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Childhood Apraxia of Speech (CAS), "Appropriate Treatment" and Some Interesting Questions

Over the past few months, many families and speech pathologists have reported hearing statements such as:

- "Children should try other treatments first."
- "Kids need time to be kids."
- "School should come before therapy."
- "Children need therapeutic breaks."
- "There needs to be more balance."

At the same time, discussions about Childhood Apraxia of Speech (CAS) and NDIS eligibility increasingly appear to reference concepts such as permanency, appropriate treatment, participation and early intervention.

With that in mind, here are a few observations, facts and resources that may be worth considering.

CAS is described as a lifelong condition

The University of Sydney Childhood Apraxia of Speech Evidence Brief describes CAS as:

"a severe, permanent and lifelong neurodevelopmental disorder of speech motor programming and planning which is present from birth and does not naturally resolve."

Interestingly, the same evidence brief also discusses evidence-based intervention, treatment efficacy and improved outcomes following therapy.

This creates an important distinction:

The existence of effective therapy does not necessarily mean a condition is temporary.

Further Reading

- University_of_Sydney_Childhood_Apraxia_of_Speech_Evidence_Brief
- ASHA_Childhood_Apraxia_of_Speech_Practice_Portal

What does "appropriate treatment" actually mean?

The University of Sydney Evidence Brief identifies the following evidence-based interventions for CAS:

- Dynamic Temporal and Tactile Cueing (DTTC)
- Rapid Syllable Transition Treatment (ReST)
- Nuffield Dyspraxia Programme (NDP3)

The same document reports that effective treatment typically requires **2-6 sessions per week**, that greater treatment intensity is associated with greater effectiveness, and that studies examining once-weekly therapy have found it to be ineffective.

This raises an interesting question:

When legislation refers to "appropriate treatment", does it mean:

- any treatment that is available?

or

- treatment that is considered appropriate for the specific condition?

Group programs and individual therapy are not the same thing

Group programs can be highly beneficial.

They may support:

- social connection
- friendship development

- confidence building
- community participation
- life skills
- school readiness

For many children, these supports can be extremely valuable.

At the same time, evidence summaries discussing moderate-to-severe CAS consistently refer to intensive, individualised motor-speech intervention.

The University of Sydney Evidence Brief also states:

"There is no evidence for any group treatment being trialed in any level of research with anyone with CAS since 1960. Group treatment is not recommended for any CAS feature."

Both of the following statements can therefore be true:

- Group programs may be highly beneficial for many children.
- Children with moderate-to-severe CAS may require intensive, individualised motor-speech intervention.

The question is not whether group programs are valuable.

The question is whether they are the most appropriate intervention for a child with a motor speech disorder.

"Kids need time to be kids"

Most people would agree that children need:

✅ Play

✅ Family time

✅ Friendships

✅ Recreation

✅ School

✅ Community participation

However, it may be helpful to consider what Australia's own early intervention framework says.

The National Best Practice Framework for Early Childhood Intervention emphasises:

- early identification
- evidence-informed supports
- family-centred practice
- individualised supports
- meaningful participation
- specialist intervention when required
- shared decision-making

Further Reading

- National_Best_Practice_Framework_for_Early_Childhood_Intervention

What some readers may find interesting is that the Framework strongly emphasises tailoring supports to the child and family.

Some readers may wish to independently review whether the Framework contains recommendations that:

- therapy should automatically reduce when children start school
- children require predetermined therapy-free periods
- school attendance automatically takes priority over clinically indicated intervention
- intensive intervention should not occur when clinically indicated

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Participation and therapy may not be opposites

For children with severe CAS, communication can influence:

- education
- friendships
- literacy
- emotional wellbeing
- independence
- safety
- community participation

For some children:

Therapy is not separate from participation.

Therapy may be one of the ways participation becomes possible.

One final thought

Many current discussions appear to focus on the question:

"Has every treatment been tried?"

Perhaps an equally important question is:

"Has the child had timely access to the intervention most likely to improve outcomes according to the available evidence?"

Readers can draw their own conclusions.

Useful Resources

- University_of_Sydney_Childhood_Apraxia_of_Speech_Evidence_Brief
- National_Best_Practice_Framework_for_Early_Childhood_Intervention
- Apraxia_Kids_–_Frequent_&_Intensive_Speech_Therapy
- ASHA_Childhood_Apraxia_of_Speech_Practice_Portal