



Department
for Education

Identifying and supporting children and young people with speech, language and communication needs: a rapid evidence review

Research report

September 2025

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Executive summary

Background

In the SEND Code of Practice, the area of Communication and Interaction includes children and young people with speech, language, and communication needs (SLCN). These children and young people may have difficulty with one, some or all of the different aspects of speech, language or social communication that may vary across development. This review focuses on children and young people who have needs related to speech, language or communication. Although children and young people with autism may also experience various difficulties with communication, approaches for these children will be addressed in a separate review on autism, and therefore, will not be examined in this review.

Approach

The evidence was collected by means of a rapid evidence assessment. A search of the literature aimed to retrieve key findings for children and young people with SLCN aged 5 to 25. The literature search focused on systematic reviews and meta-analyses evaluating effective tools and strategies for the identification and support for educational and speech, language, or communication outcomes for children and young people with SLCN in mainstream classrooms, as well as reviews evaluating collaborative practices between families, schools, and healthcare providers or specialists.

Key findings

Identification

Findings highlight a range of tools to flag speech, language and communication challenges early as well as broader areas of identification and assessment. These preliminary assessments should always be discussed with a Special Educational Needs Coordinator (SENCo), families, and speech and language therapists, since accurate interpretation of assessment tools often depends on understanding their reliability, validity and normative benchmarks. Effective identification and monitoring therefore rests on clear role definitions, collaborative practice and ongoing professional development in SLCN profiles, co-occurring needs (for example, Attention Deficit Hyperactivity Disorder (ADHD) or literacy difficulties) and dynamic assessment methods.

Support

In terms of support, a tiered model is typically recommended where all students are taught evidence-based high-quality classroom instruction (tier 1) that incorporates explicit sequencing of tasks, clear prompts, scaffolding, mnemonics (memory aid techniques) and metacognitive strategies (thinking awareness) that reduce cognitive load and benefit all learners. If children and young people struggle to learn at this level, they may be moved to tier 2, which is more intensive and targeted small group or individual instruction. Finally, children and young people who still don't make progress in tier 2 may be given more intensive instruction, typically one-to-one and sometimes delivered by a specialist at the tier 3 level.

Targeted interventions, aimed at children who require additional support, yield the strongest effects when they focus on both the meaning and sounds of language, use storytelling approaches, and are delivered by trained staff in one-to-one or small-group settings. Programmes that include visual story aids, parent-led turn-taking, shared reading, and structured lessons help improve storytelling and conversation skills. Speech-sound therapies using movement-based techniques and real-time feedback can improve articulation in younger children and those with persistent disorders. Consistent reinforcement across home, clinic and classroom settings, regular progress checks, and classrooms designed to encourage speaking (aided by audit tools such as the communication supporting classroom observation tool (CSCOT)) and reduce noise all help strengthen outcomes.

Conclusions

Despite these advances, the evidence base exhibits important gaps. Most studies rely on bespoke outcome measures, and few employ long-term follow-up. There is limited research examining teacher- or teaching assistant-led delivery models, particularly in secondary schools. Moreover, inconsistent terminology between educational and clinical contexts hinders tool selection and interpretation. Future research should prioritise standardising metrics, evaluating scalable group-delivery approaches, extending trials to older and multilingual cohorts, and developing accessible training pathways so that all educators can confidently identify, monitor and support children with SLCN.

Introduction

In England, during the 2024/25 academic year, approximately 1.44 million pupils with identified special educational needs (SEN) are educated in mainstream state-funded primary and secondary schools. This includes around 1.17 million pupils receiving SEN support, and a further 271,000 pupils with an Education, Health and Care (EHC) plan (Department for Education, 2025).

Speech, Language and Communication Needs (SLCN) is an umbrella term that encompasses a broad range of difficulties affecting a child or young person's ability to communicate effectively. These needs can be temporary or persistent and may occur independently or alongside other developmental conditions. Each child's profile is unique and can change over time. For example, children and young people with SLCN may face challenges in one or multiple areas of speech, language, or social communication at different stages of their lives. SLCN is the most common primary need among pupils receiving SEN support; as of 2025, 25.7% of pupils (304,021 pupils) on SEN support have SLCN. Additionally, 20.7% of pupils (92,004 pupils) with an EHC plan are identified with a primary need of SLCN (Department for Education, 2025). There has been growing emphasis on prioritising support for children and young people with SLCN, reflected in reviews and guidelines (Bercow, 2008; National Institute on Deafness and Other Communication Disorders, n.d.) and international consensus statements (Bishop et al., 2017).

SLCN can be grouped into several key areas of need, which may have different strategies for identification and support. Firstly, speech difficulties or speech sound disorders refer to problems with perception, production, or representation of speech or difficulty with voice quality (Daniel & McLeod, 2017). These include articulation disorders (difficulty physically producing specific sounds), phonological disorders (difficulty understanding sound patterns), stammering or stuttering (disrupted speech fluency), apraxia of speech or verbal dyspraxia such as childhood apraxia of speech (CAS) (difficulty coordinating the motor movements for speech), and voice disorders (problems with pitch, volume, or vocal quality). The cause of these difficulties is not completely understood but may result from poor motor-planning (e.g. difficulties with planning and executing coordinated motor tasks) (Cassar et al., 2022), articulatory or phonological factors (Wrenet et al., 2021), or even wider cognitive difficulties (Torrington Eaton, 2015). Speech sound disorder is relatively common in children aged 3 to 5 but may resolve by age 6 especially with intervention (Baker & McLeod, 2011).

Secondly, language difficulties can affect either understanding (receptive language) or expression (expressive language), or both (American Speech-Language-Hearing Association, 2000). Receptive language difficulties involve challenges in understanding spoken language, while expressive language difficulties affect a child's ability to use

language to communicate effectively. Mixed receptive-expressive language difficulties include both. According to Bishop et al. (2017), the umbrella term "language disorder" refers to any condition in which language difficulties have a functional impact on everyday life. Children and young people may experience significant difficulties with language, which can be either unexplained or associated with an identifiable condition. For example, language disorders can occur in the context of known conditions, such as Down syndrome, autism, or hearing impairment.

Developmental Language Disorder (DLD) occurs where language difficulties are not associated with any known condition such as hearing loss or autism. DLD refers to unexplained, persistent difficulties in using and/or understanding language that may negatively impact children's everyday social interactions and learning at school. DLD is diagnosed when a child fails to make typical progress in language learning for no obvious reason. It affects approximately 7% of children entering school in the UK (Norbury et al., 2016), persists beyond age five, and often co-occurs with other difficulties such as Attention Deficit Hyperactivity Disorder (ADHD), motor or social challenges, and literacy problems. DLD can affect children across the full range of intellectual abilities and presents unique challenges because the underlying cause of the language difficulties is not immediately apparent. Recognising the distinction between DLD and language disorders associated with other conditions is essential for appropriate identification and support.

Thirdly, communication and social interaction difficulties relate to challenges with the social use of language, such as using and interpreting language appropriately in conversations. This includes pragmatic language impairment and social (pragmatic) communication disorder. Semantic-pragmatic difficulties involve challenges understanding word meanings and the use of language in context. Autistic children and young people often experience communication difficulties that fall into this category, particularly in understanding non-verbal cues and conversational rules. While autism falls under the broad category of Communication and Interaction needs in the SEND Code of Practice (DfE/DoH, 2015), autism has been addressed in a separate evidence review.

SLCN can also be associated with broader developmental or neurogenetic conditions such as Down syndrome, cerebral palsy, hearing impairment, learning disabilities, ADHD, social emotional development and behaviour, and other specific learning difficulties like dyslexia where language is impacted (Dockrell et al., 2017; Lindsay & Dockrell, 2012; Lindsay et al., 2007; St Clair et al., 2011). These co-occurring conditions often affect language development in broad and complex ways.

Language and communication are complex skills influenced by both internal and environmental factors and are important for social and academic engagement. Language is a dynamic system that involves a set of underlying cognitive skills such as attention,

memory, perception skills, and reasoning ability such as the ability to draw connections between ideas (Moll & Tomasello, 2010). Language also involves a range of interacting components such as phonology, semantics, morphology, syntax, and pragmatics (see table 1 for definitions). Children with SLCN may experience difficulties with any number of these skills which can impact on the development of others, which in turn can lead to difficulties in accessing learning experiences.

Table 1. Components of spoken language

Element	Definition
Phonology	The aspect of language concerned with speech sounds. Phonological awareness is the ability to recognise and manipulate the sound structures of spoken language.
Semantics	Refers to the meaning of words sentences and how they are used appropriately in conversation, including recognising relationships between words (synonyms, categories) and grasping nuanced concepts in speech. Vocabulary is also typically conceptualised within this component.
Morphology	Sensitivity to and use of the smallest units of meaning in speech - morphemes like prefixes, suffixes and root words - allowing a child to form, deconstruct and infer the meanings of complex words (e.g. “un-” in “undo”)
Syntax	Refers to the set of principles and rules governing the arrangement of words into phrases, clauses and sentences to form grammatically well-formed utterances.
Pragmatics	The use of language to communicate effectively in social contexts such as knowing how and when to take turns, maintain topic, adjust tone, use eye contact and interpret implied meanings beyond the literal words spoken.

Several biological and environmental factors can also impact children’s language development. Biological factors include gender, with research showing that girls typically outperform boys on expressive early language measures during the preschool years (Wallentin, 2020). Genetic predisposition is also linked to language outcomes, with children who have a family history of speech and language impairments being at higher risk of developing language difficulties (Barry& Bishop, 2007; Bishop et al., 2006; Sriganesh & Ponniah, 2018). Sensory impairments, such as hearing loss (Ching et al., 2023; Tomblin et al., 2015) and vision impairment (Brouwer et al., 2024; Mosca et al., 2015), can hinder children's access to linguistic input, thereby affecting the development

of vocabulary, grammar and pragmatic language skills. In terms of environmental factors, there is evidence of linked between socioeconomic status and language skills (Roy & Chiat, 2013). Children and young people from lower socioeconomic background may be exposed to less high-quality language both at home (Vanormelingen & Gillis, 2016) and in school (Wright & Neuman, 2014) which can affect language development. However, social disadvantage does not automatically lead to poor language outcomes (Pace et al., 2017).

Bilingual children, including those who are learning English as an additional language (EAL), will vary in terms of age of first exposure to English, length of exposure, and the quality and quantity of English language input and experiences, resulting in variations in the level of their English language proficiency (Bedore & Pena, 2008). Assessment of language skills in children and young people with EAL or who speak multiple languages is challenging as it is difficult to determine whether their language difficulties are due to limited exposure and proficiency in English or reflect an underlying language difficulty. Educators find it difficult to differentiate children with SLCN from children who speak English as an additional language (Dockrell & Howell, 2016). This is further complicated by the limited availability of assessment tools for languages other than English, making it difficult to evaluate bilingual children accurately across all their languages. In the UK, children with EAL are both over- and under-identified with SLCN (Lindsay & Strand, 2016). Similarly, assessments are not always appropriately designed to accurately measure speech, language, and communication in children with hearing impairments or deaf children making it difficult to determine whether a child may have difficulties accessing the assessment, or if there are SLCN above and beyond that.

Aims

The goal of this rapid evidence assessment (REA) is to synthesise evidence-based strategies in the identification, support, and collaborative practices available to mainstream educators in supporting children and young people with SLCN. This goal is guided by the following research questions;

Identification:

- Which formal and informal methods and measurement tools are available to practitioners to identify children and young people with SLCN within diverse classroom settings?
 - For which ages or age ranges can these tools be used?
 - What are the performance parameters of these measurement tools (e.g. reliability/validity/specificity)?

- How can these tools be used to guide decisions regarding the provision of universal, targeted or specialist support?

Support:

- What are the most effective universal and targeted strategies, approaches, or adaptations for supporting children and young people with SLCN to improve educational outcomes?
 - What is the most appropriate level of delivery (universal or targeted or specialist) for each of these interventions?
 - What specific age groups are targeted by these interventions?
- What types of approaches/interventions do children and young people with SLCN respond best to?

Working with others:

- What components and characteristics foster effective collaboration between teachers, specialists, and parents/caregivers in the identification and support for children and young people with SLCN, and how can clear role boundaries and knowledge-sharing frameworks support this process?
- What examples are there of different models of collaboration between the multidisciplinary team?

Methods

To address these research questions, a Rapid Evidence Assessment (REA) was conducted following Cochrane rapid review guidance (Garritty et al., 2024). This REA followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement when selecting relevant articles.

We conducted a targeted search in October 2024 of two academic databases (i.e., Scopus: PsychINFO and EBSCO: ERIC) as well as grey literature using specific keywords related to the research questions (see [Appendix A: Search terms](#)). We identified systematic reviews and meta-analyses published in English between 2014 and 2024, focusing on children and young people aged 5-25 (supporting stammering, speech and language needs in the early years (0-5) has been addressed in a separate review) with identified SLCN in mainstream educational settings. Included studies evaluated identification, support, or collaborative practices that are feasible in UK classrooms, excluding medical, home-based, or highly resource-dependent interventions (e.g. beyond what is typically available in a mainstream classroom such as animals, robotics and virtual reality). Identification tools had to be usable by mainstream staff (not clinicians), and SEND status were independently verified through diagnosis, EHC plan, or standardised measures. Studies relying solely on teacher judgement were excluded. Studies reporting measurable educational attainment outcomes or communication and language outcomes were included (i.e., excluding behavioural, social or emotional outcomes).

Titles and abstracts were initially screened for relevance by trained members of the team, followed by full-text review, resulting in the inclusion of 27 studies in the final review, with 14 studies on identification and assessment, and 13 studies on support and intervention (see Table 2). Given the central role of collaboration across both the identification and intervention processes, this strand is not presented as a standalone section. Instead, within the identification and support sections, we highlight where collaborative practices are necessary and effective. Additionally, as many studies identified for inclusion relate to collaborative practices in general SEND provision or across different areas of need, a breakdown of studies specific to SLCN is not included here, with collaborative practices across the categories of SEND addressed in the [Cross-Cutting Themes Report](#).

Table 2. Number of identified studies informing each strand

Strand	Number of studies included
Identification and assessment	14
Support and intervention	13
Total	27

Data from each study were then extracted by trained members of the team. We extracted descriptive information regarding the characteristics of each study as well as information about identification tools and support strategies from the included paper(s) where available.

Our search efforts prioritised high-quality and relevant research, ensuring the inclusion of peer-reviewed studies and robust methodologies. All studies identified in the final sample were either systematic reviews or meta-analyses. However, to evaluate the quality of these studies, we used the Assessing the Methodology Quality of Systematic Reviews Tool 2 (AMSTAR2) (Shea et al., 2017). Findings suggest that the evidence base is mixed according to this tool. Most studies were rated as high or moderate confidence in the results, with some rated as low due to a 'critical flaw' (detailed in our [Technical Report](#)). The typical critical flaw was that many studies did not conduct a formal risk of bias assessment using a recognised tool (e.g., ROBINS-I, Cochrane Risk of Bias).

For a full account of our methodology including search terms, inclusion, and exclusion criteria, PRISMA flow diagram, and extraction variables, and quality appraisal see the [Technical Report](#).

Identification and assessment of need

The aim of this section is to review the studies identified in our search that focused on identification and assessment strategies suitable for use by mainstream educational professionals in identifying the needs of children and young people with SLCN.

In line with the SEND Code of Practice (DfE, 2015), the role of subject and class teachers is to support the early recognition of students who may be experiencing difficulties, particularly those affecting educational progress. Therefore, these approaches reviewed in this REA are not intended to diagnose any conditions, but they can help mainstream educators in recognising children and young people's strengths and challenges to guide decisions about support or to highlight cases where referral for specialist assessment may be warranted. Where concerns are identified, these should be discussed with the school's Special Educational Needs Coordinator (SENCo) and the child's family to determine appropriate next steps, including referral and formal assessment where necessary.

Further, although many screening and assessment tools may be effective for identification and needs-based assessment, these tools should be interpreted with caution by mainstream educators who do not hold specialist qualifications. This is because such tools are underpinned by psychometric principles (e.g., reliability, validity, and standardisation), which determine how results should be interpreted and used. Without specific training in these areas, it may be difficult to determine how scores compare to typically developing populations, whether they represent meaningful results, or what it means when scores fall within clinical ranges. In practice, this ambiguity places greater reliance on professional judgment, which can lead to variability in how results are interpreted, particularly among assessors with less experience or limited training. While educators play a vital role in completing these tools as informants, accurate interpretation should typically involve an individual with specialist training. Although the strategies outlined in this section can be useful for planning interventions or flagging potential concerns, they should not be used for labelling or diagnosis. Rather these tools should be used to identify critical areas of need that may impact a student's academic performance.

The purpose of identification is to verify the existence of an educational need, while assessment aims to characterise the nature and extent of the child's difficulties in terms of differing skills (e.g., cognitive, language, literacy) (McCauley, 2001). The terms 'identification', 'screening', 'assessment', and 'profiling' are often used inconsistently across research, policy, and practice and can have different meanings in relation to educational versus clinical context. For example, the term 'screening' in an educational context typically refers to the process by which a tool or a strategy is used to flag potential needs in a population (e.g., whole-school or whole-class) or of specific children

who may be at risk to provide timely support or targeted interventions in educational settings. In contrast, screening for clinical purposes is typically carried out by health or mental health professionals using standardised tools to determine whether a child may meet criteria for a specific diagnosis, such as DLD, with the goal of planning for further assessment. However, some processes can overlap. For example, a listening comprehension assessment could be used for identification purposes to initially identify oral comprehension and receptive language difficulties, or it could be used in formal assessment of needs (e.g., during a DLD diagnosis) or to monitor progress of an oral language intervention. For clarity throughout this document, we define each term within an educational context. Definitions of terms are provided in Table 3.

Table 3. Definitions of identification terms in the educational and clinical context

Term	Educational use	Clinical use
Needs-based identification	The process of recognising that a child may have additional needs (whether they do or do not have a diagnosis), often based on parental or child concern, observations, or professional judgement. However, this process can also include informal assessments. Informal assessments are flexible methods of gathering data to identify areas of need, guide interventions and monitor progress. These tools include checklists, questionnaires, or more structured assessments (e.g., listening comprehension, reading fluency).	Not a formal clinical term; overlaps with early signs that may prompt diagnostic referral but is not sufficient for diagnosis.
Screening	A brief, tool or procedure used to flag or identify potential concerns across a population. In educational contexts, the goal is to flag potential needs early so that timely support or targeted interventions can be put in place within the school setting. However, given that screeners are typically quick to administer and usually measure only a specific area of concern, their results should be interpreted with caution.	Tools used to determine whether further diagnostic assessment is warranted, often as a first step in a medical or psychological evaluation pathway. Typically, these tools should be administered by a trained specialist.

Term	Educational use	Clinical use
Assessment	Refers to a systematic structured process of data gathering from standardised tools to understand individual strengths and needs in order to plan intervention or monitor progress. For educational purposes, these can be informal or formal assessments. Assessment should be an ongoing process to monitor progress. Formal assessments are structured, standardised tools used to evaluate a student's performance against national or normative standards. These include GCSEs and A-levels but also standardised assessments of literacy or other types of skills. Formal assessments sometimes require input from specialists to administer and/or interpret results.	A systematic and structured process of data collection for diagnostic purposes. Assessment is conducted by specialists (e.g., speech and language therapists) and involves standardised diagnostic tools to determine specific conditions or developmental profiles.
Profiling	A holistic summary of a child's functioning, strengths, and areas of difficulty, often used to guide provision. Includes data from multiple informants and through multiple methods.	Less commonly used as a standalone concept; elements of profiling are embedded in comprehensive diagnostic assessments that explore functional impact across domains.

Key considerations for identification and assessment of SLCN

The path to identification and support for children and young people with SLCN can be initiated through health or educational channels. Thus, both these services have a responsibility for meeting the needs of children with SLCN (Law et al., 2002). The identification and assessment of needs as well as the intervention and support require effective collaboration between families, teachers, school staff, and professionals from health sectors (i.e., speech and language therapists). Here, there are a number of specialists and healthcare professionals who may be involved in the identification and

support processes for children and young people with SLCN. These professionals are listed in Table 4.

Table 4. Specialists and healthcare providers who may be involved in collaboration

Specialist/Professional	Role
Classroom Teacher	Observes speech and language difficulties in context; implements classroom strategies to support SLCN.
Learning Support Assistant (LSA) / Teaching Assistant (TA)	Supports pupils in class and may deliver speech and language programmes under supervision.
SENCo (Special Educational Needs Coordinator)	Coordinates identification, school support plans, and referrals for children with SLCN.
Specialist Teacher (SLCN)	Provides school-based assessments, guidance, and support strategies tailored to SLCN.
Educational Psychologist	Conducts cognitive and communication assessments; advises on tailored support and intervention.
Speech and Language Therapist (SaLT)	Assesses, diagnoses, and provides direct or indirect intervention for SCLN.
SaLT Assistant / Therapy Assistant	Delivers therapy programmes under supervision of a qualified SaLT.
Health Visitor	Specialist community public health nurses trained to administer a brief general assessment of motor, social and language development. Monitors early speech and language milestones; can refer to SaLT services.
Paediatrician	Screens for underlying developmental conditions (e.g., autism, global delay) impacting communication.
Audiologist	Assesses hearing ability and auditory processing to rule out hearing-related causes of SLCN.
ENT (Ear, nose and throat) Specialist	Investigates medical causes such as glue ear or anatomical issues that impact speech or hearing.
Occupational Therapist	Supports children with fine motor, sensory, and feeding difficulties that may impact communication.
Physiotherapist	Assesses physical impairments that could impact articulation, breath support, or coordination.

Specialist/Professional	Role
Clinical Psychologist	Assesses neurodevelopmental conditions and provides input into diagnosis and intervention planning.
Specialist Nurses (e.g., Community Children's Nurses, Epilepsy Nurse)	Provide health monitoring, care planning, and parent support for long-term conditions.
Interpreter / Bilingual Support Worker	Assists during assessments and interventions with children who speak English as an Additional Language (EAL).

Speech and language therapists are particularly important in identifying, assessing, and supporting children and young people with or at risk of SLCN. Speech and language therapists may either be based directly in schools or available externally. For example, in schools, speech and language therapists support the identification and assessment of students who may have SLCN and help develop interventions and whole-school approaches. Mainstream educators can work closely with speech and language therapists to support children and young people with, or at risk of, SLCN.

In educational settings, identification typically begins with classroom observations by teachers or early years practitioners who notice difficulties in speaking, listening, understanding, or social interaction (Girolamo et al., 2022). Teachers and SENCos may consult with parents and review developmental histories to gain further insight. This early identification process aligns with the graduated response outlined in the SEND Code of Practice (DfE, 2015), which emphasises the importance of needs-based support regardless of formal diagnosis.

Speech and language difficulties may be identified early in development (e.g., as part of the Early Years Foundation Stage (EYFS) progress check or the '2-year check' by Health Visitors), or they may become apparent once a child starts school. However, data from single screening measures is not sufficient in determining the development language trajectories of children and young people (Dockrell & Marshall, 2015). Assessment involves asking the parents a few questions about their child's language and/or carrying out a short comprehension/expressive activity with the child. As previously noted under 'Methods', the identification of SLCN for children aged five years and under has been reviewed separately. Consequently, this REA reports on identification and assessment tools for children and young people with SLCN aged five years and older. SLCN can persist and affect learning outcomes for children and young people in both the early years and throughout education (e.g., Beitchman et al., 1996; Dockrell & Hurry, 2018). Therefore, it is equally important to consider the speech, language and communication needs of children and young people aged five and over, as it is for children in the early years (aged 0-5). Identification and assessment approaches will be discussed according

to these different areas of need. However, firstly we note a few general practices that educators should keep in mind when identifying, screening, and assessing for SLCN.

First, teachers, early years practitioners, and SENCos would benefit from a foundational understanding of SLCN. This is important because teachers are often involved in clinical interviews with speech and language therapists and their role in identification in classroom and early years settings is important in recognition and referral of children who may have difficulties (e.g., Caesar & Kohler, 2009). However, many educators report insufficient training opportunities in SLCN, making it challenging to identify and support affected children and to distinguish these needs from those associated with other developmental disorders or among children who have EAL (Dockrell & Howell, 2016). Given the limited instruction on these difficulties in initial teacher training programmes, it may be beneficial for educators to engage in ongoing professional development to strengthen their knowledge and skills in identifying and supporting children and young people with SLCN.

Second, obtaining a family history and background information is important in the identification, assessment, and profiling process. Children's early language abilities particularly, as reported by parents and measured through vocabulary assessments at ages three and five, may be reliable predictors of whether teachers later identified them as having SLCN at ages seven and eleven (Dockrell & Hurry, 2018). Given that SLCN can be heritable (Newbury et al., 2010) and can be impacted by environmental factors, it is useful, where possible, to obtain a detailed family history of speech and language difficulties or diagnosis. Children and young people who speak two languages or have EAL may also have unique profiles influenced by their exposure to two or more languages and the contexts in which they acquire these languages (Snow, 2014; Paradis et al., 2010; Tuller, 2015). It is also useful to know whether the child or young person may have any co-occurring difficulties that could be impacting their academic performance, such as motor difficulties, handwriting difficulties, ADHD, or autism. Therefore, collaboration and the involvement of families are important in identifying, assessing, and supporting children with SLCN, especially children with speech, language, or communication difficulties who may not necessarily meet the criteria for a speech or language disorder.

Finally, the SLCN profile of children and young people can change over time (e.g., in response to intervention, change in environment, cognitive development, and other relevant changes) (Snowling et al., 2012). Further, a systematic review by Ebert and Lee (2024), included in our REA, found limited high-quality evidence identifying which child characteristics predict response to language interventions. Therefore, it is important that early identification is followed by monitoring and periodic reassessment in collaboration with a speech and language therapist. Most standardised assessments can typically be

readministered every six months, but weekly or monthly informal assessments may also be useful. These will be discussed in the following sections.

It is important to note a significant challenge in this field of research. SLCN terminology is varied across research and practice with multiple overlapping terms (e.g., disorder, deficit, dysfunction) used interchangeably, and has changed over time (Dockrell et al., 2006). For example, prior to the CATALISE consortium¹ (Bishop et al., 2017), various terms were used to describe the children and young people who have difficulties with the acquisition and processing of language, including specific language impairment (SLI), language impairment, language learning difficulties, and verbal dyspraxia. Similarly, one systematic review in our REA found that there is no systemic use of definition and terminologies of pragmatic language impairment among researchers from various disciplines, even within publications of the same author or the same paper (Alduais et al., 2022). These inconsistencies present challenges to effective collaboration between families, educators, and health professionals and may impact how children and young people are identified as having SLCN. A possible secondary consequence of these inconsistencies in research is that much research has focused on addressing these concerns in clinical practice; however, it has been argued that there is still no 'gold standard' in diagnostic procedures (Shahmahmood et al., 2016). Further, even less is known about the ways in which the needs of children are identified within the education system (Dockrell et al., 2017; Dockrell & Hurry, 2018).

Therefore, mainstream educational settings play a key role in supporting children and young people with SLCN, often without the benefit of a formal diagnosis, which underscores the importance of teacher awareness, early identification, and inclusive teaching strategies. Here, we review available evidence of different approaches that educators can use to identify different areas of difficulty and areas that need education-based support. There are also several important factors that educators should consider during the identification, assessment, referral and/or support of children with SLCN. These will be discussed according to these different areas of speech, language, and communication needs. The following summary outlines a few general practices that educators should keep in mind when identifying, screening, and assessing for SLCN.

¹ refers to a consensus study led by Dorothy Bishop and colleagues as part of the CATALISE project (Criteria and Terminology Applied to Language Impairments: Synthesising the Evidence). This consensus study led by an international group of experts aimed to clarify terminology and diagnostic criteria for language disorders in children. The key output of the 2017 paper was the recommendation to use the term Developmental Language Disorder (DLD) for unexplained language difficulties, replacing terms like SLI (Specific Language Impairment).

Key considerations for the identification and assessment of SLCN summary

- Collaboration between educators and speech, language, and communication therapists is essential to reduce capacity demands.
- Professional development can be important to learn about SLCN.
- It is important to obtain a family history and background information where possible.
- Monitoring educational needs is important as these can change over time.
- Terminology referring to SLCN is inconsistent in research and practice

Identification of speech and language challenges

Compared to typically developing children, children with different speech and language challenges may produce narratives that are less syntactically and structurally complex. Their narratives are often shorter in length (e.g., lower mean length of utterance), show reduced lexical diversity (e.g., fewer number of different words), include more grammatical errors, and display reduced fluency (e.g., more speech disruptions) (Govindarajan & Paradis, 2019). Language sample analysis is a tool used in clinical assessment of SLCN to evaluate a child or young person's spoken language in natural settings (Miller et al., 2016). One review (Scott, 2020) and one meta-analysis (Winters et al., 2022) retrieved in our REA suggest that language sample analysis of oral or written language can be useful in identifying speech and language difficulties, including those associated with DLD. A further systematic review suggests that there is also emerging evidence that language sample analysis can have diagnostic assessment utility (Ramos et al., 2022) meaning they could be helpful in distinguishing between those with and without DLD. However, more research is needed to establish this as a clinical evidence-based practice.

Language sample analysis can be useful in the identification of speech, language or communication challenges and in guiding targeted intervention. It involves collecting a sample of spoken (or sometimes written) language during everyday activities, such as conversation, storytelling, or play, and analysing it to understand the child's language abilities. Educators can elicit oral or written language samples through engaging activities, such as asking students to talk about a pet, describe a recent holiday, or narrate what is happening in a picture. Oral language samples can provide valuable insight into a student's speech rate, fluency, intelligibility, voice quality, and the presence of speech errors. They also offer opportunities to observe vocabulary use, semantic understanding, and pragmatic skills such as eye contact, topic maintenance, turn-taking,

and perspective taking. Written samples, meanwhile, can inform assessment of written language abilities, including vocabulary, syntax, grammar, productivity, accuracy and content organisation.

While language sample analysis is traditionally used by speech and language therapists, teachers can also be involved in collecting or reviewing language samples, especially when supported by speech and language therapists or trained staff. Although this resource was not identified in our REA, a manual by Shipley and McAfee (2023) provides some useful information on such strategies. However, while these strategies may be useful, Winters et al. (2022) report there is a gap in understanding how different narrative tasks (e.g., telling versus retelling, or the use of pictures) and participant characteristics (such as age or native language) can reliably distinguish between children with and without DLD. More research is needed to evaluate the utility of language sample analysis for identification purposes in educational settings, particularly when used by educators without specialist training.

Another systematic review (Pawlowska, 2014) investigated whether three specific language processing tasks could be accurate indicators of DLD versus language difficulties/delays in children aged 5 to 12. The three they investigated were (1) verb tense morphology² (Rice et al., 2009; Rice & Wexler, 1996), (2) nonword³ repetition (Bishop et al., 1996), and (3) sentence repetition (Conti-Ramsden et al., 2001; Tomblin et al., 1992). The review found that tense marking was a moderately accurate indicator of DLD. Sentence repetition also showed potential as a diagnostic marker, but its usefulness may be limited due to inconsistent findings across studies. Nonword repetition showed limited diagnostic value, suggesting that this evidence is still limited.

1. Verb tense morphology: In the review, with preschool and early primary-aged children, spontaneous language samples were analysed using the Finite Verb Morphology Composite (FVMC; Leonard et al., 1999) or the Percent Verb Tense Usage measure (PVT; Eisenberg & Guo, 2013), which quantify the correct use of verb morphemes in obligatory contexts (e.g., third person singular -s, regular past tense -ed, and forms of the verb be). Some studies also used the Tense Marker Total and productivity scores to assess the diversity and productivity of tense morpheme use. For older children, structured elicitation tasks were used, including the Past Tense Task (past tense task [PTT], Marchman, Wulfeck, & Ellis-Weismer, 1999), the Third Person Singular Task (TPS; Simkin & Conti-Ramsden, 2001), and

² Verb tense morphology refers to the way verb forms change (morph) to express tense (past, present, future).

³ Nonwords, also called nonsense words or pseudowords, are letter sequences that follow English phonics patterns and are pronounceable but have no meaning (e.g. 'yom').

the Rice/Wexler Test of Early Grammatical Impairment (Rice & Wexler, 2001), which target regular and irregular tense marking in simple sentences.

2. Nonword repetition was tested with the Nonword Repetition Test (NRT; Dollaghan & Campbell, 1998) or the Children's Test of Nonword Repetition (CNRep; Gathercole et al., 1994). In nonword repetition tasks, individuals are asked to repeat novel, word-like stimuli that follow the phonotactic rules of a particular language (Gathercole et al., 1994). Nonword repetition tasks are frequently used to detect language and speech difficulties. These tasks typically include 20 to 40 nonwords, increasing in length from one to five syllables. Nonword repetition requires perceiving speech sound sequences, retaining them in short-term memory, and accurately reproducing them through speech. Children and young people with DLD typically are less accurate at pronunciation than their peers without DLD and show difficulties when the length or complexity of the word increases (Graf Estes, et al., 2007; Schwod et al., 2021).
3. Sentence repetition was measured using either the Recalling Sentences (RecS) subtest of the Clinical Evaluation of Language Fundamentals-Revised (CELF-R, Semel, Wiig, & Secord, 1994), containing a variety of syntactic structures in sentences of increasing length, or with Redmond's (2005) Sentence Recall (SR) probe, consisting of sixteen 10-word sentences, half active and half passive. The scoring for both tasks is based on the number of lexical or morphosyntactic deviations from the original sentence. This skill may reflect receptive and expressive language ability as well as memory skills.

Identification strategies for speech and language challenges summary

- Language sample analysis (oral or written)
- Verb tense morphology
- Nonword repetition tasks
- Sentence repetition tasks

Identification of cognitive, social, emotional, and behavioural challenges

Children and young people with SLCN may also face challenges beyond their speech, language and communication difficulties. For example, children with DLD may show difficulties with social interactions or exhibit behavioural problems that overlap with difficulties associated with autism and ADHD, respectively. Social withdrawal is

sometimes observed along with difficulties with peer relationships. Additionally, difficulties with pragmatic language have been linked to wider social, behavioural, and emotional concerns, including anxiety, low self-esteem, and symptoms of depression (St Clair, Pickles, Durkin, & Conti-Ramsden, 2011). It is therefore important that educators recognise the potential links between SLCN and associated cognitive, behavioural, and mental health challenges. Identification and assessment processes should take these broader domains into account to ensure that the support provided is comprehensive, appropriately targeted, and responsive to the full range of a child's needs.

Persistent stuttering (beyond preschool and early years) can negatively impact education, occupational attainment, personal relationships, and mental health while also contributing to experiences of stigma. A systematic review conducted by researchers in Australia (Jones et al., 2021) identified six high-quality clinical assessment tools for measuring the psychological impacts of stuttering in children and young people aged six and older. Namely, the Parent Questionnaire (Erickson & Block, 2013), the Teasing/Bullying Questionnaire for Children Who Stutter (TBQ-CS; Langevin et al., 1998), Overall Assessment of the Speaker's Experience of Stuttering - School-Age (OASES-S; Yaruss & Quesal, 2010), and three self-report tests of the Behaviour Assessment Battery for School-Age Children Who Stutter (BAB; Longland, 2009). The self-report tests were the Communication Attitude Test (CAT; Brutten & Vanryckeghem, 2007), the Behaviour Checklist [BCL], and the Speech Situation Checklist–Emotional Reaction [SSC-ER]). Teachers and mainstream educators without specific qualifications can support the administration of these tools, especially in gathering information and providing context. However, interpretation and subsequent decision-making should involve speech and language therapists or trained professionals, particularly for tools like OASES-S and the BAB suite, which are designed for clinical insight into the psychosocial and communication impacts of stuttering.

Children and young people with SLCN may also demonstrate attentional shifting difficulties (e.g., the ability to disengage from one focus of attention and switching to a different focus of attention). Attentional shifting is important in oral language and literacy development (e.g., Hill & Wagovich, 2020; Kapa & Columbon, 2014; Kieffer, Vukovic, & Berry, 2013; Lubin, Regrin, Boulc'h et al., 2016). For example, individuals with the ability to shift focus from different speakers in a conversation are quicker to recognise and understand spoken words (Evans et al., 2018). This has implications for classroom behaviour, and suggests that cognitive flexibility may be a useful marker to assess alongside language ability. One meta-analysis in our REA (Aljahlan & Spaulding, 2021) found that children with DLD struggle compared to age-matched peers with switching between tasks that require different rules or ways of thinking (set-shifting). This difficulty is observed clearly and consistently across different ages and measurement methods, but not on alternating attention tasks (which involve switching between different tasks

more routinely). This distinction implies that task complexity and executive function load may influence performance. Set-shifting tasks may place higher demands on cognitive control, inhibition, and problem-solving, areas where children with DLD also often struggle.

These findings support the addition of cognitive and executive function assessment for children and young people who might be at risk of SLCN to help determine patterns of need and to guide support and intervention. However, these types of cognitive assessments should typically be administered and interpreted by a qualified specialist with training in psychometric assessment.

Identification and assessment of cognitive and behavioural challenges summary

- Children and young people with SLCN may have broader cognitive, behavioural, social, or mental health challenges
- Persistent stuttering affects educational and psychosocial outcomes; six validated tools can assess psychological impact, though interpretation should be led by trained professionals
- Children with DLD show consistent difficulties with set-shifting (but not routine attentional switching), supporting the need to assess executive function alongside language to better inform intervention

Identification of literacy difficulties

Oral language development is closely linked with literacy development (e.g., reading, writing, and spelling). The importance of language is highlighted in models of reading such as the Simple View of Reading (Hoover & Gough, 1990), which proposes that reading comprehension is a combination of word reading efficiency and language comprehension. Therefore, underlying oral language difficulties can hinder literacy development, contributing to broader challenges in reading-related tasks (e.g., following written instructions) and written expression. Difficulties with oral language are strong predictors of later reading, writing, and spelling challenges (Carroll et al., 2011). Literacy difficulties such as decoding and reading comprehension, are often observed in children with SLCN in primary school (Botting, Simkin & Conti-Ramsden, 2006; Dockrell & Lindsay, 2004), and young people with DLD (McArthur et al., 2000). Identifying and addressing these areas of literacy early could therefore be essential to providing effective support. However, it is important to note that not all children and young people with SLCN will go on to develop literacy difficulties.

Our Cognition and Learning REA outlines a number of different identification and assessment tools available to mainstream educators to identify areas of difficulty in reading, writing, and spelling. These strategies can also be used to measure literacy skills in children and young people with SLCN and therefore, we encourage practitioners to refer to this report.

Identification and assessment of literacy challenges summary

- Literacy difficulties are common in children and young people with SLCN
- Identification and assessment of different areas of reading may also help inform support strategies
- Identification and assessment tools can be found in our cognition and learning REA

Considerations for bilingual children and young people and those with EAL

As previously discussed, the number of languages that a child speaks, and their frequency and quality of exposure to the English language can impact a child's speech and language abilities in English. It can be difficult for practitioners to determine whether a speech, language, or communication difficulty is due to lack of proficiency or exposure, or for reasons beyond that. Previous research often recommends obtaining a language history questionnaire as an early step in identifying and assessing the educational needs of children and young people with EAL. Although not identified in our REA, a commonly used tool that is available online is called the QBEX (Kaščelan et al., 2022). This is an online questionnaire that can be used by teachers to gather information through parents on the child's exposure to English and other languages.

Two systematic reviews by Ortiz (2021) and Schwob and colleagues (2021) found that nonword repetition (NWR) tasks may be useful in identifying language difficulties in bilingual children and young people or those with EAL. Those with suspected SLCN may benefit from referral to speech and language therapists, who can administer nonword repetition tasks alongside other assessments to evaluate language difficulties more accurately. Since these sound sequences are linguistically plausible but unfamiliar, NWR tasks are considered less culturally and linguistically biased than many traditional assessments. NWR performance is thought to reflect phonological working memory, an individual's capacity to perceive, retain briefly, and reproduce novel phonological information (Gathercole & Baddeley, 1990; 1993). However, other cognitive and linguistic processes may also contribute, including phonological encoding (Kamhi & Catts, 1986),

phonological awareness (Metsala, 1999), broader phonological processing (Bowey, 2001), and even multiple interacting cognitive mechanisms (Edwards & Lahey, 1998; Graf Estes et al., 2007). Given this, NWR tasks may offer a valuable, relatively unbiased tool for identifying underlying language difficulties, particularly in linguistically diverse learners.

For multilingual children with DLD, measuring literacy abilities in their first language such as phonological abilities including rapid naming and blending may provide further use in determining the nature of reading difficulties in this cohort (Ramirez et al., 2023). However, this may not be a realistic option given that there are very few measures in languages other than English. Further, the administrator would also need to understand the first language to be able to assess and interpret results.

There is growing support for using dynamic assessment as an effective method for SLCN, especially in multilingual children. Dynamic assessment tools evaluate a child's learning potential rather than only their current or static ability. Dynamic assessments can be used for screening or diagnosis, monitoring change, intervention planning, or for assessing the nature and extent of SLCN. One systematic review (Bamford et al., 2022) found that the type of dynamic assessment used in assessment across research varies. Instruction components of dynamic assessment may include cueing, prompting, or direct teaching of task content. The distinction between prompting (which supports access to existing knowledge), and direct instruction (which teaches new skills) is important but underexplored. The review emphasises that different combinations of instructional methods may yield varying effectiveness depending on the skill being assessed, the population, and the purpose. For practitioners, this means that while dynamic assessment offers a promising way to assess learning potential rather than static ability, its complexity may be a barrier to adoption. Another systematic review retrieved in our REA (Hunt et al., 2022) also suggests that dynamic assessment is useful in identifying language disorders in multilingual children. However, the evidence here is limited by small sample sizes and study designs.

Based on this, the Dynamic Assessment Framework could be useful for clinicians to better match the purpose of their assessment with an appropriate methodology. However, the lack of standardisation and limited evidence on validity, particularly outside language domains, indicates a need for caution when interpreting results. For educational settings, this suggests that dynamic assessment should be seen as a complement to other assessments, especially when used by non-specialists, and that more accessible training and clearer reporting standards are needed to support reliable use.

Considerations for learners who are bilingual or have EAL summary

- Children and young people who are bilingual or EAL can have difficulties in both their native and second language
- Some tools may not appropriately measure this group due to the ways they were developed
- Nonword repetition tasks and dynamic assessment strategies may be useful in measuring the SLCN of this group

Identification and assessment summary

Mainstream educators can employ a range of identification and assessment strategies to flag strengths and challenges in pupils' speech, language, and communication. These methods are not diagnostic but serve to guide timely classroom support and, where needed, referral to specialists. Teachers' observations and initial screenings should always be discussed with the SENCo and families and interpreted in partnership with speech and language therapists or other qualified professionals since accurate use of standardised tools depends on understanding their reliability, validity, and normative benchmarks.

Effective practice benefits from collaborative working and ongoing professional development; teachers may consider foundational training on the profiles of children and young people with SLCN, co-occurring conditions (e.g., literacy difficulties, ADHD) and bilingual/EAL considerations, as well as familiarity with dynamic assessment techniques that reveal learning potential. Regular monitoring and periodic re-assessment using both formal measures (e.g., language samples, non-word repetition, sentence recall) and informal classroom checks, ensure that evolving needs are met. However, it should be noted that although these techniques may be considered evidence-based practice, it may often be the case that collaborative efforts and ongoing assessment are hindered by limited resources.

Key gaps include inconsistent terminology and a lack of agreed common metrics across educational and clinical contexts, limited evidence on the reliability and validity of many tools when used by non-specialists, and sparse research on how well classroom-based identification translates into improved outcomes. Further studies are needed to standardise definitions, evaluate the utility of language sampling in schools, and develop accessible training models so that teachers can confidently recognise and respond to SLCN. Finally, our REA did not identify any reviews examining the identification and assessment of communication skills specifically for children and young people with SLCN who do not have autism. Most existing research on social communication needs focuses

on autistic learners, and although some tools are reviewed in our [Autism Report](#), there is a notable lack of approaches tailored to those without autism-related characteristics.

Support and intervention

Support for children and young people with SLCN typically focuses on various elements of the language system and common underlying processes such as attention and listening. However, as previously stated, establishing the evidence-base for support has been challenging for several reasons including the difficulty in identifying and assessing the nature and extent of challenges associated with SLCN. Here, the inconsistency in terminology, and the lack of research applicable to educational contexts versus more specialist resources and environments contribute to this challenge.

Second, intervention methods for children and young people with SLCN are usually delivered in small groups or one-to-one, which creates barriers by reducing exposure to the entire curriculum by missing lessons and reducing children's access and class participation (Gallagher et al., 2018).

Nonetheless, there are strategies that have been shown to be effective in supporting children and young people with SLCN. For example, see Ebbels and colleagues (2019) for a recent review of effective intervention approaches for children and young people with language disorders. The section reviews the studies from our REA that focused on support and intervention strategies suitable for use by mainstream education professionals. Although the initial aim was to specifically explore approaches that are effective in supporting educational outcomes including literacy, writing, maths, science, and general attainment, our REA identified few studies that focused exclusively on these outcomes for children and young people with SLCN. Therefore, we also consider interventions aimed at improving speech, language, and communication skills. This section is organised into two parts: 1) universal provision and high-quality teaching strategies that support children and young people at the first tier of the graduated approach, and 2) targeted approaches tailored to specific areas of need such as difficulties in literacy and mathematics.

When reporting on intervention and support strategies in this REA, we sometimes refer to effect sizes that were reported in the studies reviewed. Effect sizes range from 0 to 1 and refer to how much of a difference an approach or intervention makes, beyond just whether it works. A small effect (around 0.2) means a modest improvement, a medium effect (around 0.5) suggests moderate improvement or progress, and a large effect (0.8 or more) indicates a strong impact on learning.

Additionally, evidence can come from various study designs, each differing in the strength and type of reliability they offer. Single-case designs provide strong evidence for the consistency of effects within individuals, making them valuable for understanding how interventions work in specific cases. However, their findings may not be widely generalisable (i.e., applicable to other individuals and/or settings). In contrast, group-

design studies such as randomised controlled trials offer more generalisable results across larger populations but may overlook important individual differences in how students respond to interventions. Ideally, a strong body of evidence should be based off of multiple types of study designs.

We also refer to standardised assessments or outcome measures versus researcher-created or bespoke outcome measures. Standardised assessments are norm-referenced tools that have been trialled on large, representative samples to establish reliability (consistency of scores) and validity (that the test really measures what it claims). These allow for comparison of a student's performance to a representative against a representative sample of age-matched peers, allowing for an estimate of whether a student is performing above, at or below expected levels. By contrast, researcher-created or bespoke measures are tailored to the exact targets of an intervention or teaching programme for example, a bespoke word-definition task featuring the precise vocabulary items taught and practised. Although research-created measures tend to be more sensitive to the incremental progress students make over short instructional periods, these measures lack the normative data and the extensive psychometric testing of standardised tools.

Universal support: High quality teaching and classroom support

Support for students with SEND can be provided at different levels, starting with universal strategies delivered to all students through evidence-based 'quality first' teaching approaches. Universal provision, or 'tier 1' consists of evidence-based pedagogical approaches and may be delivered as whole-class teaching, small groups, or even individual activities. When universal approaches aren't enough to meet the educational needs of students, targeted support can be offered, tailored to individual needs, and implemented either in small groups or through one-to-one interventions. Finally, if this second 'tier 2' is still not effectively addressing the needs of students, support can be offered at the third 'tier 3' which consists of specialist support which may involve external professionals such as speech and language therapists or coordinated multi-agency support (e.g., through an Education, Health, and Care Plan). This so-called tiered approach to support children's educational needs is well established in the UK educational context (e.g., see SEND Code of Practice, 2015). Similar models are also used in the US educational context such as response to intervention models (Fuchs & Fuchs, 2006) or multi-tiered systems of support (McIntosh & Goodman, 2016), where children who do not progress with effective universal treatment are offered more individualised and targeted support. The SEND Code of Practice defines high-quality teaching: high-quality teaching, differentiated for individual pupils, is the first step in

responding to pupils who have or may have SEND. Additional intervention and support cannot compensate for a lack of good quality teaching. (DfE, 2015, p. 99)

By providing high-quality teaching that is evidence-based and differentiated, schools may reduce the likelihood that students will require additional, more intensive support. Effective quality-first language teaching relies on strong classroom management and instruction, supplemented by targeted or specialist oral-language support when needed (Fuchs & Fuchs, 2006; 2009). A range of inclusive instructional strategies and classroom design approaches can support children and young people with SLCN at this first tier. The approaches identified in our REA include instructional techniques and adjustments to the physical or social environment.

Instructional approaches

Academic difficulties among children and young people with SLCN needs may stem from underlying challenges with language, but also from executive functions, including attention, working memory, planning, and organisation (for a review of executive functions see our [Cross-Cutting Themes Report](#)). For example, tasks that require flexible thinking, cognitive control, or adapting to changing rules or instructions, especially under demanding or complex task conditions can be challenging for children and young people with SLCN. These difficulties may underlie both academic and behavioural challenges. Given the challenges children and young people with SLCN may have with executive functions, it is important to use instructional strategies that support more cognitively demanding learning tasks and reduce cognitive load.

Techniques that provide structure, break tasks into manageable steps, use clear prompts/cues and explicit instruction have been found to be effective in supporting children with SLCN and can be implemented at the whole-class level or during targeted intervention delivery (e.g., Carroll et al., 2017). These techniques include explicit instruction, scaffolding, the use of mnemonics (especially for learning key facts), task-sequencing, and metacognitive approaches. Recasting can also be useful to encourage accuracy in vocabulary, grammar, and syntax (Favot et al., 2020). Recasting is a strategy where more experienced speakers respond to a child's utterance by expanding, deleting, or changing their utterances while maintaining the meaning (Saxton, 2005). For example, if a child says, "Him going to park," their conversation partner might say, "Yes, he is going to the park."

Several systematic reviews in our REA emphasised the importance of vocabulary learning for children and young people with SLCN (Clark & Reuterskiöld, 2021; Frizelle et al., 2021; Lowe et al., 2017). Educators are encouraged to allocate regular classroom time for explicit vocabulary instruction. Children should be exposed to new words in

multiple contexts (e.g., using it in a sentence, writing the word) with repeated opportunities for practice and reinforcement.

The reviews identified in our REA suggest that teachers may consider encouraging conversational participation through structured activities that encourage verbal self-regulation and structured narrative instruction to improve storytelling and comprehension (Jensen de López, 2022). Teachers can also use mediated learning strategies (e.g., scaffolding, guided storytelling, or shared-book reading) to support narrative competence pragmatic skills in children with language difficulties.

Effective universal instructional approaches summary

- Scaffolding including modelling and recasting
- Task-sequencing
- Metacognitive approaches
- Explicit instruction
- Integrating vocabulary into lessons
- Opportunities to participate in conversations or discussions
- Mediated learning strategies

Classroom environment

In the [Cross-Cutting Themes Report](#) of our collection of REAs, we highlighted several effective strategies to design inclusive classrooms which benefit children with different types of special educational needs. These techniques therefore won't be repeated here. Instead, we focus specifically on strategies demonstrated to be effective for children and young people with SLCN.

First, the importance of fostering an oral language rich environment has been widely established. Such a language environment can also provide support for literacy (Snowling et al., 2011) and can enhance learning (Mercer et al., 2009).

One approach that promotes effective communication especially in the early years (reception through year 2) is the Communication Supporting Classrooms Observation Tool (CSCOT) from the Better Communication Research Programme (Lindsay et al., 2012). The CSCOT is an audit tool designed to document the language and communication opportunities afforded by the learning environment. This tool consists of

several checklists to help educators consider the quality and quantity of the language learning environment, learning opportunities, and interactions.

Similar to instructional approaches, reducing the load of sensory information and processing demands is helpful for children and young people with SLCN (Carroll et al., 2017). Classrooms and school environments can be highly stimulating and overwhelming for pupils with different types of SEND including SLCN. For example, in a randomised controlled trial, Dockrell and Sheild (2006) found that speed of processing for children and young people with SEND can be negatively impacted by background babble and external noises such as sirens or lorries. Therefore, minimising background noise and even considering acoustic panelling can help support learning.

Considerations for supportive classroom environments summary

- Fostering a rich oral language environment
- CSCOT audit tool to help identify areas of classroom or early years setting improvement
- Minimising cognitive load
- Reducing background noise where possible

Collaborative practices

If an outside referral to speech and language has been made, the question of who is responsible in the classroom for supporting the learners' needs with SLCN (Vivash et al., 2018) may arise. The evidence base is heavily comprised of studies focusing on specialist-delivered programmes. However, this reliance on specialists may be challenging for some schools as demand for support may exceed capacity. While there is emerging evidence that specifically trained teachers and teaching assistants (i.e., beyond initial teacher training) can also effectively deliver speech and language/ typically specialist-led interventions (e.g., Carroll et al., 2017), collaborative practice between educators and specialists is key to supporting children with SLCN. It involves creating a holistic approach within mainstream classrooms with parents, teachers, and speech and language therapists working together (Glover et al., 2015). Speech and language therapists can provide support in terms of training, providing advice or suggesting strategies to apply in the classroom.

Many reviews included in our REA evaluated interventions that worked in collaboration with parents or families outside the classroom (Jensen de López et al., 2022; Shiels & Hopf, 2024). Given that the home environment also provides many opportunities for oral language exposure, it is important to work with parents and caregivers in supporting

language in children and young people with SLCN. Collaboratively planning interventions with families, speech and language therapists and teaching staff is important in maintain consistent support across home, clinical and classroom settings.

Targeted support

Pupils who do not make expected progress despite high-quality teaching and universal support should receive timely, evidence-informed targeted support, with their development regularly reviewed, and such interventions must adhere to principles shown to be effective (Law et al., 2012a). In research and practice, it is not always clear which components(s) should be prioritised for support for children and young people with SLCN, for example, vocabulary, phonology, grammar, pragmatics, or social skills.

In their review, Carroll et al. (2017) highlights the importance of small-group or one-to-one oral language interventions delivered by trained speech and language therapists, teachers, or teaching assistants to improve oral language skills of children and young people at school entry.

Oral language interventions typically target core domains of spoken language such as vocabulary, narrative discourse, semantics, phonics, grammar, and pragmatic skills. These interventions are often scripted and are typically delivered through a combination of explicit, structured teaching and broader, contextually embedded activities (Carroll et al., 2017). Each of these interventions will be described in further detail in the following sections.

Given the well-documented link between socioeconomic disadvantage and delayed oral language development, we draw on the Education Endowment Foundation's (EEF) Teaching and Learning Toolkit, which reports that oral language interventions deliver, on average, six months of additional progress for very low cost, putting them among the highest-impact strategies schools can adopt for pupils from low-socio economic status (SES) backgrounds (EEF, n.d.). Although the Toolkit does not explicitly evaluate SEND-specific programmes, the considerable overlap in language support needs suggests that its evidence-based strategies may be applicable to children with speech, language, and communication difficulties.

These approaches focus on making the most of spoken language and verbal interaction, whether through targeted read-alouds and book discussions, explicit vocabulary extension, structured questioning to build comprehension, or purposeful, curriculum-focused dialogue. Implementation typically involves adults modelling high-quality speaking and listening, scaffolding pupils' contributions, using dialogic talk to develop thinking and metacognitive strategies, providing feedback and teaching specific oral-language strategies. The Toolkit highlights that the strongest effects arise when oral

language approaches are fully integrated into the existing curriculum, ensuring refinements to classroom talk align with subject content. They can be delivered by teachers, teaching assistants or other trained staff across early years, primary and secondary phases, though high-quality professional development is crucial to maintain fidelity and maximise impact.

In addition, the Better Communication Research Programme (BCRP; Law et al., 2012) which was commissioned in response to the 2008 Bercow Review also has published a report on ‘what works’ for children and young people with SLCN. To summarise briefly, they identified 57 interventions published in the research or currently in use. Three of the interventions were rated as having strong evidence of efficacy, 32 had moderate evidence and 22 had indicative evidence. Refer to [Exploring interventions for children and young people with SLCN](#), where these interventions, their descriptions, and their quality ratings can be found along with their research report. A ‘what works’ database⁴ has been developed from their report and is maintained by representatives from the Royal College of Speech and Language Therapists and Speech and Language UK.

While we will not review the individual strategies from the Toolkit and the BCRP in depth here, we recommend that practitioners consider its guidance alongside other targeted SEND interventions. Some of the evidence cited in other systematic reviews of oral-language programmes in our REA may overlap with the findings from these reviews, reinforcing the case for integrating its approaches within broader speech, language, and communication support.

Vocabulary support

Vocabulary development is important in supporting oral and written language as well as reading proficiency. Children with DLD and more general language difficulties, school-aged and older, have been reported to know fewer words and have shallower knowledge of word meanings across all grades (McGregor et al., 2013). They have difficulty with both the number of words stored, and the ability to acquire new words (Gray, 2003; for a review, see Kan & Windsor, 2010). Challenges with vocabulary knowledge is linked to poorer academic outcomes (Dockrell et al. 2007, Nation & Snowling 2004). This deficit can persist into secondary school and beyond (Rice & Hoffman, 2015), highlighting the importance of interventions that target vocabulary development. While vocabulary intervention studies often prioritise reading comprehension over oral vocabulary measures, targeting oral vocabulary is critical for children and young people with language difficulties and DLD (Justice et al., 2005).

⁴ [What Works database: a data base of evidenced interventions to support children’s speech, language and communication skills.](#)

Vocabulary interventions are often aimed at increasing the number of words children can produce and understand. They can be scripted and often involve explicit teaching of vocabulary where an instructor provides precise definitions and illustrative examples before, during or after a shared-reading activity, followed by discussion that revisits the target words. Elaboration strategies are commonly used where an instructor actively connects target words to words and ideas already known by their learners, rather than simply presenting a definition. It involves mental operations on word meaning like asking “What category does it belong to?”, “What does it look like?”, “How is it used?”.

Vocabulary interventions may use definitional frameworks, semantic mapping, and spaced practise to deepen word knowledge, while grammatical targets are addressed via modelling or focused exercises. Five reviews retrieved in our REA investigated interventions to support vocabulary for children and young people with SLCN.

Presenting new vocabulary in its written form can enhance acquisition and retention in children and young people. One systematic review (Clark & Reuterskiöld, 2021) found that children aged 7 to 11 with DLD, Down syndrome, autism, and dyslexia benefit from including written words (orthographic representations) during vocabulary learning rather than with images or oral presentation alone. Studies found that presenting the written form alongside spoken input helps these children learn new words more quickly and accurately, especially in tasks like picture naming. These findings suggest that integrating written word forms into vocabulary instruction can support better word retention and encouraging educators to use these strategies may offer benefits for children with these needs.

A systematic review by Lowe et al. (2017) investigated different types of vocabulary interventions for children aged 9 to 16 with language difficulties, including those with DLD. The interventions all had a phonological and/or a semantic focus, meaning they aimed to improve vocabulary by providing opportunities to enhance the awareness of sounds (phonological), and/or word meaning (semantics). For example, a common approach is using a word map that visually integrates both phonological and semantic features for a target word. Central to the phonological-semantic intervention is providing repeated opportunities for spoken aloud practice within meaningful contexts (e.g., Ebbels et al., 2012). The findings show that the evidence for these types of approaches remains mixed. Semantic-only interventions produced varied results, with small single-case and specialist-class randomised controlled trials (Haynes 1992; Joffe 2006) as well as whole-class compensatory approaches (Sim 1996, 1998) demonstrating vocabulary gains for researcher-created outcome measures. However, there was limited evidence of wider generalisation or improvement on more standardised outcome measures.

Direct comparisons of phonological versus semantic teaching (Hyde Wright et al. 1993; Bragard et al. 2012) suggested a modest advantage for semantic methods. This finding makes sense theoretically, as language is related to semantics, so language difficulties

could be supported by semantics. However, it should be noted that the semantic interventions sessions were longer (30 versus 15 minutes) which may have impacted findings. In contrast, combined phonological-semantic programmes demonstrate the most robust evidence of efficacy. Individual randomised controlled trials conducted in specialist schools (Ebbels et al. 2012; Wright et al. 2017) report significant gains on word-finding and standardised vocabulary tests. Additionally, small-group and whole-class trials in mainstream secondary schools (Joffe 2017; Spencer et al. 2017; Lowe & Joffe 2017; Murphy et al., 2017) show moderate to large effects on bespoke and some standardised measures when delivered with a manualised curriculum, regular high-intensity sessions and trained practitioners. Overall, phonological-semantic interventions, especially when sufficiently dosed (30-60 minutes, two to three times weekly), systematically scaffolded (i.e., where guidance or assistance is gradually reduced as learners develop their understanding), and embedded in meaningful contexts, are effective across ages 9 to 16, with stronger generalisation evident under one-to-one or small-group speech and language therapist delivery but also scalable via trained teachers and teaching assistants.

Another systematic review found further evidence for an advantage of semantic versus phonological focused vocabulary interventions for children and young people with DLD aged 3 to 12 (Frizelle et al., 2021). However, the review raised concerns about the outcome measures used to evaluate this finding. For example, outcomes were assessed using tasks that primarily measured semantic rather than phonological skills. Therefore, the study may overestimate the effectiveness of semantic instruction relative to phonological instruction, as the outcome measures were more closely aligned with the semantic condition. This raises concerns about measurement bias and limits the ability to draw firm conclusions about the comparative efficacy of the two instructional approaches. Therefore, more research is needed to support these findings. They also found that a combined phonological-semantic approach is effective but may be more so for children who have higher ability levels in language. Effective approaches also expose the learners to vocabulary in a variety of contexts (e.g., via visual supports, elaboration to support understanding of phonology and semantic understanding).

There is also evidence from single case design studies that morphological-based interventions can be effective in supporting vocabulary acquisition for children and young people with language difficulties (Steele, 2014). Morphemes are the smallest meaningful units in language. Morphemes may be whole words such as “book” or “climb” or they might be attached to words such as a prefix or a suffix (e.g., “ed” in “climb-ed”). These also include both derivational affixes (which change a word’s meaning or part of speech, as in “happy” into “happiness”) and inflectional affixes (which mark grammatical features such as tense or number, as in “cat” into “cats”). Morphological-based interventions explicitly teach morphological rules so that children and young people can apply this

knowledge to predict the meanings of new words. However, further research with larger group studies is needed to further establish this intervention approach.

Finally, a systematic review (Louick et al., 2023) found that vocabulary interventions that also incorporated motivational techniques such as goal-setting and monitoring, self-graphing (e.g., keeping a regular recording of one's ongoing scores or progress on a personal graph, either on graph paper or on the computer), using high-interest texts, and using rewards were effective for children aged 5 and older at risk of literacy or language difficulties.

Effective vocabulary support strategies summary

- Presenting and practicing vocabulary in multiple contexts (e.g., visually, verbally, written) leveraging multisensory techniques
- Providing opportunities for rehearsal
- Interventions that incorporate phonological and semantic elements together may be most beneficial
- Some evidence for incorporating morphology and motivational techniques

Narrative interventions

Narrative interventions typically focus on the ability to produce oral accounts such as descriptions, or stories. They may employ story-grammar modules with visual supports and authentic literature, prompting children to sequence events, retell stories and infer character motivations. Children and young people with SLCN including language disorders, and language challenges associated with Down syndrome, intellectual disabilities and autism may demonstrate challenges in producing oral narratives (Baixauli et al., 2016; Bunning et al., 2016; Segal & Pesco, 2015). This may be in part because generating oral narratives is cognitively and linguistically demanding (Botting 2002). Two reviews retrieved in our REA investigated interventions to support oral narratives for children and young people with SLCN.

One systematic review (Favot et al., 2020) evaluated oral narrative interventions for children aged 5 to 16 with language disorders and/or a disability known to affect communication (e.g., autism, Williams Syndrome). They evaluated the impact of such interventions on narrative macrostructure which refers to a story's overarching framework and key plot elements (e.g., setting, initiating event, resolution), whereas microstructure refers to the finer linguistic details, such as vocabulary diversity, clause complexity and cohesion devices that enrich and clarify the narrative. They found that oral narrative interventions for children across age groups and different profiles of need yield moderate

improvements in narrative macrostructure and smaller but significant gains in microstructure, particularly in high-quality single-case studies. Given the large diversity of age ranges and severity of language difficulties in participants with different types of SEND, these findings suggest that this intervention can be applied as a needs-based approach to a wide variety of children and young people.

In Favot et al.'s (2020) review, effective programmes consistently incorporate visual supports (e.g., icon cards to represent story grammar elements and/or pictures) or book stimuli alongside clinician modelling of complete narratives and dedicated opportunities for each child to produce an entire narrative every session.

Interventions delivered one-to-one (mean total dosage of 593 minutes) show the strongest, most reliable effects. Small-group and published curricula (e.g., Supporting Knowledge in Language and Literacy, Story Champs) also demonstrate promise but require further robust evaluation. Maintenance of gains was observed up to 26 weeks post-intervention, though generalisation beyond trained materials remained inconsistent. Group studies, often of lower methodological quality, report more variable outcomes, underscoring the need for more large-scale controlled trials, exploration of group delivery models, examination of personal versus fictional narratives, and inclusion of broader generalisation measures.

There is also some evidence that syntax interventions improve syntax use in oral narratives in children and young people aged four to eight with DLD. One systematic review (Wisman Weil & Schuele, 2019) found that syntax interventions that used scaffolding techniques, such as recasts, expansions, cloze tasks and modelling, consistently outperform direct-imitation drills when teaching complex syntax. Methods that build on a child's own utterances in contexts like play, picture description or interactive book reading appear especially effective. However, more intervention studies are needed to compare different approaches and to examine their impact on specific types of complex syntax across the preschool and early school years in children with language impairments. Additionally, given that the majority of these interventions were delivered by clinicians, it is currently unclear how scalable they may be for teacher and teaching assistant use.

Effective oral narrative support strategies summary

- Narrative interventions are generally effective particularly when they are delivered one-to-one but can also be scalable
- Syntax interventions also have a growing evidence base

Social communication support

Children with different speech, language, and communication needs may also struggle with social communication skills. Interventions targeting social communication skills typically aim at addressing turn-taking, listening, conversational strategies, pragmatics, and emotion recognition, amongst other skills. However, much of the research investigating social communication have focussed on autistic children and young people with limited evidence for children who are not autistic.

Carroll et al.'s (2017) rapid evidence assessment reviews a number of social communication interventions. They review evidence that suggests that interventions delivered within typical classroom settings are generally more effective than pull-out sessions, though much of the evidence comes from small US-based studies involving specialists rather than teachers. Social communication interventions including teaching-focused social skill training, peer-mediated, video modelling, and visual or technology-based approaches. The review found that overall, these approaches show mixed evidence, often from small or individualised studies, with meta-analyses suggesting only minimal effectiveness for autistic children.

Difficulties in pragmatic skills are common in autistic children and young people (Spencer, 2014), but there is also growing evidence that other children and young people with primary needs in speech, language and communication also have difficulties with pragmatics such as understanding implied meanings or including pragmatic elements in oral narratives (Katsos et al., 2011; Mäkinen et al., 2014; Olsen et al., 2010). Pragmatic interventions typically emphasise turn-taking, conversational narrative skills, topic maintenance, non-verbal signalling, and perspective-taking. They often involve combining direct teaching with indirect modalities such as parent or peer-mediated shared-book reading, to generalise skills across settings. One review retrieved in our REA investigated interventions to support pragmatics for children and young people with SLCN.

The review revealed mixed findings for the efficacy of pragmatic interventions for children and young people with DLD aged 3 to 12 years old. The review (Jensen de López et al., 2022) investigated different types of pragmatic interventions including:

1. Narrative-based programmes, either stand-alone or combined with vocabulary teaching, which use story-grammar frameworks to scaffold coherent storytelling, model turn-taking and embed new lexical items in meaningful contexts;
2. Parent-mediated approaches that train caregivers in strategies such as responsive prompts, conversational recasting and turn-taking routines to boost verbal initiations and reciprocity during everyday interactions;

3. Dynamic-assessment interventions that first gauge a child's learning potential for narrative skills through graduated cueing, then tailor scaffolding levels across sessions;
4. Book-sharing models (including dialogic reading) which guide adult-child joint attention, questioning and elaboration around texts to foster pragmatic functions like requesting, commenting and topic maintenance and;
5. Structured curricula such as TELL (Teaching Early Literacy and Language). These were mostly delivered one-to-one, but dosage varied.

Findings revealed that intervention effectiveness was not consistent across studies. Pragmatic-language programmes for pupils with DLD yielded medium-to-large gains on bespoke outcomes, such as explicit narrative knowledge and verbal initiations in five of the studies reviewed by Jensen de López et al. (2022). However, the results varied from the child's ability in speech regulation (social, private, and inaudible speech), narrative recall and inferential responding varied considerably.

By contrast, studies using standardised tools or simple counts of communicative acts and response adequacy as outcome measures failed to detect significant change, highlighting the greater sensitivity of tailored researcher-designed measures. Shorter sessions delivered more frequently (2-3 times per week) appeared to be more effective than infrequent long sessions.

Although there were a number of methodological limitations such as small sample sizes and issues with the representativeness of the children in the studies, it can be concluded that that pragmatics should be targeted explicitly in interventions, as improvements in vocabulary or grammar skills alone do not necessarily generalise to better pragmatic skills. However, it is less clear which aspects of pragmatics should be the focus of targeted interventions for children and young people with DLD.

Grammar

Ebbels (2014) reviewed grammar interventions for 3 to 16-year-olds with DLD, speech-and-language delay and autism, finding that one-to-one implicit methods (recasts, modelling) reliably improve expressive morphology and syntax in pre-school and early primary pupils, though they may be insufficient for those with receptive deficits or severe impairment. In contrast, explicit metalinguistic approaches benefit older, school-aged children, particularly those with receptive difficulties, and appear most effective when delivered by qualified speech and language therapists. Many programmes combine explicit teaching of new forms with implicit reinforcement (for example, recasting within narrative tasks), yet direct comparisons of blended versus singular approaches remain scarce. Embedding grammar within story-grammar frameworks not only strengthens

syntactic skills but also enhances overall narrative competence. Bilingual interventions preserve or even enhance L1 (first language) proficiency without hindering L2 (second language) development, sometimes outperforming L2-only training. Finally, grammar programmes delivered by untrained school staff generally yield limited grammatical gains, whereas well-trained and closely supervised teaching assistants can successfully extend speech and language therapist-led expressive interventions.

Literacy support

As previously noted under 'Identification of literacy difficulties', literacy and oral language skills are closely linked. Reading difficulties are prevalent among children and young people with language impairment (e.g., Catts, Fey, Tomblin, & Zhang, 2002; see Adlof & Hogan, 2018 for a review). Generally, supporting oral language skills can in turn support literacy skills and vice-versa. Therefore, it is important for educators to be aware of the role that oral language plays in the classroom and in wider areas of learning. Many reading interventions focus on supporting phonology and vocabulary. Semantic or phonological principles can be embedded as part of vocabulary or narrative programmes, or they can be delivered as standalone interventions. Semantic interventions typically involve improving awareness of function, location, attribute, category, similarities, and differences, how to describe what words mean, and how words link with other words. Phonics or phonological interventions typically involve improving the recognition and production of sounds in a language. This may involve developing awareness of phonemes, syllables, rhymes, and the ability to blend or segment words or sounds. These interventions are typically explicit and focused on teaching sounds in a specific sequence. They are also often part of literacy interventions in the early years for children and young people with SLCN or literacy difficulties.

Many of these interventions are reviewed in our [Cognition and Learning Report](#) and will not be repeated here. However, one systematic review (Rodge et al., 2019) in this REA investigated instruction in linguistic comprehension skills (e.g., vocabulary, grammar, and narrative skills) for children and young people aged 5 and older with language difficulties or language delays, including bilingual children, to determine whether they may have generalised outcomes of linguistic comprehension and reading comprehension.

Rodge et al. (2019) found that linguistic comprehension instruction can improve children's overall understanding of oral language, although the apparent benefits depend heavily on which outcome measures are used. While such programmes may support general listening and comprehension skills, they alone appear insufficient to accelerate vocabulary growth or to eliminate gaps in word knowledge. Moreover, short-term gains in language understanding do not reliably transfer to improved reading comprehension, suggesting that sustained, long-term instructional efforts may be necessary to impact

broader literacy outcomes. Finally, using assessment tools that directly tap the specific vocabulary and structures taught might reveal stronger, more immediate effects than the generalised measures typically employed.

Effective literacy support strategies summary

- Literacy interventions can be effective for children and young people with SLCN
- Interventions that support vocabulary, phonology, oral narrative or grammar can be particularly effective

Persistent speech difficulties

Interventions for children aged 8 and younger with speech sound disorders typically use auditory modelling and feedback on articulator placement to correct speech errors (Sugden et al., 2019). They may also consist of motor-based drills to support acquisition, retention, and transfer of accurate speech movements (Maas et al., 2008; Morgan & Vogel, 2009). Phonological approaches, by contrast, target sound perception. Techniques such as minimal-pairs emphasise a child's ability to discriminate and contrast sounds that change word meaning, supporting their phonemic awareness (McLeod & Baker, 2017). In these interventions, minimal pairs are pairs of real words that differ by only a single sound (phoneme) (e.g., "cap" vs. "tap"). By contrasting these pairs, children learn that swapping one sound changes meaning, which helps them discriminate and correctly produce the target phoneme in meaningful contexts.

Although many speech sound disorders (SSD) may resolve by school-entry, especially with intervention, for some children, these difficulties in speech may persist beyond age eight or nine (Shriberg et al., 2010). One systematic review of case studies in our REA reported an intervention for residual speech errors in adolescents and adults (Shields & Hopf, 2024). Participants in the studies reviewed had difficulties defined as speech distortions and misarticulations that persist beyond 8 years of age. All interventions were based in clinic settings (apart from one which was delivered via telepractice) and consisted of motor-learning or feedback interventions, which are designed to support learning of articulatory movements. Ratings of participant's speech production accuracy improved across these studies and more intensive treatment tended to yield better results. Although these interventions would be carried out by a clinical specialist, educators can consider referral of children aged eight and older who may have persistent speech difficulties. There is also evidence from this study and a further systematic review that telepractice treatment (i.e., the delivery of speech and language therapy services remotely using telecommunications technology such as video conferencing or via mobile applications) with the same intensity as in-person treatment can also be effective when delivered by clinicians (Thao & Lee, 2022).

Support and intervention summary

Effective support for pupils with speech, language and communication needs begins with high-quality “universal” teaching, clear instruction, and an inclusive classroom design, augmented by targeted, specialist input when required (Fuchs & Fuchs, 2006; 2009). At the whole-class level, explicit techniques (breaking tasks into steps, clear prompts, scaffolding, use of mnemonics (memory aid techniques) and metacognitive strategies) reliably bolster comprehension and reduce cognitive load for pupils with DLD and related profiles. Embedding vocabulary instruction in multiple contexts (orthographic alongside auditory input, semantic mapping, elaboration, and spaced practice) and integrating grammar teaching within narrative frameworks (using recasts, modelling and cloze tasks) consistently yields measurable gains. Phonological-semantic programmes delivered one-to-one or in small groups by trained practitioners produce the largest effects on word-finding, while narrative interventions with visual story-grammar supports improve both macro- and microstructure of children’s storytelling. Pragmatic interventions, whether parent-mediated turn-taking programmes, book-sharing models, or structured curricula like TELL (Teaching Early Literacy and Language), demonstrate medium-to-large gains on bespoke measures of conversational skills and narrative knowledge. Finally, speech-sound therapies that leverage motor-learning principles and feedback facilitate accurate articulation in younger children and those with persistent SSDs.

In practice, these findings imply a tiered approach: prioritise sustained, high-quality classroom talk and targeted oral-language activities; collaborate closely with speech and language therapists, teaching assistants and families to reinforce learning across home, clinic, and school; and ensure ongoing professional development so that educators can administer basic screening tools, contribute to language sampling and interpret informal checklists effectively. Audit instruments such as the CSCOT helps maintain an environment rich in language opportunities, while regular monitoring (formal and informal) enables timely referrals for specialist assessment. Embedding new forms in meaningful, curriculum-relevant contexts and maintaining practice variability further promotes generalisation beyond the therapy setting.

Notable gaps, however, remain. Many studies rely on bespoke outcome measures, making direct comparisons difficult, and relatively few employ long-term follow-up to gauge durability. Evidence is heavily weighted towards speech and language therapist-delivered one-to-one programmes, with limited trials of teacher- or TA-led interventions in mainstream settings, particularly at secondary age. Terminological inconsistency between educational and clinical contexts complicates tool selection and interpretation by non-specialists. Future research should standardise outcome metrics, evaluate scalable group-delivery models, extend investigations into older cohorts and cross-linguistic

populations, and develop accessible training pathways to equip teachers and support staff to deliver evidence-based language interventions with confidence.

Conclusions

This review aimed to identify effective methods for the identification and support of children and young people with SLCN in mainstream education while highlighting where collaborative practice is essential. This rapid evidence assessment highlights the critical role mainstream educators play in the early identification and support of pupils with speech, language, and communication needs (SLCN). While classroom-based observations and screening tools are not diagnostic, they are essential in guiding timely support and referrals. These approaches are most effective when embedded in collaborative practice involving SENCo coordination, family engagement, and professional interpretation from speech and language therapists. Foundational training and ongoing professional development further strengthen teachers' capacity to recognise diverse profiles, including co-occurring conditions and bilingual learners, and to apply evidence-informed strategies.

Effective support begins with high-quality, inclusive teaching, complemented by targeted and specialist interventions where needed. A tiered approach combining structured classroom talk, adapted materials, and consistent collaboration across settings can foster meaningful gains in vocabulary, narrative, pragmatics, and articulation. However, several limitations remain, including inconsistent terminology, limited validation of tools for non-specialist use, and a research base that is disproportionately focused on speech and language therapist-led, one-to-one programmes and autistic learners.

Inconsistencies in outcome reporting and intervention design across studies limit the generalisability of some findings. Furthermore, due to the rapid nature of this review and our focus on systematic reviews and meta-analyses, it is possible that some tools or interventions currently in use, particularly newer, unpublished, or practitioner-led approaches, may not have been captured. These omissions reflect the current state of the evidence base, not necessarily the effectiveness of those approaches. Future research should prioritise robust study designs, focus on outcomes linked to educational access and attainment, and include mainstream educator perspectives.

To advance practice, future research must establish shared definitions, standardise outcome measures, and explore scalable interventions in mainstream settings, particularly at secondary level and for children with SLCN unrelated to autism. Building accessible training pathways will be key to ensuring educators are equipped to contribute meaningfully to identification, intervention, and progress monitoring across the education system.

Appendices

Appendix A: Search terms (PICOS criteria)

We conducted 15 separate searches across five rapid review categories, each focused on a distinct population: SEMH, SLCN, autism, sensory and/or physical needs, and cognition and learning. For each population, three searches were performed, focusing on: identification terms, support terms, and working with others. The intervention, comparison, and study type remained consistent across all searches, while the population and outcome terms varied to capture the unique characteristics of each group. This approach ensured a comprehensive examination of the research literature across the different populations. PICOS stands for: (1) Population; (2) Intervention; (3) Comparison; (4) Outcomes; and (5) Study type.

Population:

- Population terms: "adolescent" OR child* OR "children and young people" OR kid* OR "post 16" OR pupil* OR "school aged" OR student* OR teen* OR "young learner*" OR "young people" OR "young person" OR youth
- Educational setting terms: "alternat* educat*" OR class* OR "class* setting" OR "comprehensive school*" OR "early year*" OR educat* OR elementary OR "elementary school*" OR "extra-curricular setting*" OR "further educat*" OR "further educat* setting*" OR "grammar school*" OR "high school" OR "higher educat*" OR inclus* OR kindergarten OR "learning environment*" OR mainstream* OR "middle school*" OR nursery OR preschool OR "primary educat*" OR "primary school*" OR reception OR "remedi* class*" OR "school setting" OR school* OR "secondary education*" OR "secondary school*" OR "special educat*" OR "university" OR "whole school" OR "independent school"
- General SEND terms: SEND OR SEN OR "special educat* need*" OR "special need*" OR "learning difficult*" OR "learning disab*" OR "learning difference" OR "additional need*" OR impair* OR disorder* OR neurodivergent OR "additional learning need"
- SLCN terms: DLD OR "primary language disorder*" OR SLCN OR SLI OR SSD OR apraxia OR "articulat* disorder*" OR "childhood apraxia of speech" OR "cleft palate" OR "communicat* disorder*" OR "communicat* impair*" OR "communicati* dysfunction*" OR "comprehen* difficult*" OR "comprehen* disorder*" OR "comprehen* impair*" OR "developmental language disorder*" OR disfluen* OR dysarthr* OR "expressive language" OR "fluency difficult*" OR "fluency disorder*" OR "grammar difficult*" OR "grammar disorder*" OR "grammar impair*" OR "language delay*" OR "language development* disorder*" OR "language difficult*"

OR "language disabilit*" OR "language disorder*" OR "language impair*" OR "language need*" OR morpholog* OR morphosynta* OR "phonological disorder*" OR pragmat* OR "produc* difficult*" OR "produc* disorder*" OR "produc* impair*" OR "receptive language" OR semantic* OR "specific language disorder*" OR "speech difficult*" OR "speech disorder*" OR "speech dysfluen*" OR "speech language communication need*" OR "speech production" OR "speech sound disorder*" OR stammer* OR stutter* OR synta* OR "vocabulary difficult*" OR "vocabulary disorder*" OR "vocabulary impair*" OR voice OR "voice disorder*" OR "voice problem*" OR "word find*" OR "word learn*"

Intervention:

- Identification terms: assess* OR "assessment app*" OR "assessment tools" OR "behavio* checklist*" OR checklist OR "class* assess*" OR "classroom observation" OR "cognitive assess*" OR "computer* app" OR "curriculum-based measure" OR diagnos* OR "dynamic assessment" OR "early screening tools" OR "educational assessment tool*" OR evaluate OR "formal assess*" OR "formative assess*" OR "graduated approach" OR identif* OR "informal assess*" OR measure OR "multi-disciplinary assessment" OR MTSS OR "multi-tiered system of supports" OR "neuro* assess*" OR observ* OR "parent* report" OR "pupil observation" OR "response to intervention" OR RTI OR screen* OR "self-assessment" OR "self-report" OR "smartphone app*" OR "standard* test*" OR "student observation" OR "tablet app*" OR "teacher judgment*" OR "teacher observation" OR tool* OR "performance-based"
- Support terms: "classroom environment" OR "SEN support" OR "SEND support" OR SWPBS OR accommodat* OR adaptat* OR approach OR "assistive tech*" OR "classroom interve*" OR "collaborative teach*" OR curriculum OR "curriculum adapt*" OR "differentiat* instruction" OR "digital learning" OR "early interven*" OR "education* program*" OR "education* support" OR "evidence-based interven*" OR "evidence-informed interven*" OR "exam access arrangement*" OR "exam accommodat*" OR "graduated approach" OR "group intervention" OR "high-quality instruct*" OR "high-quality teach*" OR inclus* OR "inclusive education" OR "inclusive practice" OR "individual support" OR "individual* education plan*" OR "instruct*" OR interven* OR integrat* OR "mainstream class* support" OR "mainstream education" OR "mainstream environment" OR "multimedia learning environment" OR "multi-tiered system* of support" OR "one-to-one" OR "parental support" OR pedagog* OR "peer support" OR personali*ed OR provision OR remediat OR "school support service*" OR "school-based" OR "special* interven*" OR "special* support" OR "specialist teach* support" OR support* OR strateg* OR "targeted interven*" OR "target* teach* strateg*" OR targeted OR "targeted support" OR teach* OR "teach* adaptation*" OR "teach* principle*" OR "teach*

strateg*" OR "teach* approach" OR therapy OR "tier 1 interven*" OR "tier 1 support" OR "tier 2 interve*" OR "tier 2 support" OR "tier 3 interven*" OR "tier 3 support" OR treat* OR "universal design" OR "universal interven*" OR "universal provision" OR "universal support" OR "whole-class support" OR "whole-class teaching"

- Working with others terms: collabor* OR parent* OR carer OR caregiver OR famil* OR specialist* OR "specialist teacher" OR teacher OR educator OR TA OR "teaching assistant*" OR "support staff" OR "educational psychologist*" OR EP OR SLT or SLP or "speech and language therapist*" OR "speech and language pathologist*" OR "speech therapist" OR "speech pathologist" OR "health visitor" OR HV* OR "Ed Psych" OR counsel* OR "mental health support workers" OR "child and adolescent mental health service" OR CAHMS OR psychologist* or therapist* OR "learning support assistant" OR LSA OR "communication support worker" OR QTOD OR QTMSI OR QTVI OR "co-production" OR "joint working" OR "healthcare professional" OR "personal carer" OR "occupational therapist" OR "Inter-professional collaboration" OR IPC OR expert OR clinician OR nurse

Comparison:

- Left blank to include studies without comparison groups

Outcome:

- Identification terms: N/A - Not needed for identification terms as there is not always a specific outcome
- Behavioural, Inclusion, Motivation, and Engagement terms: attendance OR "behavio* outcomes" OR "behavio* regulation" OR "behavio* improvement" OR "cognitive development" OR "communication skills" OR criminal OR economic OR employment OR engage* OR financial OR "functional independence" OR "functional skills development" OR "access to learning" OR "improvement in learning" OR "inclusive classroom" OR "increase* inclusion" OR "independent living" OR independent* OR "mental health outcomes" OR motivate* OR offend OR "prosocial behavio* " OR "reduce* learning barriers" OR "reduce* symptom*" OR "self-regulat*" OR "school performance" OR "school retention" OR "social inclusion" OR "social-emotional development" OR "teacher perceptions of student progress" OR "well-being" OR workplace
- Educational outcomes (General): "academic achievement" OR "academic progress*" OR "academic attainment" OR "academic measure" OR "academic performance" OR "additional learning support*" OR "educat* achievement" OR "educat* assess*" OR "educat* attainment" OR "educat* measure" OR "educat* outcome*" OR "educat* performance" OR "educat* progress" "executive function"

OR "functional skill* develop*" OR "improve* learning" OR learn* OR "learning progress" OR "problem solving" OR "reduced learning barriers" OR "school outcome*" OR "school performance" OR "school retention"

- Literacy outcomes: read* OR literacy OR "letter recognition" OR "letter-sound knowledge" OR "word reading" OR phonic* OR phonolog* OR "reading comprehension" OR "reading accuracy" OR "reading fluency" OR "reading delay*" OR "print knowledge" OR decod* OR "alphabet knowledge" OR "listening comprehension" OR "word recognition" OR "sentence completion"
- Writing outcomes: writ* OR literacy OR punctuation OR spelling OR "sentence writing" OR "free writing" OR "early writing" OR "emergent writing" OR "guided writing" OR "writing fluency" OR handwriting OR "interactive writing" OR "letter typing" OR "sentence completion"
- Mathematics outcomes: math* OR numer* OR numb* "number sense" OR arithmetic* OR geomet* OR shape OR calcul* OR algebra OR counting OR addition OR subtraction OR multiplication OR division OR fractions OR statistics* OR "place value" OR "math* competenc*" OR "math* concept*" OR "math* knowledge"
- Working with others terms: collaboration* or partnership* or co-practice* or multidisciplinary* or transdisciplinary or interdisciplinary

Study type:

- Review type: review OR "systematic review" OR "meta-analysis" OR "narrative review"

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Reference: RR1550

ISBN: 978-1-83870-700-2

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