



POSITION PAPER

Developmental Language Disorder Across the Lifespan

A European position on identification, support, services and research across the
lifespan

European Speech and Language Therapy Association (ESLA)

October 2026

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Executive Summary

Developmental Language Disorder (DLD) is a common neurodevelopmental disorder characterized by persistent difficulties in learning and using language that have a significant impact on everyday life. DLD is heterogeneous and can affect different aspects of language. It may co-occur with other developmental difficulties, and its impact can change as the demands on language change across childhood, adolescence and adulthood [1,3].

A population study in England estimated language disorder of unknown origin in 7.58% of children at school entry [2]. This provides important evidence that significant developmental language difficulties are common. The study used criteria that preceded the final CATALISE definition of DLD, however, so the figure should not be treated as a precise prevalence estimate for DLD across all European countries, languages or age groups. Comparable European data remain limited.

DLD emerges during development and, for many people, continues to affect communication and learning in adolescence and adulthood. It can also influence how easily a person takes part in education, work, relationships and community life. Yet the evidence becomes much thinner with age: a 2026 scoping review identified only 53 studies of adults with DLD across 35 years [3,12].

ESLA calls for:

- recognition of DLD as a common neurodevelopmental disorder that can affect communication, learning and participation across the lifespan, rather than as a difficulty confined to early childhood;
- timely and equitable access to skilled Speech and Language Therapy assessment, intervention and ongoing professional support when needed, with opportunities for reassessment as needs change;
- service decisions that take account of how language difficulties affect everyday life, together with the person's needs and priorities, rather than relying on age, a single test score or rigid cut-offs;
- service models that combine universal and targeted support with access to specialist Speech and Language Therapy when individualized assessment or intervention is needed;
- linguistically and culturally responsive assessment and intervention. Multilingualism does not cause DLD and should never be a reason to delay or deny assessment;
- greater recognition of language needs across education, health, employment and other settings where communication is central to access and participation;
- meaningful involvement of people with DLD and their families in decisions about services, research and accessible systems;
- stronger European research across the lifespan, including effective intervention, multilingual populations, service delivery and equitable access.

ESLA calls for coordinated European action to improve identification of DLD and to ensure that people with DLD can access appropriate expertise and support as their needs change across life.

The position paper at a glance

DLD can affect communication, learning and participation across the lifespan.

Support should respond to the person's needs and to the demands of everyday life as these change over time.

01 IDENTIFICATION

Identify DLD accurately across ages

- DLD can be overlooked because language difficulties are not always immediately visible.
- Assessment should draw on several sources of information and consider the impact on everyday life.
- Diagnosis should not depend on a single score or one language domain.

02 SERVICES

Match support to individual need

- Provide universal, targeted and specialist support according to need.
- Maintain access to specialist Speech and Language Therapy when individualised assessment or intervention is required.
- Enable reassessment and re-entry when communication needs change.

03 ACROSS THE LIFESPAN

Respond as needs and demands change

- Early childhood and school: language development, learning and literacy.
- Adolescence and transition: education, self-advocacy and preparation for adult life.
- Adulthood: communication, participation, employment and independent living.

04 RESEARCH & SYSTEM CHANGE

Strengthen the European evidence base

- Build evidence across childhood, adolescence and adulthood, including multilingual populations.
- Investigate what works, for whom, and how services can be delivered effectively.
- Map DLD pathways and service access across Europe.

Language needs do not disappear at a fixed age. ESLA calls for systems that can identify DLD and make appropriate expertise and support available as communication demands change across education, healthcare, employment and community life.

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Introduction: Definitions, Evidence and Scope

Definition and terminology

The international CATALISE consensus recommends the term language disorder when language difficulties have a significant impact on everyday life or educational progress and are likely to persist. The term Developmental Language Disorder is used when those difficulties are not associated with a known differentiating biomedical condition [1]. DLD does not require a discrepancy between verbal and non-verbal ability, and the presence of risk factors does not exclude the diagnosis.

CATALISE distinguishes between differentiating conditions, risk factors and co-occurring conditions. When a language disorder occurs in association with a differentiating condition, such as autism, intellectual disability, sensorineural hearing loss, a known genetic syndrome or acquired brain injury, the recommended term is "language disorder associated with [condition]" rather than DLD [1]. DLD may, however, co-occur with conditions such as attention-deficit/hyperactivity disorder, developmental coordination disorder, dyslexia and speech sound difficulties. This terminology should never be taken to imply that people whose language disorder is associated with another condition have less need for, or entitlement to, Speech and Language Therapy.

DLD is heterogeneous. It can affect different aspects of understanding and using language, and the profile may change as language demands increase. DLD should therefore not be reduced to a fixed profile, a single underlying deficit or one test score [1,3].

How common is DLD?

A population study in England estimated language disorder of unknown origin at 7.58% at school entry [2]. The study was conducted before the final CATALISE definition of DLD was agreed, so the 7.58% figure is not a direct estimate of DLD as it is currently defined. It nevertheless shows that clinically significant developmental language difficulties are common. Comparable population data are still lacking for many European countries, languages and age groups.

A neurodevelopmental disorder with changing manifestations

DLD is a neurodevelopmental disorder that often continues beyond childhood, although its course varies considerably from person to person [3]. Its impact also changes over time as the demands on language shift from early learning and school to further education, work and adult life. For some people, difficulties become more apparent only when these demands increase, which can contribute to later identification [3].

Neurobiological research has identified group-level differences associated with DLD, but none provides a clinically useful diagnostic marker. DLD is therefore identified through language, developmental and functional evidence; neuroimaging is not a diagnostic test for DLD [4].

Evidence basis and limitations

This position paper draws on international consensus statements and the strongest available research, including population, longitudinal and review evidence. It also considers co-produced research priorities and relevant European policy documents. It is not a systematic review or a clinical practice guideline, and the references are selected to support the paper's key positions rather than to provide an exhaustive account of the literature.

The evidence base for DLD is uneven across age groups, languages and countries. Most research has focused on children, English-speaking populations and a relatively small number of high-income countries. We know much less about DLD in adolescence and adulthood, in multilingual populations and in many European languages. Evidence about how DLD services are organised and delivered is also less developed than the evidence on DLD characteristics and child language intervention. The service principles in this paper therefore represent ESLA's professional position, informed by the best available evidence; they do not imply that one service model has been shown to be superior in every context.

Why DLD Matters Across the Lifespan

Language is central to how people learn, connect with others, take part in education and work, and manage everyday life. DLD can therefore affect many areas of life, not only performance on language tests. Research has found higher rates of difficulties in academic achievement and literacy, as well as differences in social-emotional, educational and employment outcomes in individuals with DLD [5-7]. There is, however, substantial variation between individuals. These group-level findings do not predict the outcome of any one person.

Language difficulties do not occur in isolation from the environments in which people live, learn and work. Their impact depends partly on the demands of the situation and on the support available. Assessment and outcome evaluation should therefore consider the person's language profile as well as the impact of language difficulties on communication, learning and participation in everyday life. [8].

Early childhood

Early childhood offers important opportunities to identify and respond to language difficulties. When difficulties persist, affect both understanding and expression, or limit a child's participation, more focused assessment and intervention may be needed. At this age, however, it is not always possible to predict which difficulties will persist. Monitoring, family-centred support and review over time may therefore be appropriate for some children. Early intervention is important, but support should remain available beyond the early years when needs continue.

School age

At school, language becomes central to accessing the curriculum. Learners are expected to understand increasingly complex explanations, vocabulary and texts, and to use language to reason, discuss, write and show what they know. Reading comprehension depends strongly on oral language, and children with DLD are at increased risk of literacy difficulties [10]. Support should therefore address both the learner's language needs and the accessibility of teaching and the curriculum.

Research shows that targeted language intervention can improve language outcomes, although the size and nature of the benefit vary across language domains, ages and approaches [9,18,19]. Services can combine universal, targeted and specialist provision. The key is that the level and form of support are matched to the child's needs, with access to specialist Speech and Language Therapy, including direct intervention, when individual assessment shows that this is appropriate [9].

Adolescence

Adolescence remains under-represented in DLD research and service development. At this stage, academic language becomes more abstract and learning increasingly depends on independent use of language. Young people are also managing increasingly complex social relationships, learning to advocate for themselves, and making decisions about further education and future work. A 2025 systematic review described adolescents with DLD as an underserved population and found limitations in the evidence for clinically feasible screening tools [11]. Screening may identify risk, but it does not establish a diagnosis; a positive screen requires appropriate assessment.

Support during adolescence should continue to address language and literacy. It should also help young people understand their own communication profile, develop self-advocacy and take part in decisions about their support. Needs should not become invisible simply because a young person moves into a new educational stage.

Transition to adulthood

Moving from school into vocational or higher education, employment or other adult settings often means less structured support just as communication demands become more complex. Young people may also need support to understand written information, prepare for interviews, communicate effectively in the workplace and express their own needs. Transition planning should explicitly consider communication needs and provide routes to continued or renewed Speech and Language Therapy support when appropriate.

Adulthood

DLD can persist into adulthood. A 2026 scoping review found only 53 peer-reviewed studies on adults with DLD across 35 years. This small evidence base supports the persistence of language difficulties, but studies

vary widely in their samples, terminology and assessment methods, limiting firm conclusions about adult profiles and diagnostic procedures [12]. Evidence beyond young adulthood is especially sparse.

Adult outcomes are varied. Some young adults with DLD experience difficulties in education, employment and independent living, while many also achieve positive outcomes [5,6]. This variability reinforces the need to understand individual strengths, circumstances and support needs rather than infer adult outcomes from diagnosis alone.

Mental health services should also be aware of language needs. A 2024 meta-analysis found that childhood language problems, not exclusively CATALISE-defined DLD, were associated with increased risk of anxiety and depression in adulthood [13]. The practical implication is that adults with language difficulties may need communication support to take fully part in assessment and therapy. More broadly, the scarcity of adult DLD pathways remains an important service and evidence gap. Adults whose developmental language difficulties create significant barriers should be able to access appropriate assessment, support and, where indicated, intervention while the evidence base continues to develop.

Identification and Assessment

No single test diagnoses DLD. Assessment should bring together evidence about a person's language abilities, developmental history and everyday communication. The aim is to determine whether the language difficulties are clinically significant, likely to persist and having a meaningful impact on daily life [1]. Standardised measures can contribute valuable information, but diagnostic decisions should not rest on one score, one language domain or a rigid cut-off.

Assessment should build a rounded picture of the person's language and communication. This includes developmental and educational history, everyday communication, literacy and hearing where relevant, co-occurring needs, and the demands of important environments. The person's own perspective, and where appropriate that of family members or others who know them well, should also be included. The aim is not diagnosis alone, but a shared understanding of strengths, barriers, priorities and support needs.

Screening, diagnosis and decisions about support are connected, but they serve different purposes.

Screening can indicate that further assessment is needed; it cannot diagnose DLD. Diagnosis is based on a clinically meaningful pattern of language difficulties. Decisions about support are a further step and should consider the person's goals, functional needs and context, alongside evidence about effective intervention and how the person has responded to previous support.

Identification must remain possible beyond the preschool years. Opportunities for assessment and diagnosis should extend beyond the preschool years. For some people, language difficulties become more apparent as academic, social or occupational demands increase, and DLD may therefore be identified later in childhood, adolescence or adulthood. Validated adult-specific assessment approaches are still limited and research definitions vary [12], so ESLA does not recommend one diagnostic battery for adults. Adult assessment should combine developmental history, current language abilities and the impact of communication difficulties in everyday life.

Multilingualism, Equity and DLD

Multilingualism does not cause DLD.

A multilingual child or adult should not be identified as having DLD simply because their language development differs from a monolingual pattern. Equally, genuine language difficulties should not be dismissed as an inevitable consequence of learning or using more than one language. This section should be read alongside ESLA's Position Paper on Multilingualism, Equity and Speech and Language Therapy in Europe [24].

Assessment should consider the person's full linguistic repertoire, including which languages they use, with whom and in which settings. Developmental history, language exposure and everyday communication are also important. No single approach is sufficient for every multilingual person. Dynamic assessment and language-sample analysis can add useful information when they are appropriate for the languages and age involved [14,15], but the evidence is still uneven across language combinations and linguistic structures. Measures developed for one language or population should not be assumed to work in another without appropriate evidence.

International survey data show substantial variation in multilingual DLD assessment and practical barriers to equitable access [16]. When a suitable standardised test is not available in a person's language, clinicians should draw on a broader range of evidence rather than either making a diagnosis automatically or excluding the person from assessment.

Intervention should support the languages that matter in family, education, community and working life. Families should not routinely be advised to stop using a home language because a child has DLD. A systematic review found evidence of benefit from intervention with bilingual children and some transfer across languages, but also highlighted major gaps in the evidence [17]. Stronger multilingual and cross-linguistic intervention research is a priority for Europe.

Principles for High-Quality DLD Services Across Europe

Health, education and social-care systems differ across Europe, and there is limited comparative evidence about how DLD services are organised. ESLA therefore does not recommend one service model for all countries. Instead, the following principles describe what people with DLD should be able to expect from equitable, evidence-informed services, while allowing for national differences.

- **Needs-led access.** Eligibility and the level of support should reflect how language difficulties affect everyday functioning, how persistent and wide-ranging those difficulties are, and the person's priorities. Decisions should be informed by clinical judgement and evidence, not by age or a single test score.
- **Continuity and re-entry.** People should be able to return to services when developmental transitions or new communication demands create renewed barriers. Lifespan support does not mean continuous therapy; discharge may be appropriate when goals are met, provided that re-entry remains possible when needs change.
- **Access to specialist Speech and Language Therapy.** Universal and targeted support should sit alongside specialist assessment and intervention. Direct intervention may be individual or group based and can be combined with consultation, environmental adaptations and work with communication partners. The appropriate model depends on the person, the intervention target, the context and the available evidence.
- **Individualised goals and outcomes.** Intervention should connect specific language targets with meaningful communication, learning and participation outcomes. Priorities should be agreed with the person and, where appropriate, family or caregivers.
- **Use outcomes to guide decisions.** Progress should inform whether intervention is continued, adapted, intensified, reduced or concluded. There is no single evidence-based dose that applies to all DLD interventions, targets and ages [18,19].
- **Clear roles in collaborative practice.** Families, educators and other professionals are important partners. Collaboration should extend opportunities for communication and generalisation without shifting specialist responsibilities to others unless they have appropriate training, support and supervision.
- **Linguistically and culturally responsive services.** Services should be able to work effectively with multilingual people, including through trained interpreters and suitable assessment resources where needed.
- **Accessible communication.** Information about diagnosis, services, education, healthcare and rights should be provided in ways that people with DLD can understand and use.

Research shows that language intervention can be effective. We still know too little, however, about which approaches work best, at what intensity, for whom, and how well gains are maintained and generalised [18-20]. These gaps underline the need for careful outcome monitoring and stronger intervention research.

DLD in Education, Mental Health, Employment and Society

The impact of DLD is shaped partly by the environments in which people communicate. Education, healthcare, employment and public services all rely heavily on spoken and written language. When

communication demands are not recognized or support is unavailable, people with DLD may face additional barriers to access and participation.

Education

Schools, colleges, universities and vocational settings should recognize oral language as central to learning, literacy and assessment. Education staff should be able to recognize possible DLD, understand how language difficulties can affect learning and know when to involve Speech and Language Therapists. Inclusive classroom practices are important, but they should not replace specialist intervention for learners who need it.

Mental health and wellbeing

Research indicates that people with developmental language difficulties are at increased risk of social, emotional and mental health problems, although this is not the experience of everyone with DLD [7,13]. The relevance for services is practical: mental health assessment and therapy often rely heavily on language. Professionals should consider whether language difficulties affect how a person understands questions, describes experiences or takes part in verbally based interventions.

Employment and adult participation

DLD can affect communication at work in ways that are not always visible, particularly when people are expected to process complex information quickly, learn new routines through language or explain their needs. Employers and employment services should therefore consider communication accessibility and, where relevant, reasonable accommodation. Legal definitions and entitlements vary between countries.

This focus on participation is consistent with the UN Convention on the Rights of Persons with Disabilities and the European Commission's enhanced Strategy for the Rights of Persons with Disabilities up to 2030, which emphasize accessibility, inclusive education, employment and participation. The EU and all EU Member States are parties to the UN Convention [22,23].

Policy and Practice Recommendations

The following recommendations translate the evidence and principles in this paper into action for policy, services, education and professional practice.

For European and National Policy Makers

Policymakers should recognise DLD as a common neurodevelopmental disorder that can affect communication, learning and participation across the lifespan. Language needs should remain visible within relevant health, education, disability, employment and inclusion policy.

- support clear pathways for identification, assessment, intervention and re-entry across childhood, adolescence and adulthood while allowing for different national systems;
- include communication accessibility within relevant education, mental-health, employment, disability and social-participation initiatives;
- support workforce planning that reflects population need, complexity and linguistic diversity;
- strengthen data collection and cross-country comparison on DLD pathways, service access and outcomes where feasible;
- ensure that multilingualism is not used as a reason for delayed or reduced access to appropriate assessment;
- support research across the lifespan, with attention to multilingualism, effective intervention, service delivery, implementation and meaningful outcomes;
- involve people with DLD and families in the development of policies that affect communication access and participation.

For Service Providers and Commissioners

- set eligibility criteria that take account of functional impact and support needs, rather than relying on age thresholds or isolated test scores;
- maintain capacity for specialist assessment and direct intervention when indicated, alongside universal, targeted and collaborative approaches;
- create mechanisms for re-assessment and re-entry when communication demands or functional needs change;

- monitor meaningful outcomes and use them to inform changes in intervention intensity or approach;
- provide sufficient time, training and resources for multilingual assessment and interpreter-mediated work;
- develop transition pathways between child, education and adult services where relevant; and
- collect proportionate service data that can identify gaps in access, waiting times, age thresholds and outcomes.

For Education Systems

- recognise language as a foundation for learning, literacy, participation and assessment;
- equip education staff to recognise possible DLD and understand how language difficulties may present in the classroom;
- support collaboration with Speech and Language Therapists without treating classroom strategies as a substitute for specialist intervention when specialist input is needed;
- make curriculum, instructions and assessment practices as communication-accessible as possible while maintaining appropriate learning expectations;
- include language and communication in transition planning for secondary, vocational and higher education; and
- ensure that multilingual learners are not misidentified because of second-language learning and are not denied assessment when genuine language difficulties are suspected.

For Speech and Language Therapy Education Institutions and Professional Bodies

- embed current DLD terminology, assessment and intervention evidence throughout professional education;
- prepare graduates to recognise DLD across the lifespan, including adolescence, transition and adulthood;
- develop competence in multilingual and culturally responsive DLD practice;
- strengthen training in evidence appraisal, outcome measurement, dosage reporting and shared decision-making;
- support continuing professional development in areas where the evidence and service base are less developed, including adult DLD and multilingual assessment; and
- promote European knowledge exchange while recognising national variation in professional roles and service systems.

For Speech and Language Therapists

- use multiple sources of evidence and consider functional impact rather than relying on a single score;
- distinguish screening, diagnosis and intervention eligibility as related but separate clinical decisions;
- set goals collaboratively and monitor whether intervention is producing meaningful change;
- consider the person's full linguistic repertoire and communication environments;
- support self-understanding and self-advocacy, particularly during adolescence and transition;
- review needs when contexts and communication demands change; and
- communicate uncertainty transparently where the evidence base is limited, particularly in adult DLD and areas where validated assessment tools are lacking.

European Research Priorities

The 2025 DLD Research Priority Setting Partnership was led by the Royal College of Speech and Language Therapists (RCSLT), in partnership with Moor House Research & Training Institute, University College London, Afasic and the University of Lancashire. People with DLD, families, clinicians, researchers and professionals from education, health and social care were involved as partners. The resulting priorities span diagnosis, education, intervention and outcomes, employment, social care and support across different ages and circumstances [21]. ESLA builds on this work and adds a European focus on linguistic diversity, variation between service systems and the need for comparable data. The priorities below are not ranked.

1. Lifespan development, from childhood to adulthood. Research in childhood remains essential to improve identification, understand developmental trajectories and refine intervention. At the same time, adolescence and adulthood remain much less studied. Longitudinal European research should follow people across key transitions and examine how language profiles, participation and support needs change over time.

2. Effective intervention, dosage and long-term outcomes. We need to know more than whether an intervention produces change on average. Research should clarify which components are most effective, for whom, for which language targets and at what intensity, as well as how gains are maintained and generalized. Studies should report intervention content and dosage clearly enough to support replication and clinical use.

3. Outcomes that matter to people with DLD. Language test scores are important, but they capture only part of the impact of DLD. Research should also ask whether people can communicate, learn, participate and pursue goals that matter to them. Depending on age and context, relevant outcomes may include literacy, relationships, self-advocacy, employment, wellbeing and quality of life. People with DLD should help determine which outcomes are meaningful.

4. Multilingual and cross-linguistic DLD. Europe's linguistic diversity needs to be reflected in research. More studies are needed across European languages and multilingual populations, including fair identification and intervention that can support more than one language. Research should also clarify what can be generalized across languages and what needs to remain language-specific.

5. Identification across ages and diverse profiles. Research should improve diagnostic pathways for children, adolescents and adults, including people with co-occurring conditions and those identified later in life. We need better evidence on how standardized measures, developmental history, functional information and learning-based approaches should be combined. Study samples should more closely reflect the diversity seen in clinical practice.

6. Service delivery and implementation. Countries organize DLD services differently, yet comparative evidence about which models work best, for whom and under which conditions remains limited. Research should compare direct, indirect, collaborative, group, individual and technology-supported approaches, while also examining feasibility, workforce needs, cost-effectiveness and equity. The aim should be evidence that can inform real service design, not only efficacy under research conditions.

7. Communication access beyond Speech and Language Therapy services. Research should examine how DLD affects access to education, healthcare, mental health care, employment and public services, and which adaptations make those systems easier to navigate. This includes testing professional training, communication supports and reasonable adjustments rather than assuming that greater awareness alone improves access.

8. European epidemiology, service mapping and equity. Europe still lacks comparable data on DLD prevalence and service provision across many countries and languages. Mapping terminology, referral pathways, eligibility criteria and age thresholds would help identify differences in access across Europe. Comparable data on waiting times, multilingual access, adult provision and workforce capacity would further support policy and service planning.

Across all of these priorities, research should be carried out with people with DLD, not only about them. Co-production, consent procedures and dissemination should be communication-accessible. Fundamental research on genetics, neurobiology and developmental mechanisms also remains important; the priorities above emphasise areas where evidence could most directly strengthen recognition, services and participation.

ESLA's Commitment

As the European professional organisation representing national Speech and Language Therapy associations, ESLA will use its network to strengthen awareness and appropriate identification of DLD, promote evidence-informed practice and advocate for communication access in European policy.

- promote consistent evidence-informed terminology and practice;
- advocate for equitable access to specialist Speech and Language Therapy across the lifespan;
- promote multilingual and culturally responsive DLD services;
- support knowledge exchange between research, clinical practice and national associations;
- promote collaboration across health, education, employment and social systems;
- encourage accessible involvement of people with DLD in research and service development; and
- work with member associations to build a clearer picture of DLD pathways, service provision and workforce capacity across Europe.

A European mapping initiative would help identify shared challenges, inform future recommendations and show where solutions need to be adapted to national systems.

Conclusion

DLD is common, heterogeneous and often less visible than its consequences. Its impact cannot be understood from a language test score alone, and support needs may continue well beyond early childhood and compulsory education.

The central question is how language difficulties affect a person's ability to communicate, learn and participate in the settings that matter to them. Europe needs services that can respond when needs and communication demands change, alongside research that addresses the major gaps identified in this paper.

ESLA position

DLD should be identified accurately and support should be based on its impact on everyday communication and participation. People with DLD should be able to access appropriate Speech and Language Therapy expertise when needs persist, emerge or change at any stage of life.

Selected References and Evidence Base

The following references are selected to support key positions and recommendations in this paper; they are not intended to be an exhaustive review of the Developmental Language Disorder literature.

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