ISSUE 17 2020

The Link ONLINE

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Tips for transition for children with ADHD

Page 12-13

UNDERSTANDING DEVELOPMENTAL VERBAL DYSPRAXIA

By Shula Burrows

Page 4-5

CELEBRATING NEURODIVERSITY

By Louise Bingham

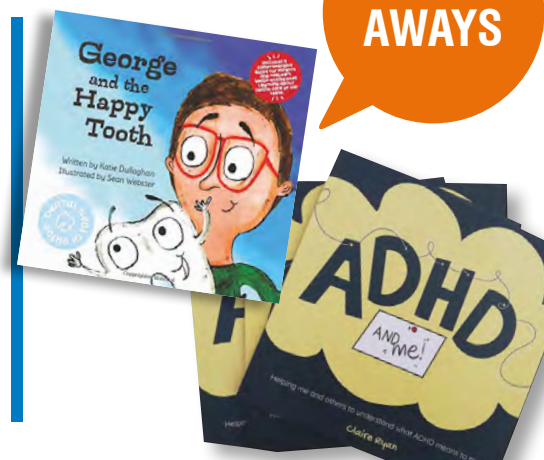
Page 6-7

THE LINK BETWEEN ORAL CARE AND SPEECH AND LANGUAGE AND HEARING

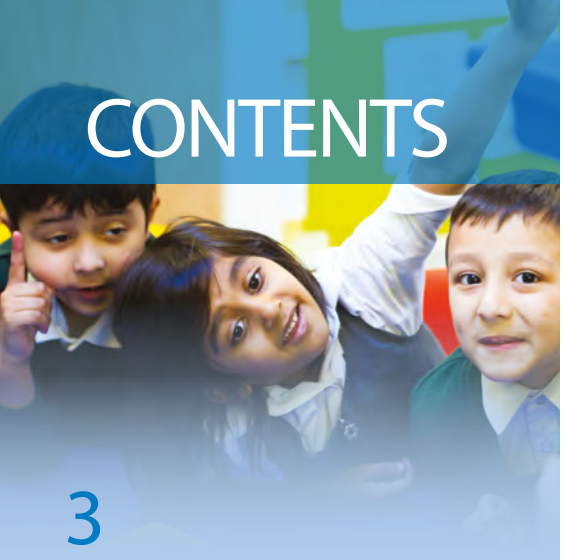
By Katie Dullaghan

Page 16-17

GIVE AWAYS



CONTENTS



Editor's Letter

Hello and I hope that you are well and are managing these unprecedented times as best as you are able. The education industry has undoubtedly been hugely impacted with school closures, and, by continuing to work in their settings with the most vulnerable children alongside key workers' children, school staff have proved, that they will always go the extra mile.

For this reason, we have decided that, this term, a digital version of The Link would be the most sensible option - we hope that you find issue 17 as interesting and informative as ever.

We are thrilled that our **Parent Portal** is up and running. We have been developing this for some time, but due to the need for parents to be able to access speech and language resources at home now, we have fast-tracked the launch of the site. Find out more about what the site offers on page 9.

So, what's in the issue? We are delighted to have specialist articles on **Developmental Verbal Dyspraxia** from **Consultant Speech and Language Therapist, Shula Burrows** and **Cathy Parvin, Director of Dyspraxia Education on Developmental Coordination Disorder**. In our **Ask a Therapist** feature, **SaLTS, Sophie** and **Louise**, answer some of your questions about **phonological awareness** and **supporting children with hearing impairment** and Louise also writes for us about the positives of **Neurodiversity. Founder of CANDOELLA** Elly Chapple, reinforces the importance of taking the lead from an individual with severe needs on how they wish to communicate (pages 14-15).

Claire Ryan, Co-Founder of ChatterPack, **talks about ADHD**, what it means to her and how transition can be a tricky time for children and young people who have ADHD. She is also giving away two copies of her book '***ADHD and ME***' in our **FREE Draw**. Finally, **Katie Dullaghan from Happy Teeth** enlightens us on how **poor oral care** can really **impact on hearing and speech and language skills** – she is giving away two sets of ***George and the Magic Tooth book*** **and chart bundle, in our FREE draw.**

As always, we welcome questions, comments and ideas from our readers. Please get in touch if there is a speech, language or communication topic that you would like to be featured in a future publication of The Link.

Don't forget to join *The Link Facebook Group* where members share practical information, resources and tips to ensure that everyone feels supported in their ongoing journey with speech and language.

From all of us at Speech Link Multimedia Ltd, we wish you a safe and peaceful summer and thank all schools for their continued hard work and dedication to their children.

www.speechandlanguage.info
Contact our Help Desk at
office2@speechlink.co.uk
or phone 0333 577 0784

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Ask a Therapist

We asked The Link Facebook Group members if they had any questions that they would like our speech and language therapists to answer.

Q1 How can I support a child who has a hearing impairment (HI) with her speech sounds?

Louise SaLT answers:

1. Reduce background noise and make sure only one person speaks at a time. Soundproof hard surfaces using blankets and cushions to stop noise from reverberating around the room.
2. Support children so they can indicate when they don't understand what is being said and ask for help. Visual supports, such as confidence indicators, are great for developing these skills. If children have equipment to support their hearing, such as hearing aids, develop their ability to tell you if something isn't working.
3. Vocabulary learning skills are an area of weakness for children with HI which affects their ability to learn the sequence of sounds in words correctly. Pre-teach key vocabulary and use visual support strategies, such as mind maps, to develop the sound structure of a word, alongside its meaning. Pupils can write new words in a dictionary to support their understanding, including reminders of how to say the word. Back up vocabulary used within the classroom with pictures, signs and natural gesture.
4. Ensure the child can see your face clearly and that you are not in front of the light source. Visuals will support the child in understanding which sound you are focusing on, e.g. cued articulation signs. Model the use of the target sound in your own speech, using signs, and support children gently to correct their errors.

Q2 How can I support pupils in Key Stage 1 with developing their Phonological Awareness skills?

Sophie SaLT replies:

If you're working on Phonological Awareness (PA) with any child of any age, the first step is to be really clear about what 'phonological awareness' means. PA is the ability to recognise, discriminate and manipulate sounds in our heads and predict the impact of those manipulations in terms of how they will change words. It's different and much broader than phonics (matching sounds to letter representations) and includes recognising syllables and rhyme as well as interpreting the sounds that make up words.

TOP TIPS FOR WORKING ON PA SKILLS:

1. Think about what stage the child is currently at in terms of their PA development and meet them where they are, stretching their skills a little at a time. E.g. Can the child recognise syllables? If not, can they mark out the words in a sentence?
2. Working on PA requires listening activities. Establish what 'good listening' means and adapt the environment so the child can be successful.
3. Almost any activity can be adapted for a listening game, so pick activities which interest the child. Physical activities work brilliantly, e.g. running to different places in the room, using hula hoops to make decisions, throwing bean bags at targets, jumping on lily-pads or stomping like a dinosaur. For children who prefer creative activities you could build a tower or use stamps on paper to make a chain.
4. Make sure to teach and not test. Build in lots of opportunities to model skills for the child and for them to practise and receive accurate feedback about how they're doing.

If you have a question that you would like Louise and Sophie to answer, please get in touch.

therapist@speechlink.co.uk

DEVELOPMENTAL VERBAL DYSPRAXIA

By Shula Burrows (BSc; MSc; MRCSLT)
Consultant Speech and Language Therapist,
Clinical Lead, Nuffield Paediatric Speech Clinic

Introduction:

Developmental Verbal Dyspraxia (DVD), also known as Childhood Apraxia of Speech (CAS) is a motor speech disorder. DVD impairs a child's ability to plan, sequence and produce precise articulatory movements for speech. Children with DVD have difficulties with accuracy, timing and speed of speech production in the absence of damage to the muscles. The cause of DVD is as yet unknown, and it can occur alongside other developmental disorders.

At the Nuffield Paediatric Speech Clinic, we offer a specialist service where the children are referred for an assessment and diagnosis of their speech.

Below is an excerpt from a conversation with Jack, aged 5 yrs 10 mths, who has DVD:

Jack: "This is a big hospital."

Jack's pronunciation of the utterance was heard as: [di i a bi ho i pel]

Shula: "Yes, it is. Tell me more about your visit to the farm."

Jack: "I like animals. I saw a caterpillar, no, no a caterpillar."

[I lie a mels. I saw a tatiar no no tapetipa].

Shula: "Let's say it together 'caterpillar'."

Jack: *Ye,[ta a pi ar]*

It would have been much harder to understand Jack's message out of context. His speech contains many omissions of sounds, substitutions, and glottal stops. Sequencing sounds and syllables within words is difficult for him and there is a distorted, almost jerky, quality in the rhythm of his speech, with the rate of speech being quite slow. He is not able to produce a target word more accurately when he copies an adult's production.

How is DVD identified?

- A detailed assessment of speech output is essential
- The importance of a thorough case history cannot be emphasised enough
- Receptive and expressive language and phonological skills need to be assessed, as well, in order to look at the child's communication holistically.

Because DVD is a speech disorder, children who are not yet producing any verbal output cannot be identified.

What signs do we look for?

From the case history:

- Frequently described by parents as a "quiet baby", did not vocalise very much
- Delayed babble
- Limited range of sounds used in babble
- Late to produce first recognisable words
- Stayed at single word level for a long time
- Late to produce two – word phrases e.g. "My teddy, more bubbles."
- Unintelligible speech
- Feeding difficulties, sensitive to certain textures, messy eater with food getting smudged over their face (currently or in the past)
- Difficulties copying lip and tongue movements and sequencing these
- Drooling (currently or in the past)
- Difficulties with blowing and sucking
- May have generalised gross motor and fine motor dyspraxia; may have an additional diagnosis of Developmental Coordination Disorder

- Understanding of spoken language is reported to be in advance of expression
- Frustration due to unintelligible speech and not being understood by others
- Family history of speech and/or literacy difficulties

From the speech assessment:

The signs of DVD have been controversial amongst speech and language therapists for a long time.

Based on the RCSLT policy statement on DVD the 3 core signs on which there is consensus are:

- Inconsistent errors on consonants and vowels in repeated productions i.e. child repeats the same word differently each time
- Difficulty transitioning between syllables and sounds (Jack's speech shows many examples of difficulties in moving from one syllable to the next smoothly and accurately)
- Inappropriate prosody (rhythm, stress and intonation) especially at word or phrase level. For example, placing the stress on the wrong syllable or placing equal stress on all syllables.

In addition, clinical experience and research literature highlight the following speech features:

- Vowel distortions
- Limited range of consonant and vowel sounds, especially compared with the language levels of the child
- Omissions of sounds
- Substitutions of sounds
- Difficulties repeating words
- Difficulties repeating non-words or made up words
- Unusual substitutions which do not necessarily follow a developmental pattern
- Overuse of one sound, known as "favourite articulation": the child may replace a wide range of consonants, for example, (b,t,d,s,sh) with [g]
- Reduced accuracy and rate in sequencing words and syllables, e.g. if you ask the child "Say digger 5 times" their production may be full of errors and at a slow rate.
- Increased number of errors when words are longer, or phrases are more complex
- Glottal stop insertions and substitutions
- Imitation does not improve accuracy of production, e.g. Jack could not imitate caterpillar
- Unintelligible speech – other people will find the child very difficult to understand, especially out of context
- Difficulty making accurate movements with the mouth and tongue

Treatment:

DVD is treatable, but it does require specialist support from an experienced speech and language therapist. Treatment approaches which are based on Motor Learning Principles, for example, the Nuffield Dyspraxia Programme, would be appropriate under the guidance of a speech and language therapist. Phonological skills should be monitored and included in therapy in order to build accurate phonological representations of words.

Children with DVD require regular, direct speech therapy, delivered by a speech and language therapist. Long breaks in therapy between courses do not help generalisation of targets and lead to slow progress, so it is important that practice is maintained between sessions. Frequent practice helps to stabilise the newly learned speech sounds and/or words and repetitive drilling helps motor patterns to become automatic. Teaching Assistants, under guidance from the Speech and Language Therapist, can support this practice effectively in school.

Supporting children with DVD:

Most children with DVD attend mainstream schools, however there are frequent educational difficulties and research evidence that confirms a high risk of children with DVD developing literacy difficulties. Unintelligible speech may lead to emotional difficulties and feelings of social isolation in some children and they may withdraw from participation. Gross and fine motor dyspraxia may mean that the child may fall frequently and have difficulties in holding their pencil and handwriting. A child with DVD may use signing to enhance their expression which, if they are the only child in their class who signs, may lead to further feelings of being different from their peers.

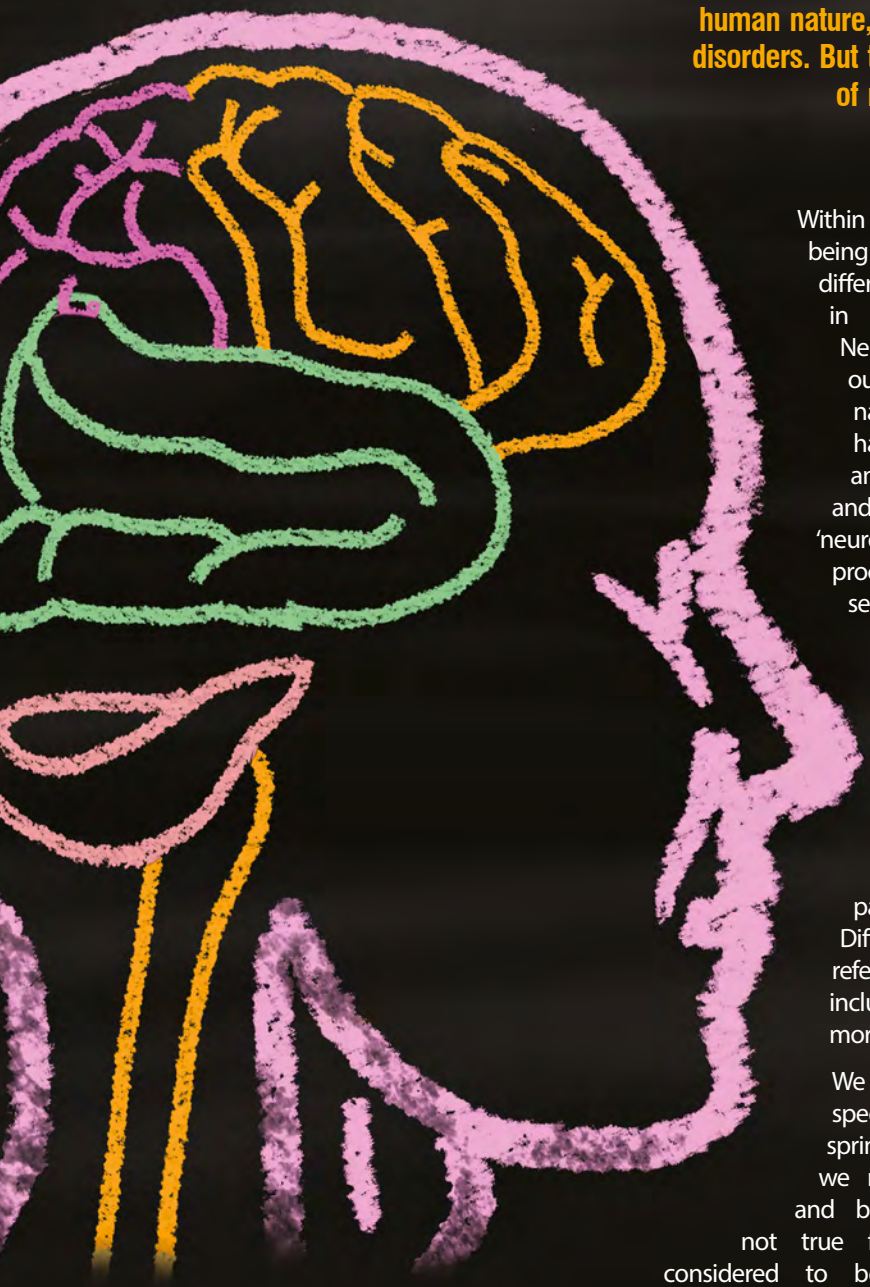
TIPS TO HELP SUPPORT CHILDREN WITH DVD:

- Give your child enough time for them to get their message across and to revise what they have said, using different words
- It may be helpful to discuss with a speech and language therapist whether a communication aid may be appropriate. (This is not to replace the child's speech, but rather to support and enhance their expression)
- Provide scaffolding to help their understanding of how to formulate sentences
- Pre-teach new concepts and topic vocabulary
- Consider providing a laptop for some children who find pencil grasp very difficult
- An assessment by an occupational therapist may give further information about the child's profile
- Try and incorporate signing into the class and identify a "buddy" who can sign with the child to avoid the child being the 'only one'

So how is Jack doing? After his initial assessment at the Nuffield Paediatric Speech Clinic, his parents received a detailed report and a speech therapy programme which could be used in his local therapy sessions. His parents, school and local speech and language therapist are all working together closely to deliver his therapy every day, and we hear that he is making good progress.

The benefits of neurodiversity

By Louise Bingham, SaLT



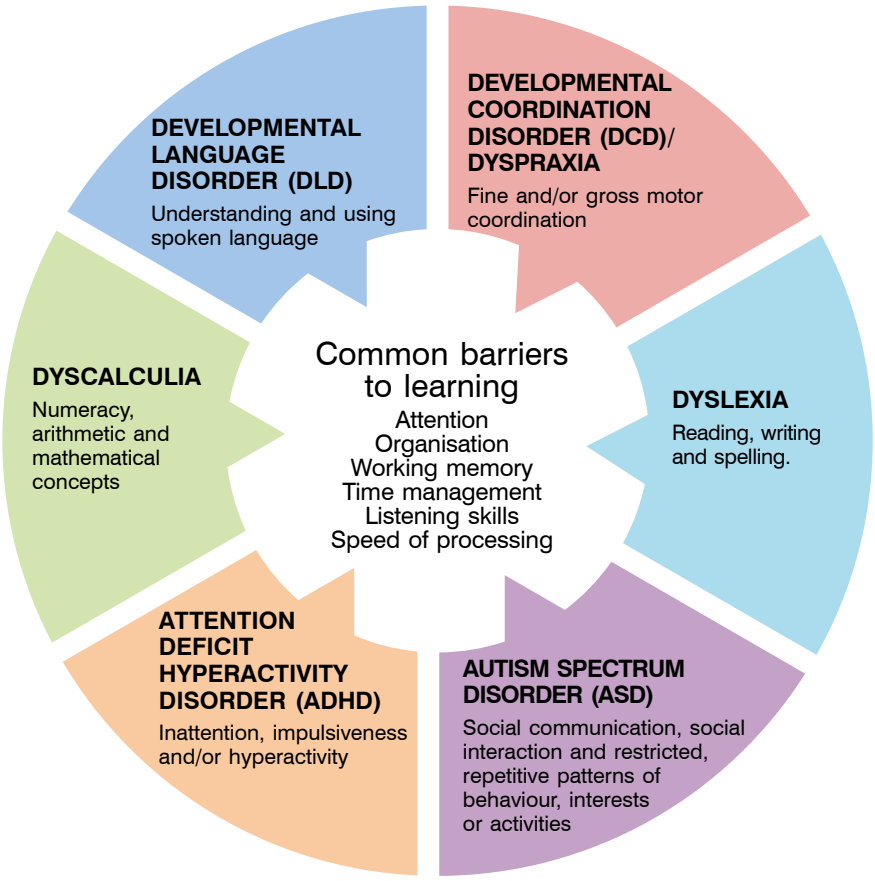
"For too long, we've assumed that there is a single template for human nature, which is why we diagnose more deviations as disorders. But the reality is that there are many different kinds of minds. And that is a very good thing."

Jonah Lehrer.

Within education, the term neurodiversity is increasingly being used to promote the view that neurological differences should be recognised and treated in the same way as any other human variation. Neurodiversity refers to the different ways in which our brains function and interpret information. We all naturally think about things in different ways; we have different likes and dislikes, different interests and hobbies, and we are better at some things and poorer at others. Most people are classed as 'neurotypical' meaning that their brains function and process information in the way that is expected or seen as 'typical' by society.

It is estimated that around 1 in 7 people (more than 15% of people in the UK) are 'neurodivergent', meaning that their brain learns and processes information differently. The term was originally used by the autistic community, looking to move away from the belief that autism is something medical to be treated or cured, rather than being a valuable part of human diversity. The term Specific Learning Difference (SpLD) is increasingly being used to refer to a number of associated learning differences, including individuals with ASD, ADHD, dyslexia and more recently, DLD.

We have all heard of these diagnostic terms and specific characteristics or 'differences' may quickly spring to mind. For children with a diagnosis of ASD, we may instantly think that they will excel at maths and be poor at making friends. But this is definitely not true for all children with this diagnosis. SpLDs are considered to be 'spectrum' conditions and although common characteristics occur, individuals vary in terms of the severity and type of difficulties they face. For example, the effects of DLD for one child will be very different to those for another child with DLD. It is really important that children are not stereotyped according to their diagnostic labels.



When supporting children with SpLDs, there can be a tendency to focus on the child's learning differences and areas of academic weakness. They can be thought of as 'different' or 'strange' because they learn and process information in a different way to children who are considered to be 'typical'. They need strategies in place to enable them to access learning. Without this support in place these children are likely to struggle to keep up with their peers, not make academic progress in line with their potential, be more likely to develop mental health difficulties and to leave school or be excluded.

It is recognised that these SpLDs share common barriers to learning and the different conditions will frequently co-occur. This means that it is very beneficial for teaching staff to implement classroom strategies to support these common areas of weakness, as they will support all pupils with SpLDs to better engage with their learning. Here are some examples of strategies for each of these areas:

Attention and Listening Skills

Ensure that you secure a child's attention, before giving them an instruction or direction. Teach the rules of good listening and use visual prompts as a reminder of these. Encourage children to identify when they don't understand information and support them to request specific clarification within the classroom, using visual support.

Organisation

Task management boards can support children to understand the steps within a task, so that they know how to start and what the finished task should look like. They can include information about equipment that is needed so that the child can prepare this themselves.

Working Memory

Use short, simple sentences when explaining tasks and break down instructions into smaller chunks. Discuss strategies that can help you to remember spoken information e.g. visualising things in your head, making lists or writing key points on a white board.

Time Management

Explicitly teach children the meaning of words relating to time, e.g. 'before', 'after', 'today', 'tomorrow', using visuals and practical activities, then regularly use these words within context. Use visual timetables, diaries and calendars to support children to orientate themselves in time and develop strategies to improve their time management skills.

Speed of Processing

Support spoken information with visuals, e.g. pictures, symbols, gestures and the written word, so that children do not need to rely only on the spoken word which is fleeting. Use the 10 second rule and allow time for processing before expecting a response.

Once strategies are in place to support these common barriers to learning, it is important to remember that each child is an individual, with their own strengths and weaknesses. It is increasingly being recognised that alongside areas of learning difference, these individuals have areas of strength. For example, individuals with dyslexia are recognised to have strengths in creative, visual and problem-solving skills and as a result are very successful in related careers. The path to achievement can be much harder and require greater effort, due to the impact of the learning difference on areas such as literacy, memory and coordination, but individuals with SpLDs can be very successful.

It is important that teaching staff focus on the child as an individual, regardless of their diagnosis, and identify their profile of strengths and learning differences. This enables strategies to be put in place to support learning differences and the child's strengths can be celebrated and boosted. It is important to explore methods and techniques to facilitate the optimal learning environment for the child, based on knowledge and experience of the child.

Timetable in activities to celebrate the strengths of all of the children that you are working with, so that we can promote the positive qualities of children with SpLDs. These children are viewing the world in a different way and should be accepted as they are, because their differences are a valuable part of human variation and innovation.

From one TA to another – From parent to TA

By Claire Chambers, Former TA and Speech and Language Therapy Assistant for the NHS

Parents across the country now have the difficult task of continuing their child's education at home. This is undoubtedly a challenge for all parents and will be additionally tough if they are not confident in their own skills alongside teaching topics that are unfamiliar or, are a far distant memory! I remember only too well, looking at a piece of my children's homework and feeling completely overwhelmed! Add to that the natural disinclination of children to work as hard for their parents as they do for their teachers, is it any wonder that the weeks ahead seem a bit daunting?

In essence, parents (albeit temporarily) are the new TAs. The learning objectives and tasks are set by the teacher but now, will be delivered by new, untrained, 'TAs' in restricted environments, while looking after other family members of different ages and, who have different needs.

Schools are brilliant, they have done everything possible to support their parents and children by providing structured learning packages, online support and remote learning. The internet has a plethora of free resources to access, particularly for core subjects and let's not forget the fabulous, free, daily fitness videos available to help get everyone moving! I think it's important, that parents remember that this is not 'home-schooling' – that is a choice, this is trying their very best to keep things going during a very difficult time.

An even greater task for parents, may be the continuing of their child's speech and language support at home. Even with a good understanding of their child's needs, it can be really difficult for parents to think of different activities to do with their children at home, that will support their child's speech and language needs. We have set up **The Parent Portal** to help with just these issues and we are providing a wealth of free resources, advice and activities to support parents.

I asked Sophie and Louise, our speech and language therapists, did they have any advice they could give to schools to pass on to their parents who are struggling to support their children with SLCN at home? Here's what they said:

"The best way for parents to encourage their child's speech and language development at home is to do lots of talking and listening together - there is no need to have special tasks or extra time set up in the day. Encourage parents to use everyday activities like mealtimes, having a bath and even household chores like the washing, to develop their children's speech and language skills. By using everyday activities, they can talk about events or situations that are really familiar for their child, enabling them to practise the language skills they have already learned, and build on these skills."

We have been working on a **Parent Portal** so that parents have a wealth of free resources and activities to enable them to support their children, at home, on specific areas of SLCN. We were due to launch this site later this year, but with the advent of schools closing, we have brought this forward in order to support families now.

The site has information about why speech, language and communication skills are so important, and how parents can support them.

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DCD

Developmental Coordination Disorder

By Cathy Parvin, Director of Dyspraxia Education

Josh's story

Our charity first became involved with supporting Josh when his mum contacted our helpline for support after concerns were expressed by his teacher at parents' evening.

At the time he was 9 years old and in the summer term of year 4. Josh was described as "bright", giving excellent verbal responses in class, but his knowledge was not reflected in his written work. The teacher also commented that he quickly lost focus in class and needed bringing back to task frequently.

His mum described him as clumsy and disorganised, with no sense of time, but most concerning was the fact that he had changed from being a happy, chatty child to being quiet, withdrawn and reluctant to go to school. She described his development as "on the late side of normal". He walked at 17 months and struggled with many things like dressing and feeding himself. He seemed to be constantly falling over and breaking things. Whilst his brother learnt to ride bikes and kick footballs easily, Josh found this very difficult and needed support. When she asked Josh what he thought he was good at, he looked at his feet and replied, "Nothing really". At this point, Josh had not been assessed by any professionals.

I observed Josh during a literacy lesson. He was at the back of the classroom sitting side on to the interactive board. He initially listened well and gave a couple of good verbal replies, but he quickly lost focus, especially when the class were given a written task. He was observed to fiddle with items from his pencil case and on several occasions, he flopped his head on his arm and did no work at all. He yawned frequently and, compared to his peers, his work was poor in quantity, legibility, quality and spelling. His writing seemed to take considerable effort on his part and many letters were incorrectly formed and/or reversed.

From the classroom window, I observed him at playtime and noticed he had a slightly awkward run. Whilst his brother readily joined in football games, Josh never attempted to kick the ball, but when it went offside, he ran after it and threw it back into the game. This seemed to be his role. He looked generally low muscle toned (hypotonic) and he didn't engage much with the other children.

Following my observation of Josh, I discussed his main areas of difficulty with his mum and school staff and we agreed a plan of strategies to address these. Firstly, it was felt that Josh needed further assessment to fully understand his needs and I recommended a referral to the Community Paediatrician plus an Occupational Therapist. His mum decided to pay for a private Educational Psychologist to assess him with regard to his spelling, letter reversals and focus.

As DCD presents very differently in different children and can be further complicated by the high co-occurrence with other conditions, it is important that support strategies are developed on an individual basis. There are, however, some golden principles for supporting pupils with DCD:

- **Training:**
  Understanding DCD and co-occurring conditions through training is essential for supporting pupils
- **Break it down:**
  Children with DCD often struggle to process more than one thing at a time and can quickly become overloaded.

Definition of Developmental Coordination Disorder

Developmental Coordination Disorder (DCD), also known as dyspraxia in the UK, is a common disorder affecting fine and/or gross motor coordination in children and adults. Children may present with difficulties with activities such as self-care, writing, typing or riding a bike. In adulthood, many of these difficulties will continue, as well as difficulty learning new skills such as driving a car and DIY. These difficulties can significantly affect an individual's ability to function at home, in education and in employment.

This applies to all tasks related to learning or home. For example, if asked to write a story, a child with DCD will find it very difficult to create a story, remember punctuation and manage the motor skills of writing. Breaking down the task into recording their spoken story and then writing it can support with this.

- Regular practice:
  Provide opportunities for frequent practise of skills so that children can regularly revisit what they have learnt, for example within daily exercises for 15 minutes.

A plan to support Josh in school was devised focusing on the following areas:

Handwriting and spelling:

Josh completed the 'Jimbo Fun' programme (an intervention to support the development of handwriting skills, including gross and fine motor skills) and completed daily handwriting practice, with a focus on accurate letter formation. Various pencils and pens were tried, and Josh selected one he found easy to use. The emphasis was on quality not quantity for handwriting and rewarding effort, rather than the final result. For longer pieces of work, he used a laptop to record his story and then write it down.

Maintaining focus:

Josh was given a fiddle toy to help him concentrate and his mum bought him a hug vest which he found very helpful. He was relocated to the front of the classroom face-on to the interactive board and was given regular "get up and move breaks" during lessons.

Tiredness:

Children with DCD need to work harder than other children to complete tasks and therefore often become very tired. Josh and his mum agreed a deal to reduce his screen time in the evenings and to establish a good bedtime routine. She also recognised the need to balance his workload during the week well and teaching staff agreed more flexibility around homework.

After nearly 6 months Josh was seen and assessed by an Educational Psychologist, Community Paediatrician and Occupational Therapist. He received diagnoses of DCD and dyslexia and was found to have some challenges with working memory. It is important that key adults understand and recognise DCD in order to support children effectively. For Josh this meant that he improved academically, but he was also happier, grew in self-confidence and was more engaged with his learning. In his own words, he's "not in trouble anymore".

Cathy Parvin, Director
Dyspraxia Education

http://www.movementmattersuk.org
https://www.jimbofun.co.uk/

Dyspraxia Education

Registered Charity 1185572

ADHD and transition

By Claire Ryan, co-founder of ChatterPack and Senior SaLT TI (Technical Instructor) NHS

A bit about me

I come from a very colourful, neurodiverse family and it was no surprise when I was diagnosed with ADHD in 2004. I always knew I was different; I just didn't know 'how', 'why' or 'what' to do about it. Diagnosis answered some of my questions, but I still needed to understand what a diagnosis of ADHD meant for me, for my child, and what it meant for the children I work with.

Through my studies as a SaLT TI, I have learned that effective support and improved outcomes are achieved through reflection of what we 'know' about ADHD and by enabling adults and children to develop a better understanding of what having a diagnosis of ADHD means to them. I wrote 'ADHD and Me', a guide for children and young people to help them understand what ADHD means to them as a unique individual.

A bit about ADHD

ADHD (Attention Deficit Hyperactivity Disorder) is a neurodevelopmental disorder that can cause above-normal levels of hyperactive and impulsive behaviours.

An under recognised strength of ADHD is the ability to find creative, unique solutions to problems. ADHD brains do not think in a linear way, so they might come up with what seem to be bizarre suggestions. It is incredibly empowering for a child however, when adults recognise and utilise their unique ideas and, with some gentle guidance, it is likely they'll come up with an idea which may not have been considered before!

An area which is often of most concern to adults, is behaviour difficulties. However, ADHD isn't a 'behaviour problem' and many children with ADHD do not exhibit any behavioural difficulties at all. Children with ADHD experience emotions to a much greater degree and are unable regulate them. They might be thought of as 'over-reacting' or 'too sensitive' but this isn't a choice they make; it is a difference in their brain's functioning. Emotional dysregulation can be crippling - it batters self-esteem and fuels the internal negative dialogue: 'Everyone else can do it, why can't I?'

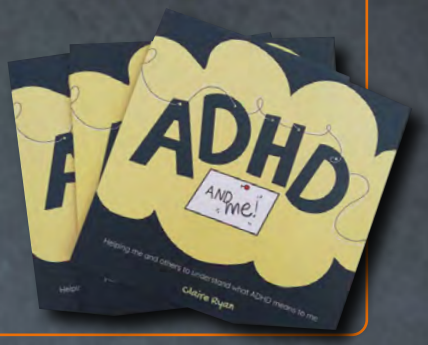
Children (and adults!) with ADHD struggle with the most basic of everyday tasks due to core difficulties with executive functioning and we are often much harder on ourselves than people realise. This means we often don't trust ourselves, but having someone else trust us can really help. Finding creative ways to show that you trust and believe in individuals with ADHD will really help boost their self-esteem, especially during a transition where they might struggle to visualise themselves being successful.

Please challenge what you 'know' about ADHD. For example, inattentiveness and hyperactivity are core features of ADHD, but the ways in which they present and impact a person can manifest in countless ways. No two children are alike just as no two children with ADHD are.

GIVE AWAYS

We are giving away a copy of **'ADHD and ME'** in our **FREE** draw.

Please email office2@speechlink.co.uk to enter.



TIPS FOR TRANSITION

It is common for children with ADHD to have more than one diagnosis and trying to unpick strategies for each diagnosis is not always possible, nor the best place to start. Children with ADHD can become very distressed during transitions, and skills, such as switching and maintaining attention, organisation, planning, reflection and prediction can be difficult to get back on track after a change to routine.

- Assess core executive functioning skills in a variety of situations including working memory (for example the ability to read a text, hold onto the information and use it to answer questions), flexible thinking (finding relationships between two different concepts) and self-control (the ability to ignore distractions and resist temptation e.g. not blurting out an answer in class).Try using countdowns, visuals, reassurance and let them know if expectations will remain the same or change.
- If the child struggles with the transition, try switching from a rules/ consequences approach, to a positive, solution-focused approach using motivation, reward and understanding.
- Try analysing situations in which the child succeeded, and those in which they struggled. Gather information on when and why they needed support as well as when and why they were able to achieve unaided, as it is this information which will provide you with a starting point for your planning.
- Ensure that expectations are achievable and individualised, rather than setting 'typical' expectations. One example might be to break the transition down into small, achievable chunks rather than talking about it as a single, large, complete event. This can really help lower anxiety, improve understanding and help them to feel as if it is something they can manage.

A bit about ChatterPack

ChatterPack creates accessible, effective, practical information, and resources to support children with special educational needs. We share these via our free monthly SEND newsletter and store them on our website for future use. We have also written a book, 'ADHD and Me', a guide to help children figure out what ADHD means to them as a unique individual. **Find out more at ChatterPack.net**

Finally, ADHD is underdiagnosed and under medicated in the UK (REF: https://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(17)30167-0.pdf & NICE Guidance) Early identification and the right support can help to avoid significant mental health problems which can improve long term outcomes. So, please, please seek assessment if you are ever in doubt.

"The **shoeness** of a shoe"

#Flipthenarrative

By Elly Chapple

Most people with learning disabilities have some speech, language and communication difficulties. These can be hidden or overlooked. Everyone needs to know what good communication support 'looks like' and what reasonable adjustments they can expect.

(RCSLT 5 Good Communication Standards, 2013)

Founder of CanDoElla

I often think about how much we have yet to learn about how people communicate differently, and that when you are faced with a child, young person or adult who communicates in a different way to others, we can become entangled in the *'I don't know how to*' or *'I don't have time'*. Yet we learn languages every day in this world – we study them, and we add them to our human skill set - we can communicate with others in different countries. So why would differing modes of communication that don't always rely on words, not require the same level of learning and onus on our part? I wonder if that is driven more from the perspective that it's not quick enough, or the variance is too large. But is it?

Six years ago, my eldest daughter, Ella, lost her vision as her needs had been misunderstood – her stress by this point was extreme. Fundamentally, the fact she was congenitally Deafblind had been missed until she was age seven, and this required a specific way of supporting to understand her communication and development as 95% of her incidental learning was missing. We knew she could learn, but the **how** had not been understood. Ella's primary communication tool being Deafblind, is touch.

Twice a day, Ella would investigate the shoe box by our front door. In it were various items of footwear owned by the whole family. Using touch and persistence, Ella learned that the concept of 'shoe' came in all manner of variations: large, small, lace up and Velcro, high, low, smooth and rough. Ella had to be able to delineate via touch, that all the objects had the same function although they were all different. She persistently did this for nine months until one day, she sat in a chair stuck out her foot and said "boots!" She had mastered the task and embedded her understanding of 'the shoeness of a shoe', which all children do – just in different ways. It put an onus on us, as observers and educators, to learn more about this and widen our understanding of the 'why' and 'how' within learning. It removed the glass ceiling of 'can't learn' and replaced it with 'can learn'. It helped to #flipthenarrative.

What we learned, that developed our understanding of how best to support Ella's communication, was that in the first instance, there is no silver bullet, no one 'programme' we could use that would cater for her very specific needs and style of learning. What we did do was to listen and closely observe Ella. By working on gaining her trust and strengthening our relationship with her, she began to show us more about what she was trying to achieve, and we began to learn how to communicate with her.

Hayley, our wonderful SaLT, was prepared to walk with us, as a partner, in every sense of the word.

Hayley didn't 'tell' us what to do, she actively listened (a lot) to our reflections and questions and what Ella showed her too. Small, human things, but utterly invaluable from a professional working closely with you.

Hayley - Speech and Language Therapist

I have been working with Ella, her family and her team for six years and lots has changed and evolved over these years. In this time Ella has made significant progress with her speech, language and communication skills. When we first met, she was, in essence, non-verbal, using a range of vocalisations, gestures, some signing and her body language to communicate. At times this was unsuccessful for Ella and led to frustration, miscommunications and struggles to cope with everyday situations.

The aim from the start has been to work together with the family to find the most successful way for Ella to communicate. We are well down this path now and Ella can use speech alongside signing to communicate a great many things. She is now joining spoken words together; to comment - "my clothes", to describe - "loud" and to request - "go Laura's car" are just a few examples. Ella is using her signs to spell names and to explore the links between spoken sounds, signs and written letter formations.

Reflecting on the last six years I feel the way we have been able to achieve this hasn't been through focussing on technical strategies, complex alternative/augmentative communication systems or specific interventions but through keeping things simple for example:

- Building relationships with each other and truly listening to Ella so anything we wanted to try or introduce was motivated by Ella
- Ella has always loved stories and songs, so we have focussed on using repetitive lines in stories to build Ella's confidence to expand her spoken words and speech sounds

Now Ella knows everyone is listening and she is in control of her own life, she knows she can express enjoyment, anger, make jokes, be silly, be quiet, say no, ask for something and the people around her will respond regardless of how she conveys that message. This is truly embedded total communication.

As a speech and language therapist working so closely with the family the advice I would give would be to:

- Focus on building relationships first and foremost (this has really been key to Ella's success)
- Ensure that everyone working with the young person understands how the development of communication is progressing and what is working so they have the confidence and skills to continue this
- Repeating the child's vocalisations in play to show you're listening
- Offer a photo choice board so a child can point to an image to help them communicate what they mean
- Have regular discussions with other staff to share what is going well
- Build on spoken words or encourage specific speech sounds within daily activities so it's motivational and truly embedded, e.g. getting dressed, making breakfast, on car journeys
- Understand that it's OK to stop when something isn't going well
- Using a total communication approach means all forms of communication are given meaning, are valued and responded to at all times which is key to progress regardless of which specific strategy you're using

Focussing on relationships both with Ella and with each other really has been the key to the success we've seen and the success we know we'll continue to see in Ella's future.

> "Relationships count for a huge amount of the success – between us and Ella, and the professionals supporting us – we work together, we communicate, and we question and re-question – so that we can be the best possible support."
>
> Elly

How can oral health affect speech, language and hearing?

Written By Katie Dullaghan, Director of Happy Teeth Oral Health Educator

Children's teeth in the UK are in crisis.

Britain's tooth decay epidemic statistics show that 23.3% of 5-year olds have tooth decay with an average of 3.4 teeth that are either missing or filled.

NHS data shows that more than 160000 children starting primary school already have tooth decay, with sugar being blamed for creating an oral health crisis.

Hospital teeth removals take place when a patient requires general anaesthetic, which cannot be given by a dentist and the NHS has spent £165 million on such treatment since 2012. This represents a crisis in dental health, brought on by excessive sugar intake among young people.

The link between oral health and speech and hearing.

Poor oral health causes unnecessary pain and suffering to the child, absence from school and the cost to the NHS is in the millions, but have we thought about how those missing teeth will affect speech development during this crucial window?

Teeth are for more than just chewing. They also play a big part in speech development and as their health can also impact on our hearing and wider communication skills.

While talking comes naturally to many of us, we sometimes forget how complex speech actually is. Humans typically learn how to talk by listening to and imitating those around them. This process involves a number of physical and neurological structures that work together to produce words, including the lips, the tongue, the jaw, the vocal cords and the teeth. When any of these important structures are not functioning properly, people may develop speech difficulties.

Teeth help us to produce all kinds of sounds, including "f" in 'facts', "v" in 'van', "s" in 'summer', "z" in 'zebra' the "ch" in 'china', the "sh" sound in 'shoe', and the "th" in 'thirst' or 'that'. Think about all the words that use these sounds and imagine how missing or misaligned teeth might make speaking more challenging.

Having a tooth removed not only leaves a hole in the smile, it also affects speech. Losing a baby tooth early is especially detrimental since this can negatively affect the child at a critical time of speech development. It's common for a child with a missing tooth to develop a speech difficulty which may require help from a speech and language therapist later.

Tooth decay is caused by pathogenic bacteria. These can enter the bloodstream and threaten a person's overall health. Because of the ear's proximity to the mouth, harmful bacteria that originate in the mouth can also inflame and narrow in the blood vessels located in the ears and brain, which are crucial to hearing health. Hearing impairments, temporary or permanent, can also impact on speech and language development in children.

What can we do?

Dental decay is 100% preventable.

The Relationships, Education, Relationships and Sex Education and Health Education guidance from the Department of Education (published in 2019) states that "pupils should know about dental health and the benefits of good oral hygiene and dental flossing, including regular check-ups at the dentist." This is something that may be inspected by Ofsted as part of the education inspection framework. We should work towards promoting good practice amongst both dentistry and education professionals, so that we can support schools and families to deliver appropriate early support. By tackling oral health in early childhood, we can have a positive impact on overall health and wellbeing, as well as mitigating the impact of poor oral health on speech, language and communication difficulties.

So how can we make a change?

George and The Happy Tooth is an initiative designed to improve the oral and general health of children in the UK. Its colourful and fun design, with age appropriate characters, encourages a love of the book and associated resources. At Happy Teeth we believe that really simple messages are the key to effective oral health prevention education for children.

5 KEY MESSAGES THAT WE CAN TAKE AWAY FROM GEORGE AND THE HAPPY TOOTH.

1. Brush teeth BEFORE breakfast to remove bacteria and plaque that sugar sticks to.
2. Use fluoride toothpaste with at least 1400ppm fluoride. Don't rinse - leave the fluoride to work on the teeth to help strengthen enamel and prevent decay.
3. Keep sugary snacks to mealtimes. Instead, choose healthy snacks including apples, carrots, or cheese in between meals.
4. Drink water or milk throughout the day - sugary drinks wash over the teeth, creating a sugar attack with each sip.
5. Try one of the experiments in the George and the Happy Teeth Book.
6. Visit your dentist at least every 6 months to make sure that teeth are happy and healthy.

IF YOU WOULD LIKE TO FIND OUT MORE ABOUT WHAT WE DO AT HAPPY TEETH GO TO
https://www.happyteetheducation.com/
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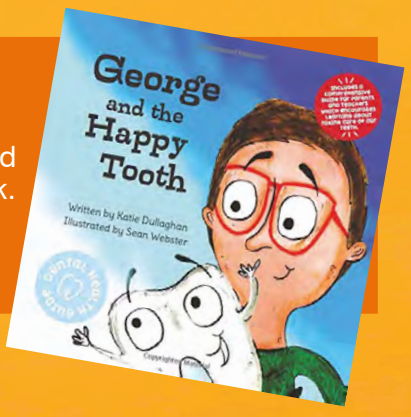
GIVEAWAYS

Happy Teeth are giving away a FREE George and The Happy Tooth Book and Chart bundle to the readers of The Link. Email office2@speechlink.co.uk to enter.



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*A start up cost of £150+VAT is applicable in the first year for each package

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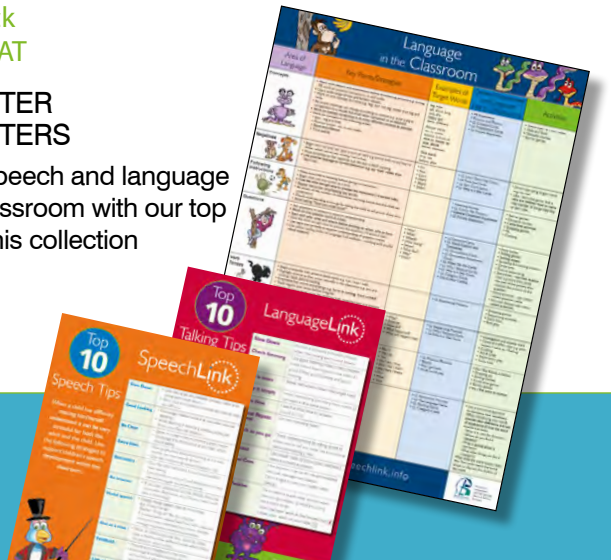

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