

INTRODUCTION

Developmental Language Disorder (DLD) is a common yet often under-recognised neurodevelopmental condition affecting around 7.5% of children, approximately two in every classroom (Norbury et al., 2016). Characterised by persistent difficulties in understanding and/or using language without an identifiable cause, DLD impacts learning, social interaction, and emotional development (McGregor, 2020). Despite its prevalence, awareness among educators and the public remains low (RCSLT, 2023). This poster critically evaluates how DLD is identified and diagnosed in early years settings, analyses two key barriers to inclusion, and explores the Picture Exchange Communication System (PECS) as an effective strategy to support communication and participation.

1) IDENTIFICATION & DIAGNOSIS OF DLD

In early years education, DLD is typically identified when a child exhibit delays in reaching communication milestones. Initial concerns are often raised by parents, early years practitioners, or health visitors. The EYFS framework in the UK prioritises language and communication as prime developmental areas, encouraging early observation and referral (DfE, 2021).

Diagnosis is made by a qualified Speech and Language Therapist (SALT) through a combination of standardised assessments, observational data, and developmental history (Bishop et al., 2016). Key criteria include significantly below-average language skills, persistent difficulties beyond age five, and functional impact on daily life (Bishop et al., 2016). Importantly, these deficits cannot be attributed to other conditions such as hearing impairment or autism.

Barriers to early identification stem from low awareness, variable presentation, and inconsistent terminology. Historically, over 30 labels were used for DLD, causing confusion among professionals (Bishop et al., 2016). Many educators misattribute language challenges to shyness or poor behaviour (RCSLT, 2023). Bilingual children are particularly at risk of misdiagnosis, as their difficulties may be seen as part of second language acquisition (Norbury et al., 2016).

From a medical model perspective, DLD is viewed as a deficit within the child, diagnosed through clinical assessment and requiring intervention (Honeybourne, 2018). The social model, in contrast, highlights external barriers, such as lack of training, communication-unfriendly environments, or inaccessible routines, that exacerbate the impact of DLD (Curran, 2020). Recognising these dual perspectives encourages practitioners to think critically about both assessment and the role of inclusive practice in early years settings.

Despite the clear benefits of early identification, many children still face long NHS waiting lists and under-trained staff, meaning diagnosis often occurs only at school entry (Speech and Language Link, 2024; Law et al., 2020).

2) IMPACT OF BARRIERS ON CHILDREN AND FAMILIES

Barrier 1: Low Awareness and Delayed Recognition

Lack of awareness remains a fundamental barrier to supporting children with DLD (McGregor, 2020). Teachers and even health professionals often misidentify language difficulties as behaviour or attention issues (RCSLT, 2023). This misinterpretation can result in children being excluded or reprimanded unfairly, negatively affecting confidence, mental health, and classroom engagement (Conti-Ramsden et al., 2017).

From the medical model perspective, this reflects a failure in diagnosis and access to professional intervention. From the social model, it reveals a systemic barrier, educators lacking training or tools to differentiate between non-compliance and communication need (Honeybourne, 2018).

Families frequently report long, disjointed referral pathways, poor communication, and having their concerns dismissed. This results in increased emotional strain, and in some cases, parents blame themselves for the child's difficulties (Brighter Futures for Children, 2020).

Barrier 2: Inconsistent Support Provision

Even once DLD is identified, many children receive fragmented or insufficient intervention. SALT services are often overstretched, with waiting lists exceeding six months in some areas (Speech and Language UK, 2024). While some children may be offered short-term consultations, many require long-term, targeted support which is rarely available unless privately funded.

From the social model viewpoint, these gaps represent systemic inequity, especially for families in deprived areas, where DLD is more prevalent (Conti-Ramsden et al., 2017). The medical model would identify this as a failure in health service delivery or inadequate clinical pathways. For families, the burden of navigating complex services adds financial and emotional pressure, particularly if parents have language difficulties themselves (Law et al., 2019).

For children, missing early support means starting school already behind, with long-term academic and social consequences (Norbury et al., 2016).

3) SUPPORT STRATEGY: PECS

PECS is a structured augmentative communication approach enabling children to express needs and initiate interaction using picture cards (Bondy and Frost, 2001). Originally developed for autistic learners, it is equally effective for non-verbal or minimally verbal children with DLD (Kid Sense, 2023).

PECS is taught in phases, from single-word exchanges to constructing simple picture-based sentences. Research shows PECS significantly reduces frustration, improves behaviour, and often supports the emergence of verbal speech (Tincani, 2004; Hart and Banda, 2010). In early years settings, PECS can be embedded into daily routines, allowing children to independently request items, actions, or attention.

Critically, PECS aligns with both medical and social models. Medically, it compensates for expressive language delays by providing an evidence-based intervention. Socially, it removes communication barriers, allowing the child to engage with peers and adults meaningfully in the environment (McLeod and Baker, 2014). It also facilitates inclusive practice by supporting participation during group routines such as snack or story time.

A pilot study by Zink et al. (2016) demonstrated that PECS can reduce anxiety and increase cooperation in clinical contexts, such as dental procedures, highlighting its broader applicability. This reinforces PECS as a flexible strategy not only for developing communication, but also for reducing emotional stress associated with unmet needs.

While initial implementation requires training and resources, the gains in emotional well-being, participation, and confidence are significant. PECS also helps practitioners better understand children's preferences and intentions, reinforcing positive relationships (Hart and Banda, 2010).

CONCLUSION

DLD is a prevalent yet frequently overlooked ALN in early years education. Early, accurate identification, enabled through trained practitioners and responsive systems, is essential. Barriers such as low awareness and underfunded services delay intervention and exacerbate educational inequalities. Strategies like PECS empower children to communicate and participate, reducing frustration and supporting inclusion. Applying both social and medical models ensures a balanced, child-centred approach where communication is recognised as a right, not a privilege.

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