The current evidence base for intervention for Developmental Language Disorder (DLD)

Dr Susan Ebbels
@SusanEbbels @MHResTrain

Moor House Research and Training Institute;
Department of Language and Cognition, UCL.

With many thanks to: Elspeth McCartney, Vicky Slonims,
Julie Dockrell and Courtenay Norbury
Only 15% parents said speech and language therapy was available in their area as required.

Support planned and funded based on the available resources, rather than what is needed.

Services rationed based on arbitrary factors rather than evidence of what works.

52% of parents said their family's experience of speech, language and communication support was poor.
Aims of this talk

• Document the evidence re what is needed for SLT services to be effective

• So we can all contribute to the effort for better, evidence-based services

Ebbels et al. (in press) *Evidence based pathways to intervention for children with Language Disorders*. International Journal of Language and Communication Disorders
Main messages

1. Communication is a human right and children with difficulties have a right to support
2. Ineffective services benefit no-one
3. Sufficient intervention needs to be provided to have a positive impact
4. Those delivering the intervention need sufficient training, coaching and support
5. Need to consider who benefits from each intervention (and who doesn’t)
6. Children at highest risk of long-term difficulties should be prioritised (not those most likely to be ‘cured’ and discharged)
Terminology for intervention

**Education**
- Tiers/Waves/Levels for different children
  - **Tier 1** = all children
  - **Tier 2** = children just below age expectations
  - **Tier 3** = children with identified SLCN

**SLT services**
- Universal / targeted/ specialist services
  - **Universal** = training or awareness raising programmes to improve
    - Identification of SLCN
    - Adults’ practice
  - **Targeted** = indirect intervention
  - **Specialist** = direct individualised intervention
Children with identified Language Disorder

COMPLEXITY & SEVERITY

Children just below age expectations

Poor response to intervention

Intervention

All children

High quality teaching for all

Education-led groups following language programmes

Indirect SLT-led intervention

Direct SLT-led intervention

Individualised intervention

Education tiers

Tier 1

Targeted selective

Universal

Tier 2

Targeted indicated

Tier 3

Tier 3A

Tier 3B

SLT services

Specialist
Intervention

All children

Children

Education tier

Tier 1

High quality teaching for all
Colour-coding system for evidence

• Dark green – strong evidence is effective (RCT)

• Light green – weaker evidence is effective (some experimental control, not RCT)

• Orange – no reliable evidence re (in)effectiveness
  – Evidence insufficient or too weak to draw conclusions

• Red – strong evidence is NOT effective
Tier 1: Whole class teaching using programmes for “at risk” children

• Large scale randomised control trials in the US show improved vocabulary knowledge in “at risk” pre-school & primary-aged children (Neuman et al., 2011; Vadasz et al., 2015; Apthorp et al., 2012)

• Another US study found improved grammar and vocabulary (Justice et al., 2010)

• Danish study (Bleses et al., in press)
  – Significant effect on pre-literacy skills
  – No effect on language skills
  – BUT, only 25/40 planned sessions actually provided
  – Gains correlated with number of sessions provided…!!
Tier 1: training for education staff
Meta-analysis by Markussen-Brown et al., (2017)

• Effects of teacher CPD
  – Large effects on physical classroom space
  – Small-medium effects on children’s PA and alphabet knowledge
  – Medium effect on adult-child interaction
    • BUT, improvements in child outcomes not mediated by improvements in adult-child interaction
  – Small (non-sig) effect on children’s vocab
Tier 1: training for education staff
Meta-analysis by Markussen-Brown et al., (2017)

- Features of CPD associated with improved educator outcomes
  - Better outcomes for CPD which was longer and more intense
    - Average amount in studies was 50-60 hours
  - Courses alone had no sig effects,
  - Courses + coaching had significantly larger effects
  - Most important factor was whether training included more than one component
Sufficient intervention, training and feedback

<table>
<thead>
<tr>
<th>Study</th>
<th>not effective</th>
<th>effective</th>
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<tbody>
<tr>
<td>Bleses et al., in press</td>
<td></td>
<td>Studies in Markussen-Brown et al., 2017</td>
</tr>
<tr>
<td>intervention</td>
<td>25 sessions (of planned 40)</td>
<td>Approx 50-60 hours</td>
</tr>
<tr>
<td>training for trainer</td>
<td>14 hours (28 hours for 1/3 of group)</td>
<td>very important component</td>
</tr>
<tr>
<td>coaching for trainer</td>
<td>not mentioned</td>
<td></td>
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</table>
Tier 1 interventions for parents
(results from meta-analyses)

• Parenting education programmes (Grindal et al., 2016)
  – Show little beneficial effect unless parents given opportunity to practise new skills.
  – Adding coaching and feedback led to larger effects

• Emergent literacy interventions (Mol et al., 2008; Manz et al., 2010) and vocabulary interventions (Marulis & Neuman, 2013) delivered by parents
  – Generally effective
  – BUT, less effective for “at risk” children
Hardly any studies consider children with Language Disorder specifically.
Functional impact

LD

low average

high average

above average
Evidence for *SLT specific roles at Tier 1*

Possible roles for SLTs:

1. Health promotion via training/coaching for parents and education staff re
   a) Identification of Language Disorder
   b) Changing practice and interactions with children to improve children’s language and/or access to curriculum and social participation

2. Working collaboratively with parents and education staff (often in relation to specific children, therefore across all tiers)
Pre-school children

• >50% of SLTs work at Tier 1 with children aged 0-2 years (Law and Pagnamenta, 2017)

• For children aged 0–3 years, a range of family-focused primary prevention practice is being delivered by SLTs (Smith et al., 2017)

• However, “Quality of evaluations is low” and “Lack of quality in study design results in inability to draw any conclusions re effectiveness of SLT in health promotion services for early language delay” (Smith et al., 2017)
School-aged children

• Primary
  – Language and literacy skills improved after 6 days teacher training and follow up support (Snow et al., 2014)
  – No effect on language or reading comprehension following Talk of the Town (which included training, observation and support for staff in identifying and providing intervention for children with SLCN) (Thurston et al., 2016)

• Secondary
  – Improved writing and listening, but not reading or speaking following 8 hours training, plus observation and coaching for teachers (Starling et al., 2012)
Summary of evidence for Tier 1

- Teachers using published programmes (with training) can improve oral language of (at risk) school children in their classes

- **50-60 hours** training for education staff plus 1:1 follow-up support and/or coaching improves average abilities of populations of (at risk) pre-school and primary aged children

- Parent programmes are more effective when
  - they include coaching and opportunities to practise, and
  - children are at lower risk

- Very little evidence that these approaches improve language, communication, participation or well-being of pre-school or primary school children with language difficulties

- >8hrs training by SLTs + lesson observations & feedback may improve some aspects of language in secondary aged children with DLD
Thoughts and questions re Tier 1

- Training / coaching / feedback for all teachers and parents may improve language development of all children
- However, this is a huge time commitment
  - Who pays for this?
  - Who delivers this?
- Do all children benefit, or just those at lower risk?
Children

Education tier

Intervention

SLT roles

All children

Tier 1

High quality teaching for all

Work collaboratively with & provide training/coaching for others

Influence public awareness and policies and recommend evidence-based programmes
Working with education staff

- All children
  - Children with identified language disorder
  - At risk children
    - Children just below age expectations

Intervention

- DLD (5 years)
  - Hadley et al. (2000) - vocabulary
  - Gillam (2014) – narrative & vocabulary

- Grade 1 classes
  - Smith-Lock et al., (2013 a, b) - grammar

- Kindergarten classes
  - DLD (5 years)

- Kindergarten to grade 3
  - Other children

- Working collaboratively with & provide training for others
Aim of intervention?

Functional impact

LD average high average above average
Aim of intervention?

Functional impact

LD  low average  high average  above average
Aim of collaborative work in the classroom?
Aim of collaborative work in the classroom?
Tier 1: Led by education
Tier 1: Led by education

High quality teaching

School monitor progress

Good progress?

yes

no
High quality teaching

School monitor progress

Tier 1: Led by education

Good progress?

“Red flags” and risk factors:

High risk?

yes

SLT Assessment

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“Red flags” and “risk factors”

- **Red flags** = if child has these they should be assessed by an SLT and may need intervention
- **Risk factors** = indicate increased risk of long-term difficulties, but
  - risk factors do not predict difficulties at an individual level
  - a child with language difficulties (but no “red flags”) may not (yet) need SLT assessment, but education support and “watchful waiting”
  - more risk factors indicate more likelihood of long-term needs, therefore closer monitoring needed
“Red flags” in pre-schoolers

From Visser-Bochane et al. (2017) & Bishop et al. (2016)

• **1 to 2 years**: no babbling, not responding to speech and/or sounds, no interaction;

• **2-3 years**: minimal interaction, no display of intention to communicate, no words, minimal reaction to spoken language, regression or stalling of language development;

• **3-4 years**: at most two-word utterances, child does not understand simple commands, close relatives cannot understand much of child’s speech.
Risk factors for persisting language difficulties

- **School-age** (Conti-Ramsden et al., 2009, Stothard et al., 1998, Tomblin et al., 2003)
- **Family history of language or literacy difficulties** (Zambrana et al., 2014)
- **Lower non-verbal IQ** (Bishop and Edmundson, 1987, Eadie et al., 2014, Tomblin et al., 2003; Oliver et al., 2004)
- **Neurodevelopmental disorder, e.g., Down syndrome, ASD** (Pickles et al., 2014)
- **Male** (Zambrana et al., 2014; Rudolph, 2017)
- **Socioeconomic status** (Fisher, 2017) & maternal education (Rudolph, 2017)
- **Multiple risk factors** (Zambrana et al., 2014)
"Red flags" and risk factors:
• Severity/pervasiveness
• Family history
• Age
• Neurodevelopmental disorder

High risk?

yes → SLT Assessment

Tier 1: Led by education

Quality first teaching

School monitor progress

Good progress?

yes

no → High risk?

yes → SLT Assessment

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“Red flags” and risk factors:
• Severity/pervasiveness
• Family history
• Age
• Neurodevelopmental disorder
High risk?

Teacher / parent concern

Good progress?

School monitor progress

Quality first teaching

Tier 1: Led by education

yes

yes

SLT Assessment

no

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Teacher / parent concern

Tier 2: Led by education

"Red flags" & risk factors:
• Severity/pervasiveness
• Family history
• Age
• Neurodevelopmental disorder

Small group work

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Intervention

Children just below age expectations

Education–led groups following language programmes

Children

Education tiers

SLT services

Tier 2
Education-led language programmes primary aged children

• Improve expressive language, narrative and vocabulary (Bowyer-Crane et al., 2008; 2011; Fricke et al., 2013; Lee & Pring 2016; Lonigan & Phillips, 2016)
  – in primary school-aged children with weak language
  – delivered at least 3x30 mins per week in small groups, 2-4 children (often plus 2x30mins 1:1 sessions), >15 hours
  – by very well-trained (>20 hours) and regularly supported teachers or TAs
  – improved language and vocabulary can lead directly to improved reading comprehension (Clarke et al., 2010)

• Do not appear to improve listening comprehension

• Effect sizes smaller when rolled out (?training quality/quantity)
Education-led language programmes pre-schoolers and secondary

• Effectiveness of NELI more limited in pre-schoolers
  • taught only in groups, with no 1:1 element (Fricke et al., 2013).
  • Only vocabulary improved more than for controls, not other areas of language (Haley et al., 2017)
  • due to age or due to lack of 1:1 element or reduced total intervention?

– No published evidence with secondary aged children
## Sufficient intervention, training and feedback

<table>
<thead>
<tr>
<th></th>
<th>not effective</th>
<th>effective</th>
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<tbody>
<tr>
<td><strong>Fricke et al., 2013</strong></td>
<td>nursery</td>
<td>reception</td>
</tr>
<tr>
<td>amount intervention</td>
<td>7.5 hours in group</td>
<td>30 hours in group + 10 hours</td>
</tr>
<tr>
<td>Training, support and</td>
<td></td>
<td>2 days training, fortnightly supervision and</td>
</tr>
<tr>
<td>monitoring for trainer</td>
<td></td>
<td>5 sessions of coaching / feedback</td>
</tr>
<tr>
<td><strong>Lonigan and Philips 2016</strong></td>
<td>Study 1</td>
<td>Study 2</td>
</tr>
<tr>
<td>amount intervention</td>
<td>15 hours in groups</td>
<td>15 hours in groups</td>
</tr>
<tr>
<td>number in group</td>
<td>max 6</td>
<td>max 4</td>
</tr>
<tr>
<td>amount training for trainer</td>
<td>8.5 hours</td>
<td>20 hours</td>
</tr>
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</table>
SLT roles in Tier 2 intervention?

- Only a minority of the studies above involved SLTs training education staff to deliver programmes
- Most developed by psychologists
- Where SLTs provided training
  - Effects smaller (Fricke et al., 2017)
  - Effects not significant (Thurston et al., 2016)
- Intensity and quality of training crucial
Intervention

Children

Education tiers

SLT roles?

Education–led groups following language programmes

At risk children

Children just below age expectations

Advise & problem-solve re evidence-based programmes

Tier 2
Teacher / parent concern

Consider risk factors:

- Family history
- Severity/pervasiveness
- Age
- Neurodevtl disorder

High risk?

SLT Assessment

Tier 1: Led by education

School monitor progress

Good progress?

Tier 2: Led by education

Small group work – provider must be well-trained and very closely monitored

School monitor progress

Good progress?

Continuing mild-mod impact?
Tier 1: Led by education

Quality first teaching

School monitor progress

Good progress?

Teacher / parent concern

Consider risk factors:
- Family history
- Severity/pervasiveness
- Age
- Neurodevtl disorder

High risk?

SLT Assessment

SLT concerns?

Tier 3 SLT-led intervention

Tier 2: Led by education

Small group work – provider must be well-trained and very closely monitored

School monitor progress

Good progress?

Continuing mild-moderate impact?
SLT-led Individualised Provision (Tier 3)

- Individualised approach, led by SLT
- SLT has duty of care
SLT-led individualised interventions

• Usually for children with ‘additional or complex needs’
  – a need for interventions involving technical SLT knowledge and skill,
  – and/or persisting conditions with poor prognostic factors.
• Where long-term intervention is also anticipated.
• Training/coaching of others and collaborative work would be child specific
Intervention

Children

Direct SLT-led intervention

Indirect SLT-led intervention

Tier 3B

Tier 3A

Tier 3

Complexity & Severity

Children with identified language disorder

Poor response to intervention
**Intervention**

**Children**

- Poor response to intervention

**Complexity & Severity**

- Children with identified language disorder

**SLT roles in intervention**

- **Tier 3A**: Assessment, planning, training & monitoring others’ delivery of indirect intervention, monitoring of progress
- **Tier 3B**: Assessment, planning, direct intervention, monitoring of progress

**Direct SLT-led intervention**

**Indirect SLT-led intervention**
Boyle et al. (2007, 2009)
Comparison of 1:1 vs. group and SLT vs. SLTA

• Large RCT comparing:
  – SLT 1:1
  – SLT ‘group’ (2-5 per group)
  – SLTA 1:1
  – SLTA ‘group’ (2-5 per group)
  – “normal therapy” (mostly “consultancy”, half had little or no contact with SLT)

• Project intervention 3x 30-40 mins per week for 15 weeks (mean 38 sessions = 19-25 hours)
• **Results**
  – All project methods of delivery equally effective for improving expressive language
  – Progress maintained a year later
  – no change in receptive language in any group
  – children with E-LI > RE-LI in both receptive and expressive language

• Dickson et al (2009) found
  – SLTA group intervention was cheapest, but
  – SLT group intervention provided most gain per £
Children with identified language disorder

Poor response to intervention

Complexity & Severity

Intervention

Indirect SLT-led intervention

Tier 3A

Assessment, planning, training & monitoring others’ delivery of indirect intervention, monitoring of progress
“Indirect” SLT-led intervention (Tier 3A): key factors

• Who employs provider
  – McCartney et al. (2011): intervention provided by school staff under “consultative model” was not effective
  – If assistant is provided to the school by a research project (Boyle et al. 2009), or SLT services (Mecrow et al., 2010) intervention can be effective, but not for those with receptive language difficulties (Boyle et al. 2009).

• Training and support
  – McCartney et al. (2011)
    • little training / support (although targets, manual and materials provided)
    • limited monitoring from SLTs (one mid-intervention meeting)

• Amount of intervention provided (need for monitoring)
  – McCartney et al. (2011): 10 hours (aimed for 20)
  – Boyle et al (2009): 20 hours
  – Mecrow et al. (2010): 29 hours
## Sufficient intervention, training and feedback

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<tr>
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<th>effective</th>
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<tbody>
<tr>
<td><strong>intervention</strong></td>
<td>McCartney et al., 2011</td>
<td>Boyle et al., 2009</td>
</tr>
<tr>
<td><strong>training for trainer</strong></td>
<td>20 sessions (45 planned)</td>
<td>38 sessions (in groups or 1:1)</td>
</tr>
<tr>
<td><strong>support/monitoring for trainer</strong></td>
<td>manual + one mid-intervention meeting</td>
<td>substantial in-service training and official course</td>
</tr>
<tr>
<td><strong>support/monitoring for trainer</strong></td>
<td>none</td>
<td>employed by project</td>
</tr>
</tbody>
</table>
Tier 1: Led by education

- Good progress?
  - yes → Quality first teaching
  - no → Teacher / parent concern

Teacher / parent concern

- "Red flags" & risk factors:
  - Family history
  - Severity/pervasiveness
  - Age
  - Neurodevelopmental disorder

- High risk?
  - yes → SLT Assessment
  - no → School monitor progress

School monitor progress

- Good progress?
  - yes
  - Tier 3B: Direct SLT
  - no → no

Tier 2: Led by education

- Small group work

Teacher / parent concern

- "Red flags" & risk factors:
  - Family history
  - Severity/pervasiveness
  - Age
  - Neurodevelopmental disorder

- High risk?
  - yes → SLT Assessment
  - no → School monitor progress

School monitor progress

- Good progress?
  - yes
  - Tier 3A: Indirect SLT-led intervention
  - no → no

Tier 3A: Indirect SLT-led intervention

- Continuing concerns?
  - yes
  - Tier 3A: Indirect SLT-led intervention
  - no

Tier 3B: Direct SLT

- SLT concerns?
  - yes
  - Tier 3: SLT-led intervention
  - no
Continuing concerns?

Small group work

School monitor progress

Teacher / parent concern

“Red flags” & risk factors:
• Family history
• Severity/pervasiveness
• Age
• Neurodevt/ disorder

High risk?

Good progress?

Good progress?

SLT Assessment

SLT concerns?

Tier 2: Led by education

Small group work

School monitor progress

Good progress?

Continuing concerns?

Tier 3B: Direct SLT

direct SLT

Comprehension difficulties or complex needs?

Tier 3A: Indirect SLT-led

Indirect intervention – provider must be well-trained and very closely monitored

Tier 1: Led by education

Quality first teaching

School monitor progress

Teacher / parent concern

“Red flags” & risk factors:
• Family history
• Severity/pervasiveness
• Age
• Neurodevt/ disorder

High risk?

Good progress?

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Quality first teaching →

School monitor progress →

Good progress?

Teacher / parent concern →

Consider risk factors:
- Family history
- Severity/pervasiveness
- Age
- Neurodevt disorder

High risk?

Tier 3A: Indirect SLT-led

SLT Assessment →

SLT concerns?

Comprehension difficulties or complex needs?

Tier 2: Led by education

Small group work →

School monitor progress →

Good progress?

Good progress?

Continuing concerns?

Tier 3B: Direct SLT

direct SLT

Continuing mod-sev impact?
What constitutes good progress?

• Education-led input (Tiers 1 & 2):
  – increasing rate of progress
  – attainment gap with peers closing

• Indirect SLT (Tier 3A)
  – if making progress against specific targets continue indirect SLT (introducing new targets)
  – if not making progress against targets, move to direct SLT

• Direct SLT (Tier 3B)
  – if making progress against specific targets continue (introducing new targets)
  – if not making progress against targets, increase frequency, change targets, try a different approach
Children with identified language disorder

Poor response to intervention

Complexity & Severity

Intervention

Direct SLT-led intervention

Individualised intervention

Tier 3B

Assessment, planning, direct intervention, monitoring of progress
Direct SLT intervention (Tier 3B)

- Likely to be long-term
- May involve referral to a different service
- Most evidence is for direct SLT
Aims of direct SLT intervention

• Cure is probably not the goal
• At this stage aims are to
  A. Teach new skills
  B. Teach new strategies
  C. Help people in the environment to maximise learning and functional communication, participation and well-being
Effectiveness of direct SLT (Tier 3B)

- Direct SLT intervention can be effective (Reviews: Law et al., 2003; Ebbels et al., 2014; Lowe et al., 2018)
  - for primary and secondary school-aged children with DLD
  - delivered at least 30 mins per week by SLT, or via telehealth (Wales et al., 2017)
  - for improving expressive language and vocabulary
Effectiveness of direct SLT (Tier 3B)

• Less evidence for children with more pervasive difficulties including receptive language difficulties
  – Intervention effects often not found on standardised tests (Boyle et al., 2009; Gillam et al., 2008)
  – But are in studies where outcome measures are more specific
    • Range of targets (Ebbels et al., 2017; Gallagher & Chiat, 2009)
    • Comprehension and production of grammar (Ebbels et al., 2007; 2012; 2014)
Intervention

Children

Direct SLT-led intervention

Indirect SLT-led intervention

Assessment, planning, direct intervention, monitoring of progress

Assessment, planning, training & monitoring others’ delivery of indirect intervention, monitoring of progress

SLT roles in intervention

Tier 3B

Tier 3A

Poor response to intervention

COMPLEXITY & SEVERITY

- of impact of impairment on functioning in current contexts
- of receptive language difficulties

Children with identified language disorder
Tier 1: Led by education

- Quality first teaching
- School monitor progress
- Teacher / parent concern
- “Red flags” & risk factors: • Family history • Severity/pervasiveness • Age • Neurodevtl disorder
- High risk?
- Good progress?
- SLT Assessment
- SLT concerns?
- Comprehension difficulties or complex needs?
- Good progress?
- Continuing moderate-severe impact?

Tier 2: Led by education

- Small group work
- School monitor progress
- Good progress?
- Continuing mild-moderate impact?

Tier 3B: Direct SLT

- Change something!
- direct SLT
- SLT monitor progress
- Good progress?
- Continuing severe impact?

Tier 3A: Indirect SLT-led

- “Red flags” & risk factors: • Family history • Severity/pervasiveness • Age • Neurodevtl disorder
- High risk?
- Good progress?
- Continuing mild-moderate impact?

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All children

Children with identified language disorder

Children just below age expectations

At risk children

Poor response to intervention

Complexity & severity

- Impact of impairment on functioning in current contexts
- Receptive language difficulties

Direct SLT-led intervention

Indirect SLT-led intervention

Education-led groups following language programmes

Quality first teaching for all

Work collaboratively with & provide training/coaching for others
Working with and via parents

- No studies regarding working with and via parents for children over 7 years
- Most studies involve pre-school children
- Parental delivery of individualised SLT intervention (Tier 3A) can lead to improved language (most focus on expressive language) (Roberts & Kaiser, 2011; DeVeney et al., 2017; Tosh et al., 2017)
  - More effective with high dosage and when parents receive direct coaching from an SLT (Tosh et al., 2017)
Main messages

1. Ineffective services benefit no-one
2. Sufficient intervention needs to be provided to have a positive impact
3. Those delivering the intervention need sufficient training, coaching and support
4. Need to consider who benefits from each intervention (and who doesn’t)
5. Children at highest risk of long-term difficulties should be prioritised (not those most likely to be ‘cured’ and discharged)
Sufficient intervention

• Depends on:
  – Desired outcome
  – Nature and severity of difficulties and functional impact
  – Skills of those working with the child
  – Demands of child’s environment

• Much more research needed in this area
Sufficient training, coaching and support

• Tier 1 – Bleses et al., in press
  – 14 or 28 hours training (no coaching)
  – ? deliverers not convinced of value of intervention

• Tier 2 – Lonigan & Phillips, 2016
  – 8.5 hours vs 20 hours

• Tier 3A – McCartney et al., 2011
  – Collaborative model: 1 or 2 meetings with targets and manual provided (no coaching)
  – ? Too many other demands on deliverers

• Coaching is very important component – takes time
Prioritisation

Children

All children

At risk children

Children just below age expectations

Children with identified language disorder

Complexity & severity

Poor response to intervention

• Impact of impairment on functioning in current contexts
• Impact of receptive language difficulties

Intervention

Quality first teaching for all

Education-led groups following language programmes

Indirect SLT-led intervention

Direct SLT-led intervention

Individualised intervention

Work collaboratively with & provide training for others

Assessment, planning, direct intervention, monitoring of progress

Assessment, planning, training & monitoring others’ delivery of indirect intervention, monitoring of progress

Advise & problem solve re evidence-based programmes

Influence public awareness and policies

SLT roles in intervention
Thank you for listening!