**Care Pathway encompassing Local Guidelines for**

**Children with a Developmental Language Disorder (DLD)**

(previously referred to as Specific Language Impairment SLI)[[1]](#footnote-1)

The care pathway outlined below is designed for any child referred to the Speech and Language Therapy Service who subsequently presents with a Developmental Language Disorder (DLD).

For children with a number of high risk factors, DLD can be diagnosed before the age of 5 years. For those at low risk, it is recommended that a DLD diagnosis is not given until 5 years. Therefore this care pathway should be read alongside and in combination with the care pathway for Developmental Speech and Language Delay.

Risk factors associated with poor prognosis include: positive family history of language difficulties, poverty, low level of parental education, pre/perinatal problems, and being male.

These children will present with

A. Persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production that include the following:

1. Reduced vocabulary (word knowledge and use).

2. Limited sentence structure (ability to put words and word endings together to form sentences based on the rules of grammar and morphology).

3, Impairments in discourse (ability to use vocabulary and connect sentences to explain or describe a topic or series of events or have a conversation).

B. Language abilities are substantially and quantifiably below those expected for age, resulting in functional limitations in effective communication, social participation, academic achievement, or occupational performance, individually or in any combination.

C. Onset of symptoms is in the early developmental period.

Developmental Language Disorder (DLD) is used for children whose language disorder does not occur with another biomedical condition, such as a genetic syndrome, a sensorineural hearing loss, neurological disease, Autism Spectrum Disorder and are not better explained by intellectual impairment of global developmental delay.(DSM-V, 2013)[[2]](#footnote-2)

1. **Referral**

As with other client groups, referrals for children with suspected developmental language disorder (DLD) should come via a health professional for preschool children, or, for school age children, via an EHA/EHFSA form.

1. **Referral accepted**

Referrals received are screened by a senior Paediatric Therapist using the information on the referral form. The Care Aims model Section 1 form is used to prioritise referrals. Accepted referrals are allocated to either a triage appointment or an assessment appointment, depending on the level of risk indicated by information on the referral.

Accepted referrals will be seen by a community clinic therapist in the first instance. These children are rarely identified before the age of 3 years, and so most often children will transfer onto this care pathway from the Developmental Speech and Language Delay Care Pathway.

1. **Diagnostic assessment**

Children are seen for assessment in a clinic environment or via a video link, via observation, parental report, informal and formal assessment as deemed appropriate by the assessing therapist. Preference should be given to face to face assessment where possible, and where health and safety guidance allows, in order to gain the most robust information. A case history is completed during the initial assessment process, using the questionnaire on SystmOne.

Given what is known of the impact of Developmental Language Disorder on all areas of school life, once it is being considered, additional diagnostic information should be gathered from the pre-school/school environment. This should be carried out through observation and/or discussion with staff.

The purpose of the initial assessment is to gather information about the nature and severity of the child’s speech and language difficulties and how these impact upon their functional communication. It is also relevant to seek information on the child’s general developmental profile, and non-verbal IQ skills.

As DLD is not a homogenous disorder, assessment may involve all of the subcomponents of language including:

* Receptive language
	+ Expressive language
	+ Word-finding/Vocabulary
	+ Speech/phonology
	+ Pragmatics
	+ Attention and listening
	+ Auditory memory

In order to do this, a wide range of formal assessment procedures will be considered, bearing in mind the child’s cognitive, physical and perceptual abilities. A combination of formal and informal procedures will be used.

The therapist will ascertain whether any previous therapy has been accessed, and the outcome of any such intervention. Parental expectations for therapy will be discussed and motivation for change will be considered.

Following the diagnostic assessment, the child / parents / carers will be given information about management options if assessment findings indicate the individual will benefit from Speech and Language Therapy intervention.

Those children who do not need the intervention of the Speech and Language Therapist to continue to develop communication skills will be discharged from the service at this point. For example, children who have a communication difficulty but for whom input may have no real benefit or effect on their skills and/or rate of progress will be discharged.

At this point in the pathway, the local clinician may seek the advice of the specialist therapist, via a supervision discussion or second opinion if indicated, or may continue to manage the case at a local clinic level. Opinion of the specialist therapist can also be sought later in the pathway if required.

1. **Intervention episodes**

Information from the diagnostic assessment is used to guide an informed decision about the level of clinical risk each individual child has at that time. Children may be offered indirect or direct treatment at any time based on their level of clinical risk and need, and the therapist’s informed decision about which intervention strategy is most appropriate at that time. Different direct treatment options are available, and are outlined on the care pathway flow chart. A therapist may work alongside colleagues in Health and Education Services when working with this client group.

Due to the recognised ongoing and pervasive impact of DLD on learning and all areas of the National Curriculum, the preferred option is to integrate therapy targets into the curriculum through collaborative practice with educational staff. [[3]](#footnote-3)

1. **Management commenced with goal negotiation**

Management is guided by assessment findings. Any intervention begins with an agreement of long and short- term goals for each episode of care. All goal setting is agreed with the individuals involved in therapy. The Malcolmess Care Aims model is followed. It is likely that intervention will aim to develop the child’s language abilities to their maximum potential, and teach strategies to the child and those around the child to minimise the impact of their difficulties on their interactions and educational success.

* 1. Indirect

The therapist may make an informed decision that an individual’s case is most appropriately managed by offering indirect therapy. This may involve advising the child or parents / carers of strategies to implement in the home setting with monitoring at individually agreed intervals by the therapist; or implementing indirect intervention strategies at school / nursery, by verbal or written liaison with education colleagues.

This management may be overseen by the client’s local therapist or by the specialist therapist for DLD.

* 1. Direct

Direct therapy may involve 1:1, group or pair work in the clinic or the educational setting, at intervals agreed between the therapist and child and parents/carers. Different therapy approaches are used as judged most appropriate for the individual, based on assessment findings and discussion with the child and / or parents/ carers.

Therapists have responsibility to ensure intervention is evidence-based.

It is likely that a period of direct intervention will be for up to 20 sessions in a 12 week period, followed by a consolidation period of up to 8 weeks before the individual’s status and clinical risk is reviewed. This management may be overseen by the client’s local therapist or by the specialist therapist for DLD.

1. **Reassessment**

Following an episode of care the individual’s needs are reassessed. If there is an ongoing clinical risk they may re-enter the care pathway for a further episode of care.

Children who transition into Fairways Speech and Language Resource Base (a specialist unit for children with Developmental Speech and Language Disorders) will be on the caseload of the Specialist Therapist for DLD.

1. **Discharge**

Local discharge procedure is followed when aims of intervention are achieved; no further difficulties present; discharge is requested by the patient (this may be implied through non-attendance) or it is agreed that an individual is able to self-manage their own communication needs. Additionally, a child may be discharged at assessment if it is felt they do not present with communication difficulties and Speech and Language Therapy will not be of benefit to them.

1. **Referral for specialist assessment outside Trust**

Where it is felt that a more specialist opinion is required than can be offered locally, a child may be referred for assessment at a Specialist Centre at any point in the pathway. This may, for example, involve a referral to the Nuffield Hearing and Speech Centre at the Royal National Throat, Nose and Ear Hospital.

**At any point in the pathway, referral may be instigated to other relevant agencies to support needs which go beyond the scope of Speech and Language Therapy, e.g. the Local Authority for Education**

Referral (i)

Liaison with educational setting

Discharge (vii)

Referral tertiary specialist centres where appropriate (viii)

Evidence based 1:1, group or pair work in the clinic or the educational setting for up to 20 sessions in a 12 week period with a period of consolidation. consolidation.

**Direct** (vb)

Strategies to introduce at home and monitoring

**Indirect** (va)

Reassessment (vi)

Management commenced with goal negotiation (v)

Further assessment carried out if appropriate

Local specialist therapist

Local therapist

Intervention Episodes RISK BASED (iv)

Advice sought from local specialist

Diagnostic Assessment (iii)

Local community therapist

Community Clinic setting (local clinic)

Group Triage

Referral accepted (ii)

**References**

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1. Bishop, D.V., Snowling, M.J, Thompson, P.A., Greenhalgh, T. The CATALISE consortium. (2016) CATALISE: a multinational and multidisciplinary Delphi consensus study. Identifying language impairments in children. PLOS One, 11(7), <http://dx.doi.org/10.1371/journal.pone.0158753> [↑](#footnote-ref-1)
2. American Psychaitric Association (2013) Diagnostic and statistical manual of mental disorders (5th Ed.). Arlington, VA: American Psychiatric Publishing [↑](#footnote-ref-2)
3. Clinical Guidelines:School-Aged Children with Speech, Language and Communication Difficulties (2005) RCSLT [↑](#footnote-ref-3)