

**Care Pathway encompassing Local Guidelines for
Children with a Severe and Specific Speech and Language Impairment
(SSLI)**

The care pathway outlined below is designed for any child referred to the Speech and Language Therapy Service who subsequently presents with a severe and specific speech and language impairment. (SSLI). These children are rarely identified before the age of 3 years, and so most often children will transfer onto this care pathway. Therefore this care pathway should be read alongside and in combination with the care pathway for Developmental Speech and Language Impairment.

By definition, these children will present with persistent deficits in comprehension or production of language or speech sound production substantially below age level, beginning in the early developmental period, and not due to other disorders or conditions. (DSM-5, 2013)

One or more of the following will also be seen: a close positive family history of specific difficulty in language development, evidence of cerebral dysfunction (rare), a mismatch between the subsystems of language in relation to other aspects of cognitive development, and a failure to catch these differences up with 'generalised' language help. (CQ 3, RCSLT)

SSLI can affect all areas of learning and access to all areas of the National Curriculum, and these children are more vulnerable to social and behavioural problems, which increase over time (Redmond and Rice, 1998)

- (i) **Referral**
As with other client groups, referrals for children with suspected severe and specific speech and language impairment should come via a health professional for preschool children, or, for school age children, via a CAF or EHA form.
- (ii) **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 group 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.
- (iii) **Diagnostic assessment**
The initial assessment will usually be completed in a clinic environment, via observation, parental report, informal and formal assessment as deemed appropriate by the assessing

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therapist. A case history is completed during the initial assessment process, using the Paediatric Service questionnaire on SystemOne

Given the known impact of SSLI on all areas of school life, once SSLI is being considered, additional diagnostic information should be gathered from the pre-school/school environment. This should be carried out through observation and 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, in order to ascertain any discrepancy between verbal and non-verbal skills. *This discrepancy is frequently quoted as a characteristic of SSLI.*

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

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

In order to do this, formal assessment may include the Reynell Developmental Language Scales (RDLS), Test of Reception of Grammar (TROG), Clinical Evaluation of Language Fundamentals (CELF), Assessment of Comprehension and Expression (ACE) and the Nuffield Dyspraxia Assessment.

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.

(iv) **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 SSLI on learning and all areas of the National Curriculum, the preferred option is to integrate therapy targets into the curriculum through collaborative practice.

(v) **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 maximise the child's communicative potential, and minimise the impact of the specific language impairment on their interactions and educational success.

a) 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 SSLI.

b) 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.

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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 SSLI.

(vi) **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 Specific Language Impairment) will be on the caseload of the Specialist Therapist for SSLI.

(vii) **Discharge**

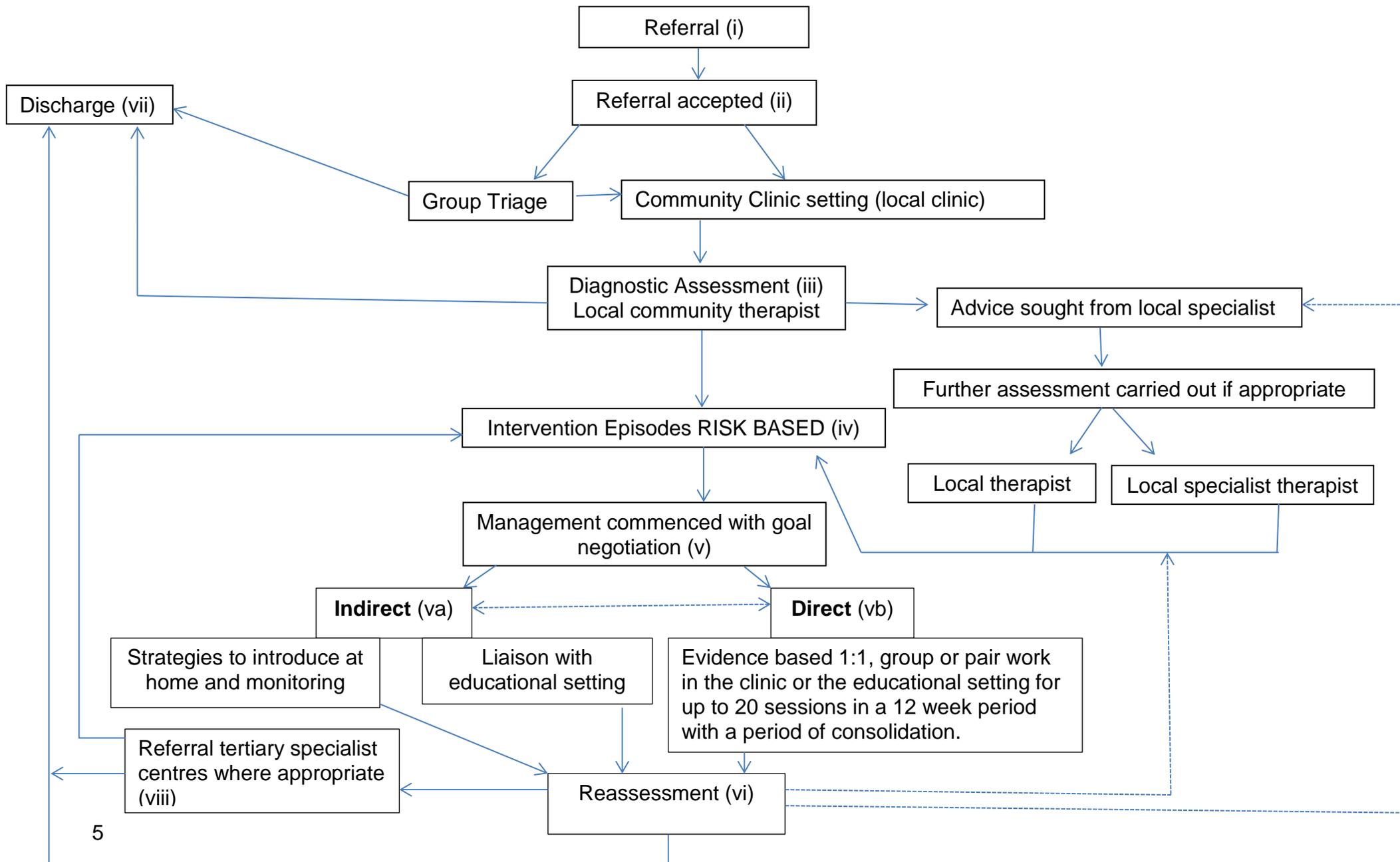
Local discharge procedure is followed when aims of intervention are achieved; no further difficulties present; discharge is requested by the patient (this may be implied through non-attendance) or it is agreed that an individual is able to self-manage their own communication needs. Additionally, a child 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.

(viii) **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

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References

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Redmond, S.M. & Rice M.L. (1998) The socio-emotional behaviours of children with Speech and Language Impairment: Social adaption or social deviance? *Journal of Speech, Language and Hearing Research*, 41, 688-700

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