

Promoting the development of young children's language

James Law and Emma Pagnamenta examine speech and language therapy provision for children aged 0-3 years from a public health perspective

ILLUSTRATION BY **Laura Redburn**

As you may recall, 2015 saw the completion of a UK mapping exercise of speech and language therapy services providing public health interventions for children aged 0-3 years. This was done in collaboration with Newcastle University's Professor James Law and the Early Years Collaborative in Scotland. We were interested to find out about current practice in promoting the development of young children's language.

The political profile of public health work concerning children's early language development has grown in recent years. Public Health England has selected the 'best start in life', including children's early language skills, as one of its key priorities. The transfer of responsibilities for commissioning public health for 0-5 year olds to local authorities, in October 2015, stimulated discussion regarding children's early language development at a local level.

'Read On Get On' - Save the Children's national literacy campaign - has helped to raise political awareness regarding the importance of early language skills in supporting school readiness. We expect

political interest in early intervention and early language to increase in the coming months, with the pending publication of the UK Government's 'Life Chances Strategy'.

Online questionnaire

We invited representatives from UK children's speech and language therapy services to complete an online questionnaire, disseminated through the RCSLT Bulletin, RCSLT Research Newsletter, social media and RCSLT networks. In Scotland, this was in collaboration with the Early Years Collaborative. Data collection was in two rounds. The first between June and September and the second between October and December.

The questionnaire asked about universal/primary prevention activities (directed to the whole population) and targeted/secondary prevention for children at heightened risk of speech and language difficulties. For each, we asked about partner agencies, activities provided across age bands, training provided, commissioning and staffing. We also asked about public health messaging, criteria for targeting children and for information on some specific targeted interventions (health promotion activities, parenting programmes, family literacy and home learning interventions). Finally, we





collected information on how services were evaluating their public health approaches and collected examples of evaluations that had already been carried out.

Response mapping

We mapped the responses of the 137 speech and language services who replied onto local authorities. This amounted to 99 out of 201 authorities across all four nations (see map overleaf). We had responses from most regions of Scotland and some regions from England, Northern Ireland and Wales. Of these, 124 provided universal services and 79 provided targeted services. Despite two rounds of data collection, it is not possible to know whether the gaps reflect a lack of universal/targeted provision in these areas or just a lack of response to our questionnaire.

We asked respondents about their ethnicity and English as an additional language rates, but in most cases they were not able to provide this information. We included data on free school meals rates for all of the local authorities that responded using publically available administrative data. The average free school meal rate across all responses was 19.1% of all school children, falling above the national average (18.3%).

The NHS was the main commissioner, commissioning 83% of services. Local authorities also commissioned services directly (43%) as well as other education services (17%). Sixty-six services offering universal provision had a dedicated member of staff responsible, 34 were Band 7 and 20 were Band 8a.

Partnership working seems to be a key component of universal services. The most common partners were health visitors (57%), local authority early years workers (57%) and private early years settings (39%). Other partners included voluntary sector organisations, midwives and libraries. General practitioners were the least common partner (only 7% of services). Others included 'specialist teaching services', local teachers of the deaf, Every Child a Talker, family mentors, child minders, Citizens' Advice, adult learning community partner, school health, SureStart, Flying Start (Wales) and local authority housing/sports leisure services.

As table one shows, the most common universal activities were training of health visitors, strategic input to the focus and skills of the development of the children's workforce and public health messages. Screening and surveillance were the least common activities. Some services →

also reported training communication champions and using family literacy and home learning interventions. Most of these activities showed a trend for more services using them with older age bands, ie from two to three years.

The most common public health messages that speech and language therapy services reported using were talking (48%), no dummies and less TV (20%) playing (19%), stories (9%) and singing (7%).

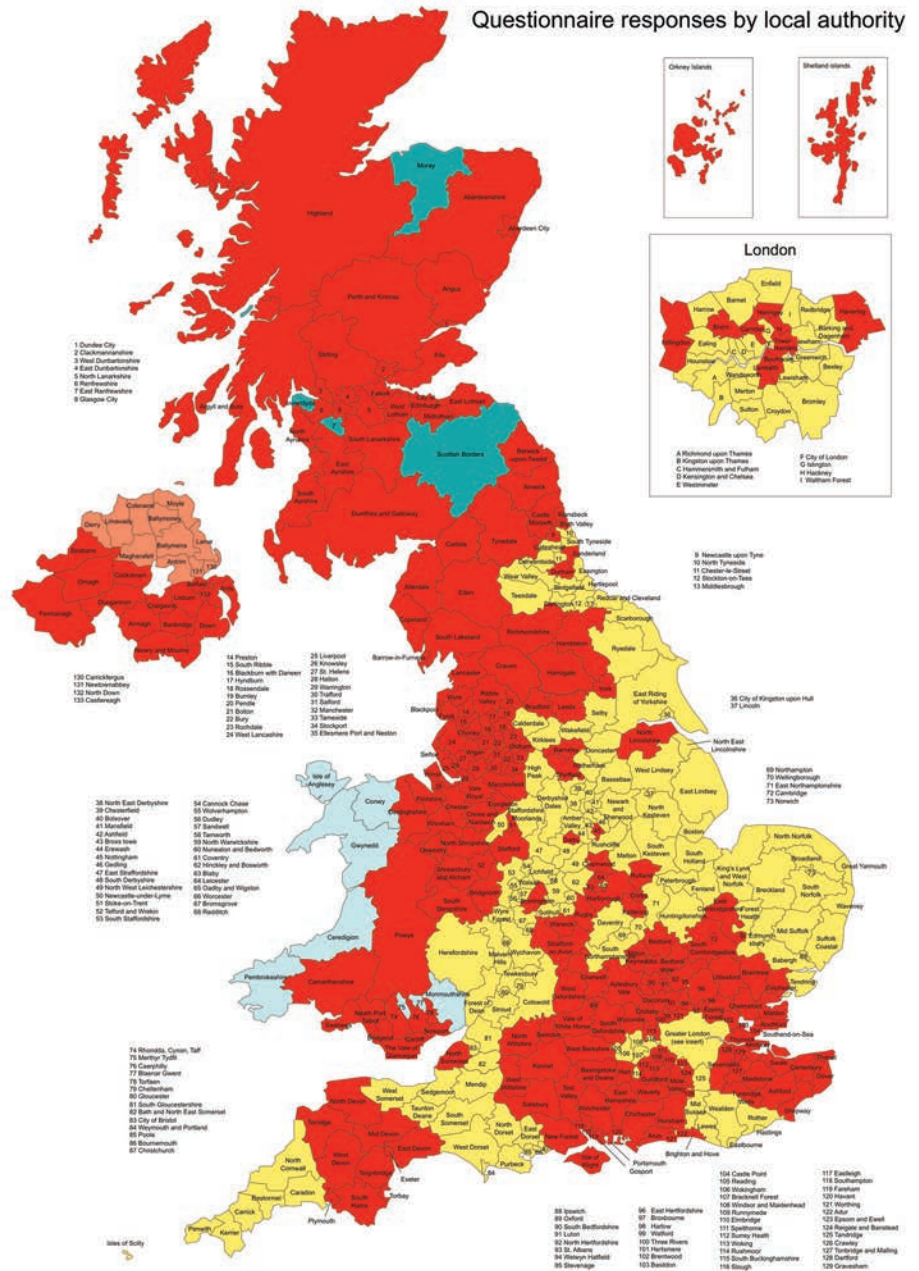
Targeted and universal services

Children receiving targeted services were selected using a variety of criteria. Forty-nine percent identified children by where they lived and 51% by schools involved in a screening programme. Slightly fewer services targeted children based on whether the families were receiving support from other agencies (35%) or by the community they came from (32%). Forty-eight percent indicated ‘other’, of which one of the most common was SureStart or an early years school setting.

As for universal services, the most common partners were local authority early years workers (90%) and health visitors (80%). More than half (57%) also worked in partnership with private early years settings. Other partners such as GPs, libraries and voluntary sector organisations were much less common. Most (84%) targeted services offered training to local authority early years workers, 68% to health visitors and 68% to private early years practitioners.

The interventions delivered as part of targeted services varied quite considerably:

- 64/76 (84%) delivered health promotion activities directly and through training others.
- 46/76 (61%) offered parenting programmes (29 (39%) of the responses indicated that the services were not



- offering this service).
- 39/74 (53%) provided family literacy home learning interventions directly, via training others or both (34 (47%) said they did not offer this service).

Current practice examples

Nine services submitted reports that allowed us to look into current practice in more detail. One report was from a Sure Start in Northern Ireland, one from Scotland and

Table one: Number of services delivering public health activities across seven different age bands up to three years

	Antenatal	0-6 months	7-12 months	13-18 months	19-24 months	25-30 months	31-36 months
Screening	2	9	15	17	24	21	25
Surveillance	1	11	12	15	15	16	18
Health visitor training	31	58	59	59	61	63	57
Communication champion training	11	23	24	28	31	34	35
Public health messages	30	41	42	46	50	49	48
Children's workforce knowledge and skills	24	51	52	56	64	73	72
Family literacy	8	15	17	18	25	27	26

seven from England. Seven of these provided universal services and three targeted specific populations of children, parents and/or practitioners.

The most common aims were engagement and support of families; training of early years practitioners (EYPs) and/or parents; identification and tracking of speech language and communication needs (SLCN); and enhancing or developing child language levels. Specific aims for targeted services tended to be development of language levels of the targeted population in relation to the wider population.

Seven of the services provided training programmes and specific interventions (for example three services reported delivering Hanen programmes). Three services provided health promotion information or messages and two provided screening, advice to parents and/or toolkits.

In all cases, staffing included an interdisciplinary team that could include early years practitioners, setting managers, healthcare professionals, 'communication champions', advisers, inclusion support workers, a business manager and administration support, as well as SLTs.

Outcomes measurement

The nine services measured a range of different outcomes. The most frequent were experience/attitudes towards the intervention, self-reported changes in practice, self-reported changes in knowledge and reported changes in child communication and interaction. Four services measured knowledge, six measured change in practice, and two measured child communication and interaction directly. Three measured prevalence of SLCN, one measured numbers accessing support and three measured the number of referrals. Two reported on measures of system change, eg action plans in setting.

Seven projects were evaluated by parent or practitioner report after an intervention. Three services also used a measure before and after a period of intervention and were able to report on changes in numbers of children meeting expected levels. For example, 'Talk for All' reported a 6% decrease in children falling below expected levels and a 13% increase in those exceeding expected levels in communication and language after the project. 'Stoke Speaks Out' found a decrease in the proportion of children with language delay, as assessed using standardised language measures, from 71% at the start of the project to 54% three years later.

Spotlight on Nottinghamshire

The Nottinghamshire Children and Families Partnership has carried out a range of evaluations for their public health initiatives. One example is 'Home Talk', a parent-implemented intervention for two-year-old children with delayed language development involving a series of home visits by a children centre worker. Health visitors identified the children and the speech and language therapy service provided the training. This intervention was evaluated with 16 families before the intervention, immediately after and at four-month follow up by measuring expressive vocabulary, pragmatics and parental stress. Twelve of the children's language skills developed at an accelerated rate and had caught up with age expectations by three years of age. Five were identified as having SLCN and were referred to specialist services. The team is currently carrying out more research to investigate the impact of 'Home Talk' on child outcomes.

Find out more: <http://tinyurl.com/hjs674a>

This service has also evaluated an abridged Hanen 'Let's interact' training programme (a short version of Hanen 'Learning Language and Loving It') for early childhood educators (McDonald et al 2015). Eight received three, three-hour group training sessions delivered fortnightly by an SLT and early years specialist teacher using video feedback. They used a measure of adult interaction behaviour (Conversational Responsiveness Assessment and Fidelity Tool – Friel et al, 2007) three to four weeks before training, just before training and after training. Significant changes were observed: from an increase in use of comments to cue turn taking and a decrease in use of questions. Semi-structured interviews with seven educators found they more consistently reported learning and using communication-facilitating strategies than language-modelling strategies. Several features of the training course that facilitated learning were identified, for example the practical, interactive nature of the group training sessions, the use of video feedback and the repetition of key strategies in several training sessions.

Find out more: <http://tinyurl.com/gofrhh7>

The impact of the evaluations in several examples resulted in a continuation and/or scaling up of the initiative across the region. For example a 'Message of the month' initiative at Shankill SureStart in Northern Ireland was updated and cascaded to 15 new partner settings following evaluation. Other impacts cited included streamlined care pathways, a commitment to joint agency working and improved systems for the identification of SLCN.

What this means

This mapping exercise suggests that universal and targeted provision to children aged 0-3 is being provided in many regions of the UK. In providing these services, SLTs are working closely with a range of other professionals from very early on in life. Training the wider workforce seems to be a key component.

A number of issues were highlighted in how to evaluate and demonstrate impact of public health initiatives. Measuring the effectiveness of preventative interventions is challenging in the short term, with a time-lag between changing inputs/processes and demonstrable outcomes. By examining evaluations that have been carried out

it can be seen that measuring baseline levels before intervention is useful as are outcome measures that go beyond views/attitudes towards a training programme or intervention. Starting out as an evaluated pilot scheme can create valuable evidence to make the case for scaling up of initiatives. ■

Professor James Law, Newcastle University and Dr Emma Pagnamenta, RCSLT Research Manager Email: James.Law@newcastle.ac.uk or emma.pagnamenta@rcslt.org

For more information about public health and speech and language therapy visit: tinyurl.com/z7v33ho for public health pages



References & resources

Friel S, Wiggins A, Justice L. *Conversational Responsiveness Assessment and Fidelity Tool: Coding Manual*. Charlottesville, VA: University of Virginia, 2007.
McDonald D, et al. Increasing early childhood educators' use of communication facilitating and language modelling strategies: Brief speech and language therapy training. *Child Language Teaching and Therapy* 2015, 31: 305-22.

Thanks to Janet Cooper for her input into the questions and everyone who completed the questionnaire