Developmental Language Disorder: Steps Toward Implementation in Ontario
An OSLA working paper

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Developmental Language Disorder: Steps Toward Implementation in Ontario
An OSLA working paper
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Intended audience: Speech-Language Pathologists in Ontario
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THE GENERAL ASSEMBLY (or MEMBERSHIP),

Recognizing the right of parents, caregivers, educators, and the general public to know the name and characteristics of their child's or student's communication disorder;

Observing the inconsistency with which speech-language pathologists provide a specific name or label for a child's language disorder;

Expressing our concern that failure to clearly identify developmental language disorders contributes to a lack of understanding about and resources devoted to the disorder;

Noticing the recent international consensus in terminology for children with language disorders and efforts to raise awareness of people with language disorders

RESOLVES the following:

1. We strongly recommend the adoption of the international consensus terminology for describing children with persistent language problems with a significant functional impact including *language disorder* as the overarching term and the subtypes *language disorder associated with {a biomedical condition}* and *developmental language disorder*;

2. We urge the allocation of appropriate resources to meet the needs of children with language disorders from various sources including, but not limited to, government funding, non-profit organizations, and private support;

3. We commit to action towards advocacy, awareness, and resource development to support children with language disorders and their families and teachers, as children learn, grow, and achieve their potential.

For details regarding the development of this working paper, readers are referred to the report that follows from the OSLA workshop on November 9th, 2018 (Developmental Language Disorder (DLD): A Provincial Working Session about Implementation).

Developmental Language Disorder: Steps Toward Implementation in Ontario
Report from the November 9th (2018) Workshop

Preamble:
On November 9, 2018, the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) hosted a workshop, Developmental Language Disorder (DLD): A Provincial Working Session about Implementation, led by Drs. Lisa Archibald, Janis Oram Cardy, and BJ Cunningham from The University of Western Ontario. Dr. Chantal Mayer-Crittenden from Laurentian University also presented. Approximately 83 speech-language pathologists (SLPs) registered to attend the workshop, with almost half attending by webinar. Based on an online poll for which approximately 45 responses were received, attendees were from the following geographic regions of Ontario: 47% southwest, 24% central, 13% northeast, 9% southeast, 7% northwest. As well, responders were employed in the following service settings: 52% school board, 32% private practice, 9% preschool service agency, 7% school health support service agency. A draft version of this document was created based on content from the presentations, online comments, question and answer periods, and group discussion sheets. The draft was circulated to presenters, attendees, and international experts for comment prior to finalization. This report summarizes the issues and suggestions for next steps regarding implementation of a consistent approach to identifying children with language disorders in Ontario.

Practice snapshot
Considerable variability exists among SLPs with regards to the use of a specific term, a 'label', to identify children with a persistent language disorder. In an informal poll, 65% of workshop attendees responded that they do not provide a label for a child's language disorder in their clinical report or when sharing findings with a caregiver. In contrast, 64% and 76% of responders, respectively, indicated that they would use terms such as 'stuttering' and 'aphasia', when appropriate. Results of a survey study of Canadian SLPs (Kuiack & Archibald, in preparation) indicated that 23% of 353 respondents from across Canada rarely or never use a label to describe children with a language delay. These findings are in line with a 1997 study of 216 children with language disorder in which 29% of parents had never been informed that their child had a communication disorder (Tomblin et al., 1997). In fact, providing parents with an informative name or label was considered the lowest of 5 assessment priorities by workshop participants, Canadian survey respondents (Kuiack & Archibald), and a US sample of 60 SLPs (McGregor et al., 2017). In many cases, then, **parents seeking to equip themselves with knowledge about how to assist, support, and advocate for their child are not given the informative label they need to carry out such inquiries.**

Why label? Why provide an informative name?
A label provides an ease of communication or a 'verbal shorthand' for representing the features of a disorder. Knowledge of the label can promote understanding, awareness, legitimacy for the child's struggle, and hope for enhancing treatment access, availability, and effectiveness. There are concerns that a label is deficit-focused, influences expectations, and can be stigmatizing. Stigmatization, however, needs to be addressed by 'breaking the silence', by identifying the problem and working to improve understanding and inclusion. Nevertheless, providing a label is

just a first step. There is a need to go beyond the label to describe a child's strengths, challenges and individual learning needs. It has also been argued that labelling is unnecessary when no service exists, or can restrict services to those with the label, which is especially problematic if labels are applied inconsistently. Importantly, however, increasing a system's capacity for meeting the needs of children with a disorder makes that system better prepared to support those with similar difficulties but who do not qualify for the label. Of course, failing to identify children with a disorder means that there will be no service for these children. **Consistently identifying children with a language disorder is the responsibility of SLPs, and a necessary first step in advocating for service for these children.**

Can Ontario SLPs use a label to describe a language disorder?
According to the Ontario Regulated Health Professions Act, communicating a diagnosis is a controlled act that SLPs and audiologists are not legally allowed to perform. In June 2018, the College of Speech-Language Pathologists and Audiologists (CASLPO) clarified the distinction between communicating clinical information and communicating a diagnosis through webinars and a published practice advice article. Briefly, SLPs are considered to have the knowledge, skills, and judgement to make a SLP diagnosis within their scope and area of practice. **SLPs do have a professional obligation to communicate clinical findings regarding symptoms and dysfunctions, and may use terms such as 'language disorder' to describe those dysfunctions.** SLPs cannot communicate to the patient/caregiver the underlying disease or disorder that *causes* the identified communication disorder, but can refer to this biomedical diagnosis once it has been communicated to the patient/caregiver by an authorized health professional. Clinicians are encouraged to read in detail the CASLPO practice advice article on communicating clinical information (June 2018). Given that SLPs can use a specific label to describe children's language-related communication impairment, what label should we use?

What label to use: An international consensus for developmental language disorders
In 2016-7, two consensus studies, 'the CATALISE studies', involving a panel of 59 international experts (8 Canadians) were completed with the aim of clarifying criteria and terminology to describe children with language disorders. These papers and other summary resources are freely available, and readers are encouraged to refer to these sources for further details. Briefly, study 1 (Bishop et al., 2016) identified referral indicators, assessment suggestions, and consideration of additional factors. Importantly, no prescribed tools or procedures were recommended for assessment, rather reliance on clinical decision making was reinforced. In addition, the challenge of identifying language disorders in children who are under 5 years of age was recognized. Specifically, we know that a large proportion of children who are late-to-talk at 2 years of age will recover by 4 years, whereas some children for whom there are no concerns regarding language development at 2 years will be found to have atypical language development at 4 years of age (Reilly et al., 2018). At present, there are no measures with sufficient sensitivity and specificity to reliably predict which children under 4 will go on to have a persistent language disorder, although risk factors for persistence include impairments across language domains, receptive deficits, lack of gestures, lack of imitation of body movements, and positive family history. Conversely, children under 4 with expressive phonology deficits only have a good prognosis and are less likely to go on to have a persistent language disorder.

Study 2 (Bishop et al., 2017) recommended the terminology shown below to describe children with language disorder. Prevalence estimates in brackets are based on Norbury et al. (2016).

<table>
<tr><td colspan="2">Language Disorder (9.9%)
Persistent language problems with significant impact on everyday social & educational progress

This overarching term does not include late talkers whose language deficits are resolved by 5 years of age, uncomplicated phonology problems in preschoolers (i.e., those with a Speech Sound Disorder), and those for whom the exclusive concern is with limited exposure to the language of instruction (i.e., English Language Learners).

This term may be used when determination between the subtypes below is uncertain, or when otherwise preferred (e.g., an adult with DLD may refer to the condition as a language disorder)</td></tr>
<tr><td>Language Disorder associated with {biomedical condition} (2.3%)

This term identifies those whose language disorder occurs secondary to a biomedical condition (e.g., Autism Spectrum Disorder (ASD), intellectual disability, sensori-neural hearing loss)

In Ontario, this label can be applied once the biomedical diagnosis has been shared with the patient/caregiver by an authorized health care professional.</td><td>Developmental Language Disorder (7.6%)

A language disorder with no differentiating condition (acronym: DLD)

Labels for further subtypes of language disorder (e.g., receptive/expressive language disorder) were not included because relevant research has not identified reliable subtypes of language disorder. The broad label DLD should be applied and can be further described according to how it manifests in a particular child.

Discrepancy scoring relative to nonverbal ability was not recommended. Children with DLD may have a low level of nonverbal ability. This does not preclude a diagnosis of DLD (except in cases of a diagnosis of intellectual disability in which case, the label Language Disorder associated with Intellectual Disability would be applied).</td></tr>
</table>

These terms for language disorders are unquestionably broad and provide only a starting point for describing a child's language profile. The label needs to be provided along with additional information such as the following, where applicable:

Nature of language impairments	**Risk factors**	**Co-occurring disorders**
• Phonology	• Family history	• Attention
• Syntax	• Poverty	• Motor skills
• Semantics	• Low level of parent education	• Literacy
• Word finding	• Neglect or abuse	• Speech
• Pragmatics/language use	• Prenatal/perinatal problems	• Executive functions
• Verbal learning & memory	• Male	• Adaptive behaviours
		• Behaviour

Readers are referred to Figures 1 and 2 from Bishop et al. (2017) for a decision pathway and Venn diagram of terms for speech, language, and communication needs, respectively.

Under 5s

From 5 years of age, clinicians can be confident that a language difficulty fitting the criteria described above will persist and should apply the label language disorder or DLD. For many children under 5 years, however, the determination of persistence will be difficult. In this case, the term *language difficulties* has been included in a briefing paper by the Royal College of Speech and Language Therapists (UK) and in a forthcoming resource page by Speech-Language Audiology Canada (SAC). Importantly, the term 'delay' was not recommended for several reasons: (1) delay vs disorder cannot be reliably distinguished, (2) there has been a historical misuse of the terms delay and disorder to describe flat vs spiky profiles, and (3) delay may create expectations for resolution that may not occur and thereby underestimate the seriousness of the issue for parents. Given the lack of evidence for these profile distinctions and potential for misleading parents, it is suggested that the field move away from the use of the term 'delay' altogether in order to disentangle the new terms from this previous thinking. Cunningham, Kwok, Tursktra, and Oram Cardy (under review) conducted a consensus study of SLPs working in the **Ontario Preschool Speech and Language (PSL) Program** on the classification of preschoolers' communication, speech, and language needs, and reported the agreed-upon terminology. **The adopted classifications are consistent with Bishop et al. (2017) shown above with the exception that *Language Disorder* is replaced by either *Language Difficulty or Language Disorder* for the overarching term and each subtype (Language Difficulty or Disorder associated with {biomedical condition}; Developmental Language Difficulty or Developmental Language Disorder).** The term Difficulty is recommended for preschoolers with few risk factors for whom it is not yet clear whether the condition will persist, however it is strongly encouraged that the term Disorder be communicated when SLPs have reason to believe the condition will persist – even for children under the age of 5. This classification system will be unrolled in the Ontario PSL Program in the coming months under the leadership of Drs. Cunningham and Cardy.

French language

The French translation of DLD as Trouble développemental du langage (Developmental Disorder of Language), or TDL, is used in Quebec, and is being adopted in Ontario, France, and Belgium. Identifying TDL in Ontario is challenging because minority language monolinguism rarely exists due to the ubiquitous exposure to English as the majority language. SLPs should use caution when interpreting the results of bilingual children's scores on standardized assessment tools since the normative data for most tools have been obtained using a monolingual population or a bilingual population for which the language of testing is the majority language of the community. In determining whether to apply the TDL label, SLPs should also use information collected through informal measures, clinical judgement, assessment of risk factors, and information about co-occurring disorders. Readers are referred to Dr. Mayer-Crittenden's webpage, botte-boot.com, for additional resources on the assessment and treatment of children who are Bilingual in Ontario.

Specific learning disabilities
According to the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5), a specific learning disability (SLD) impedes the ability to learn or use specific academic skills (e.g., reading, writing, arithmetic). **A diagnosis of a SLD (such as dyslexia) does not preclude the identification of DLD**. That is, DLD and dyslexia can co-occur. Dyslexia affects word-level reading accuracy, reading fluency, and spelling usually as a result of a phonological processing deficit. Although phonological awareness is often deficient in children with DLD, a primary and disproportionate deficit in phonological awareness only (but not other aspects of oral language) would be the basis for a diagnosis of dyslexia and not DLD (Bishop et al., 2016; Adlof & Hogan, 2018). Given that both dyslexia and DLD are language-based disorders, assessments for these disorders should include measures across written and oral language domains.

Intellectual disability
An intellectual disability may be diagnosed by an authorized healthcare professional based on intelligence test scores, adaptive functioning, and age at onset (DSM-5). Individuals with intellectual disability typically have intelligence (IQ) scores below 70 (+/- 5), but IQ scores alone are insufficient for diagnosis of intellectual disability. Severity specifiers (e.g., mild) are defined based on level of adaptive functioning, not IQ score. For children with a diagnosis of intellectual disability, the term 'language disorder associated with intellectual disability' would be appropriate. Prior to the diagnosis/identification, the overarching term 'language disorder' may be used.

In the Ontario education system, the terminology used for intellectual exceptionality designations is different from the terminology used for DSM-5 diagnosis and can cause confusion in determining whether to use the term language disorder associated with intellectual disability or DLD in individual cases. The Ontario Ministry of Education identification category 'Intellectual' includes two exceptionalities: (1) *Developmental disability* is synonymous with the DSM-5 diagnosis of intellectual disability, and the term, 'language disorder associated with intellectual/developmental disability', may be applied as appropriate. (2) *Mild intellectual disability* describes children who have IQ scores falling between 71-79 and thus do NOT meet criteria for a DSM-5 diagnosis of intellectual disability, a developmental disability exceptionality, or a learning disability exceptionality. For children with an Ontario exceptionality designation of mild intellectual disability (i.e., who do NOT meet criteria for a DSM-5 diagnosis of intellectual disability) and who also have a language disorder, the term 'DLD' is appropriate.

Unexpected/unknown biomedical conditions
In cases where a SLP is concerned about a child's development beyond speech, language, and communication, and refers the child for further investigation of potential biomedical conditions (e.g., ASD), the SLP may use the term language disorder (i.e., the overarching label) to describe a child's profile as appropriate. Once a diagnosis is ruled in or out, the SLP can then apply the appropriate subtype label (i.e., language disorder associated with {biomedical condition} or DLD).

At the time of a speech and language assessment, however, there may be no reason to suspect the presence of any biomedical condition in a child who later goes on to have a biomedical condition diagnosed. In the case where there is no reason to expect a biomedical condition, the term DLD may be used. If a biomedical condition is later diagnosed, it is appropriate to change the label to the term 'Language disorder associated with {biomedical condition}'.

Practice change

Barriers. Workshop participants identified a number of barriers to implementation of consistent terminology to describe children's language disorders in Ontario including the following: uncertainty about use/definition of diagnostic terms, inconsistency in diagnostic terms, inconsistency in use by SLPs and by other clinicians (physician; psychologists), misunderstandings with colleagues making related diagnoses, terms providing no causal explanation, fear of making professional practice errors/professional liability, concern over parent reaction/need for labels, negative impact of having a label (expectations; stigma), lack of services, lack of administrative/organizational support, lack of resources (time; money).

Solutions. Overarching recommendations for making practice change included the need to act in a timely fashion, and to take significant (i.e., large) and coordinated action. Specific suggestions were aimed at several levels.

1. **SLPs** – Share information with all practicing SLPs (within worksites; workshops; recommended readings), generate position papers at all levels (OSLA; SAC; CASLPO), create a provincial working group, create a sense of momentum, build professional confidence and skill in sharing terms and descriptions of persistent (lifelong) disorder, provide wording for sharing terms, share research/practice on making accurate diagnoses, include terminology in graduate training programs, engage in advocacy and public awareness campaigns about the disorder and intervention (e.g., May month)
2. **Other professionals** (psychologists; physicians; teachers) – Share information in a common message (ideally in large, interdisciplinary groups)
3. **Ministry/government** – Share information with relevant ministries (Education; Children, Community, and Social Services), special education advisory committees (SEAC), advisory council on special education (MACSE)
4. **Parents/family/public** - Empower parents as advocates (e.g., OAFCCD; Facebook group), develop educational resources (parents; teachers), build trusting relationships with parents, allow time for discussion with parents

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