Late Talkers

Why the Wait-and-See Approach Is Outdated

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KEYWORDS

• Late talkers • Wait-and-see • Early intervention • Toddlers • Language disorder
• Specific language impairment • Parent-implemented intervention • Late bloomers

KEY POINTS

- A wait-and-see approach delays referral of a child for further developmental evaluation when s/he fails a language screening in toddlerhood.
- The view that most late talkers "catch up" seems to be outdated because they do not necessarily meet their same-age peers in all aspects of development.
- Late talking can also impact early socialization and school readiness, and can place some late talkers at risk for life-long disability.
- Interprofessional education and practice supports early referral for late talkers who are at-risk.
- Advances in the science of brain development, language development and disorders, and epigenetics support early identification and intervention, not a wait-and-see approach for late talkers.

INTRODUCTION

A wait-and-see approach with late talking toddlers—that is, not referring a late talker (LT) who fails a language screening for evaluation—can occur for a number of reasons. For example, a lack of knowledge in bilingual development has led nurses to delay referrals.[1,2] Nurses have reported lack of training in screening procedures as well as in bilingual development as primary problems in following through on referring LTs for further evaluation. **Box 1** reports related issues and suggestions for serving bilingual toddlers. From a speech-language pathologist's perspective, there is a gap between what is known about LTs and their outcomes when deciding on referral of a child for

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Box 1
The unique circumstance of screening bilingual children

Bilingualism raises unique challenges for professionals without interprofessional practice training to screen children under 3 years of age for potential language delay.[1,2] Challenges include:
- The linguistic variations between the child's languages themselves
- The variations of timing each language introduction
- Cultural mismatch between screener or evaluators and the child/family

Professionals may feel underprepared in the knowledge of bilingual development and in the skill of screening procedures. Lack of training can result in:
- Using the screener's primary language rather than the child's language as the screening language
- Altering the screening procedure
- A misconception that bilingual children need more time to learn 2 languages

The consequences of these actions are:
- Invalidation of screening results,
- Delay to refer the child for further evaluation, or
- To overrepresent children of individual cultural backgrounds in evaluation/treatment

The American Speech-Language-Hearing Association's position when differentiating between LANGUAGE DISORDER and a language difference[3]:
- Communication disorders will be evident in all languages used by an individual
- Account for the process of (dual) language development, proficiency, and dominance
- Fluctuation

In addition to parents, consider working alongside other caregivers, siblings, or cousins who are familiar with the child, and his or her culture and language. Discuss the processes of screening/referral for evaluation within the family's cultural framework. In some cultures, an individual's development may not take precedence over behaviors that contribute to the family unit.

Concepts to understand:
- Simultaneous bilingual—before 3 years of age, the child acquires 2 languages at the same time
- Sequential bilingual—before 3 years of age, the child learns a primary language, and after 3 years of age, the child learns a second language
- Proficiency—the degree to which the child can speak and/or comprehend with native-like competence
- Code switching— the child changes languages between phrases or sentences that is considered typical in bilingual development

further evaluation. The American Speech-Language-Hearing Association (ASHA) has implemented a 10-year plan to advance interprofessional education and interprofessional education practice (IPP) as part of its *Strategic Pathway to Excellence* (http://www.asha.org/uploadedFiles/ASHA-Strategic-Pathway-to-Excellence.pdf).

The aim here is to bridge some of the interprofessional education and IPP gap with what is known about LTs and their long-term outcomes so that alternatives to the wait-and-see approach will be considered. One alternative to the wait-and-see approach is to refer an LT to a state's early intervention program. IPP is well-established in the early intervention system under Part C of the Individuals with Disabilities Education Act[4] (**Box 2**). Over the short or long-term, at least 2 professionals will collaborate in service of a LT, at any given time. The following professions may be involved in managing the child's health care, overall development, and education:

- Audiology
- Medicine (eg, pediatrician, pediatric otolaryngologist)