a framework for communicating information about the studentôs progress to parents and to the student. (Ministry of Education, 2004)

Permanent Hearing Loss (PHL)

Within the IHP, a hearing loss of 30 dB HL or more at 500, 1000, 2000 or 4000 Hz in any ear caused by disorders of the cochlea, brainstem auditory pathways or structural abnormalities affecting sound conduction through the external or middle ear structures. Within the IHP, the hearing loss is considered

APPENDIX B: LANGUAGE DEVELOPMENT FOR CHILDREN WHO ARE D/HH

IMPLICATIONS OF PERMANENT HEARING LOSS ON LANGUAGE DEVELOPMENT

Knowledge regarding language development for infants born with various degrees of hearing and support for language development is necessary and provided for parents through the IHP.

Within the Ontario IHP, approximately 85% of infants who are identified with permanent hearing loss (PHL) fall within the mild to moderately-severe hearing loss range (25 ï 70 dB HL; Bagatto et al, 2016). With current technology and evidence-based protocols for hearing aid fitting, infants with mild to moderately-severe permanent hearing loss will have sufficient access to speech through the consistent use of well-fitted hearing aids (Bagatto et al, 2016; Moodie et al, 2017); keeping in mind that additional goals should support the childôs social, emotional, and academic wellbeing (Bodrova & Leong, 2008; Gray et al., 2007) and development of world knowledge (Convertino, Borgna, Marschark, & Durkin, 2015). For infants and young children who have hearing loss within the severe to profound range (71 dB HL and greater), access to speech through hearing aids may be limited, depending on the amount of residual hearing and limitations within the technology, among other factors. These children may benefit from signed language either as a primary language and/or in addition to spoken language development. Children with severe to profound hearing loss may be candidates for cochlear implants following a trial period with hearing aids during infancy and may benefit from signed language either as a primary language and/or in addition to spoken language.

SPOKEN AND SIGNED LANGUAGE ACQUISITION

Languages can be produced through hearing and speech or through vision and the manual modality. Given that 92% of infants born with PHL have hearing parents (Mitchell & Karchmer, 2004) it is frequently unexpected when parents learn that their infant has a hearing loss (Benedict, 2013) as they may have never met a person who has hearing loss, before their baby. Therefore, families are to be supported in their understanding of how children who are D/HH acquire language. Families should be informed of the facilitators and barriers to signed and spoken language development, to help them decide which they will choose as the primary pathway to be supported by the IHP. Families should also be informed about how their childôs progress will be assessed during intervention to support them in decision-making over time and as their child grows. To achieve success in either language, parents should be supported to understand how to provide a supportive, language-rich environment for their developing child.

A recent longitudinal outcomes study of language development of children with mild to severe permanent hearing loss (which the data from the IHP indicates is approximately 85% of the children in the program) showed language M9ap l59TeR35 Tm 316.97 164.66 dri(u)(im)-4(a)-ge renrwth aexTc[llrogby

Children who are D/HH with age-appropriate exposure to signed language (such as ASL/LSQ) from signing ASL/LSQ parents demonstrate language, literacy, cognitive and psychosocial development similar to their typically developing hearing peers (Hall, Eigsti, Bortfeld, & Lillo-Martin, 2016). Hall and colleagues (2016) emphasize that ónatural sign languageôrefers to ña language that arises

APPENDIX C: LANGUAGE DEVELOPMENT SERVICES SHARED DECISION AID AND SUPPORT

My/our goal is for the Infant Hearing Program to support my/our child's development of:

Spoken language – YES NO UNSURE **Signed Language – YES NO UNSURE**

Receiving both spoken <u>and</u> signed language services through the Program for a trial period

In some complex cases, you and your child's team of professionals may decide that it is unclear if your child should receive spoken language or signed language development services through the Infant Hearing Program. In these exceptional cases, an initial decision may be made to focus early language development on using spoken language and signed language for a limited time

Research has shown that when parents who are highly fluent in ASL have children who have a well-developed language foundation in ASL, it enables the child to reach higher levels of English literacy regardless of parental hearing status (Snodden, 2008).

In addition to language development, consideration should also be given to factors that will support the childôs social-emotional wellbeing and development of a positive identity as a person who is D/HH.

WHAT ARE THE POTENTIAL CHALLENGES?

Approximately 30% to 40% of children with PHL will have an additional medical condition that impacts development, including language development (Bagatto et al., 2011; 2016). Depending on the condition, the development of spoken and/or signed language may be challenging.

The requirements for a child to develop spoken or signed language requires concentrated and active participation from parents, other family members, and early childhood educators (Beckley, 2016; Head Zauche, Thul, Darcy Mahoney, & Stapel-Wax, 2016). Parents who wish for their child to develop spoken language need to have sufficient communication skills so that they include rich and varied spoken language experiences in their everyday activities (Head Zauche et al., 2016). Parents who wish for their child to develop signed language need to develop age appropriate signed language skills so that they can participate fluently and frequently at every opportunity within their family environment, and alongside their children in the D/HH community (Snodden 2016; 2015). Parents who wish to learn signed language need access to programs that understand the unique needs of these parents for learning signed language for use within a family-centred, early language development context (Chen Pichler, Lee, & Lillo