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Title: Discharge of children with developmental language disorder by Croatian speech-language pathologists: a qualitative study of influential factors

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Purpose: Discharge decisions pose a challenge in speech-language pathology practice.

Although professional guidance exists, there is little research on what factors influence discharge decisions in practice. This study aimed to explore the discharge decisions of speech-language pathologists (SLPs) in the context of children with Developmental Language Disorder (DLD), in particular to identify influential factors.

Method: This is a qualitative study using individual interviews and a focus group to explore the knowledge of 19 Croatian SLPs with more than two years-experience of working with children with DLD.

Findings: SLPs described a complex process that was influenced by four overarching case-related factors: a child reaching a plateau, the child's achievements, support, and motivation. Much of this knowledge was tacit and challenging for SLPs to define and measure. SLPs also reported the influence of resource pressures.

Conclusion: The process described by SLPs broadly follows published professional guidance. Since the knowledge is still mostly tacit, support and monitoring for novice SLPs is recommended; discussion between SLPs will also support the emergence of consensus and build confidence in discharge decision-making. Further explication of the influential factors and development of ways to measure and evaluate levels of support and children's functional performance is needed.

Introduction

Deciding about discharge is one of the major challenges in speech-language pathology (SLP) and a highly relevant topic for clinical practice since it intersects with ethics, evidence-based decision-making, client care, and service management. It reflects the application of evidence-based practice: discharge decisions require clinicians to integrate clinical expertise, current research evidence, and individual client factors. As such, the discharge process becomes a point where the theoretical foundations of assessment, intervention planning, and outcome measurement are practically tested. Advancing the scientific evidence surrounding discharge enables speech-language pathologists (SLPs) to actively shape service delivery models, ensuring they are grounded in the realities of clinical practice and supported by research. This helps align services with both client needs and professional standards, rather than relying solely on external administrative or policy-driven decisions. In doing so, it strengthens the role of clinicians and researchers in guiding how and when services are provided, ultimately promoting more effective, equitable, and sustainable care. It is a complex decision and a source of anxiety for SLPs and clients; yet the explicit knowledge of what is involved in this decision is sparse. This paper considers the issue of discharge with reference to children with Developmental Language Disorder (DLD) through a qualitative study of SLPs' perceptions of their discharge decisions. First, we review the research and professional guidance that is relevant to the discharge decision. Through our study we identify factors that SLPs reported as influential and consider changes that could make the decision-making process more accessible to stakeholders and more open to research and evaluation.

This study was conducted in Croatia, where there is no restriction on the number of sessions provided in SLP services. Thus, this context was particularly well-suited to the aim of the study; however, it also required careful methodological consideration, as data collection was carried out in Croatian, while the analysis was conducted in both Croatian and English.

Research evidence relating to discharge in Speech and Language Pathology

Being an important issue for SLP services and health care in general, one might assume that the decision-making process and factors affecting discharge are well described and researched. However, literature about discharge **within SLP practice** is scarce. A notable exception is the clinical forum led by Hersh (2010). As well as considering the emotional and cognitive load that discharge decisions carry, the clinical forum raised two important issues for therapists: the involvement of clients and their families in the discharge decision process, and resource allocation. The SLP is potentially facing conflict on both counts: between SLPs' autonomy and clients' involvement, or between the wishes of the client and fairness in using the resources available. Roulstone and Enderby (2010) referred to these issues in **SLP practice** as making decisions of partnership and prioritisation. Examples from the clinical forum illustrate these two aspects. Kambanaros (2010), reported that SLPs responding to a survey in Greece and Cyprus, found discharge difficult when progress is minimal, the client is plateauing, or the family disagrees with the decision to stop therapy. **Hersh (2010)** reported data from semi-structured in-depth interviews with Australian SLPs working in the field of aphasia; they suggested that an emphasis on early discharge from hospital, limited time and cuts to outpatient services were a source of stress. Thus, factors from both policy and resources were seen as influential. **Hersh (2010)**

concluded that the decision was a “complex negotiation (involving) a great deal of emotional energy” often with significant personal impact on the therapists.

Definitions, policies and professional guidance

Definitions of discharge and discharge policies focus on a client’s goal attainment, improvement or lack of it and the conditions for ongoing change. For example, Luterman (2008) states that therapy should be finished when the “patient has *acquired the skills* or has the necessary *support to function* better than when therapy was initiated” (cited by Quattlebaum & Stepling, 2010, p. 315). Fey (1988) provided an annotated decision tree guiding practitioners through a series of steps from assessing a child’s progress, considering the need to modify the intervention plan, the levels of environmental support and client motivation before ‘dismissal’. ASHA guidelines require that treatment is producing ‘no measurable benefit’ for discharge to occur; the guidelines include criteria such as achieving ‘...optimal communication across environments and communication partners...’ or the ‘... individual demonstrates behaviour that *interferes with improvement...*’ (ASHA, [Admission/Discharge Criteria in Speech-Language Pathology](#)). However, what counts as a *measurable benefit*, the extent to which a skill should be *acquired*, what kind of *support* is necessary, what constitutes *optimal communication* and how to determine whether behaviour is *interfering with improvement* are not further defined and left largely to the therapists’ judgement. ASHA does provide a checklist of steps to be followed at the point when discharge is being considered; these steps consist of a review of evaluation and treatment objectives, methods and outcomes along with a review of other support and provision available to the client.

Local policies governing therapy offered to children with DLD vary widely. Such policies are now often posted online. These generally reflect the literature and professional guidance, stating for example, that identified needs have been met or that no progress has been made after a period of intervention. Some policies specify criteria such as the severity level of a child's impairment or a child's age or sustained failure to attend. A European survey, conducted as part of the COST Action IS1406 (McKean *et al.*, 2019) found that approximately 70% of SLPs responding to the survey reported that they could only provide a limited number of sessions, varying from more than 50 to less than 6. These extremes were the most frequent responses; more than half of the respondents could offer more than 50 sessions or open-ended intervention. McKean *et al.* (2019) draw on the discussion of Law & Conti-Ramsden (2019) who, (on the basis of a systematic review (Law *et al.* 1998) and a community randomised controlled trial (Glogowska *et al.*, 2000)) argued that six hours of intervention was insufficient to effect change, even on specific and narrowly defined intervention targets. McKean *et al.* (2019) concluded therefore that 15% of services could not offer enough sessions to ensure efficiency. The COST Action also created vignettes describing services for children with DLD across 35 participating countries (Law, McKean, Murphy & Thordardottir, 2019). Examples of discharge criteria included: completion of the fixed number of sessions or the therapist's opinion that the child no longer needs support. There were also examples where the length of waiting lists limits the service offered (e.g. Iceland; Einarsdóttir & Úlfisdóttir, 2019). Other issues, such as the limited availability of appropriate assessments create challenges for discharge decisions, perhaps in judging the severity of the disorder or therapy progress (Theodorou, Petinou, Kambanaros, 2019). This can also lead to differences in the way that information is communicated with different stakeholders (policy makers, teachers and clinicians) and thus in how they conceptualise the

language disorder and the need for speech and language therapy services. This paper is part of a larger study investigating decision-making regarding the discharge of children with DLD, which is especially challenging given the lifelong nature of the disorder.

Explicit and tacit knowledge

Despite the lack of empirical data, explicit criteria or precise definitions, SLPs must continue to make decisions about when to offer intervention and when to withdraw. In that process, they use both explicit and tacit knowledge. Explicit knowledge – commonly understood as knowledge acquired through formal and informal education – is typically drawn from textbooks, published research, and other documented sources. In contrast, tacit knowledge refers to the experiential understanding that professionals develop over time through practice, observation, and reflection. In the context of speech-language pathology practice, practitioners are not always fully aware of the significant role that tacit knowledge plays in shaping their clinical decision making. Hence, as Caplan *et al.* (1987) observe, professionals are rarely able to clearly explain the criteria that they use when deciding whether to stop treatment. Nonetheless the tacit knowledge used by professionals has a vital role in clinical decision making. Firstly, it is the underpinning knowledge of clinical expertise, one of components of evidence-based practice. From the beginning, the field of evidence-based medicine has recognized a requirement for the “conscientious, explicit and judicious integration” of external research evidence with clinical expertise (Sackett *et al.*, 1996). Explicit research evidence cannot be applied in an ad hoc way. Secondly, the development of professional knowledge and evidence is primarily iterative or cyclical and often begins with tacit knowledge, that is surfaced and shared within the professional community. In the

absence of explicit knowledge, eliciting therapists' tacit knowledge can be a methodological starting point for the exploration of an area of practice.

In summary, empirical research regarding discharge in SLP deals mainly with the emotional experiences of discharging the client (Hersh, 2010; Kambanaros, 2010, Quattlebaum & Stepling, 2010) and the effects of logistical difficulties on discharge policy/practice, such as the scarcity of services, traveling costs, or inequity in different areas (e.g. Ahmad, 2010). Information regarding discharge of children with DLD is purely descriptive and reflects wide variability in policy and practice (Law *et al.*, 2019). The vacuum in empirical evidence upon which to base discharge decisions and lack of a close examination of discharge decision-making leaves children with DLD vulnerable to policy and practice which may not serve their needs and may not be aligned with our current understanding of the nature of DLD. Making therapists' current decisions explicit and testable can help to plan more efficient discharge policies and develop the explicit knowledge base of the profession.

This paper seeks to address this important gap in the evidence regarding SLP for children with DLD. **The aim of this study is to explore how therapists' make their discharge decisions and specifically to identify what are their criteria for discharging children with DLD.**

Methods

This study set out to explore the knowledge that underpins the decisions that SLPs make as they discharge children - a process known as 'knowledge elicitation' (Shadbolt & Smart 2015). An expert draws on various different types of knowledge; for example it may be both explicit and tacit; it may be procedural or conceptual, highly contextual or more abstract and theoretical. Knowledge elicitation studies employ both quantitative and qualitative approaches in order to elucidate the knowledge of the expert. In this study we focused on a

particular phenomenon, the discharge decision of SLPs; our epistemological position is that the knowledge of that decision is largely tacit and thus based on SLPs' experience and observations. Thus our methodological paradigm was qualitative where we sought to elucidate aspects of SLP's knowledge, rather than testing a priori hypotheses.

Participants

SLPs were recruited in two phases. For the interviews, SLPs came from a single large group of therapists working in a city in Croatia. Departmental heads were asked to identify qualified SLPs who had been working for two or more years with children with DLD, providing direct individual interventions for children aged between five and twelve years. SLPs (n = 32) were provided with information about the study and gave permission for their details to be shared with the researcher. Recruitment continued until a purposive sample of ten SLPs had been established for the interviews. To extend the range of experience for the focus group phase, a further 17 SLPs working with a 200-mile radius of the first author's base were contacted with information about the focus group. It was determined that a focus group should have between four and twelve SLPs to be viable; eleven were purposively recruited, including two who had participated in the interviews. Details of the experience of final sample are provided in Table 1.

Insert Table 1 about here

Data collection

We anticipated that much of the SLPs' knowledge would be tacit, which required techniques that generate deep reflection and as, Schon said, encourage participants to 'turn thought back' (Schon, 1988, p. 69) in order to surface their reasoning for this decision. Observation

and protocol analysis are common techniques in knowledge elicitation studies; however, the knowledge that is used to make a discharge decision is not necessarily accumulated by the practitioner within a single session, making these two techniques of limited value to this study. Therefore, we selected two 'knowledge elicitation' data collection processes that allow the summation of practice; they are also techniques that are consistent with a qualitative paradigm in that they focus on the participants' perceptions of a phenomenon and still allow a tight focus on the phenomenon of interest.

Individual fixed probe interview (Shadbolt & Smart, 2015): This is a structured interview that focuses on a specific task, in this case, the discharge process. The technique is to provide an open question to elicit a general description of the task, in this case the discharge of a child. Participants were asked to *'Think about the last child you discharged, how did you decide to discharge that child?'* Each procedure or criteria or description offered by the respondent is then probed for an explanatory rationale, an example or for more explicit detail. For example, *'Tell me what sort of things you took into account'; 'how would you do that'; 'why would you do that'; 'can you give me an example'*. These probe questions tend to elicit factors that influence the practitioners' decisions and their reasoning behind the focus on such factors.

Focus group discussion: The purpose of this phase was to stimulate discussion between experts in order to validate the preliminary findings and to pursue therapists' explanations and rationales for their discharge decisions. The main objectives for the focus group were:

- to confirm the main factors identified in the interviews
- to further define those factors and identify relationships between the factors

Factors that influence therapists' discharge decisions, that had been identified in the interviews, were presented to participants in the focus group. To confirm the relevance of the factors and to deepen the understanding of the factors, discussion was instigated to explore participants' views about the relative importance of the factors and how they would define and/or measure each factor.

Field notes were taken during all data collection sessions. Audio recordings of interviews and the focus group, which were carried out in Croatian, were transcribed verbatim by MK and KPD respectively.

Analysis

In knowledge elicitation studies, the analytical strategy is often subsumed within the data elicitation or data representation strategy (Crandal et al., 2006, p.22) and draws on the methodologies appropriate to the general paradigm adopted. In this study, our analytic strategy adheres closely to a thematic approach following Braun & Clark's (2006) six stages (familiarization, generating initial codes, searching and reviewing themes, defining and naming themes and reporting), but retains flexibility in order to focus on our very particular aim of identifying influential criteria and factors (Braun & Clark, 2014)

The first three of the ten conducted interviews were translated into English for the purposes of the initial analysis and coding. MK and SR analysed and coded these interviews independently and discussed and agreed the coding that formed the basis of all subsequent data analysis; this ongoing analysis was both deductive and inductive in order to be alert to new themes.

Initial coding involved finding all the factors identified by the therapists as influential or, most often in the form of an "if-then" rule (e.g. If the child has a team of specialists at school, I will discharge him early.). All these factors, together with heuristics (i.e. if-then rules), explanations and illustrative quotations were entered into a grid, and were considered codes organized by the authors into factors (e.g. *a small school, a school with a team of experts, a motivated teacher* were classified in the 'support' factor, and *a smaller number of errors, reads and writes, asks questions, knows when he made a mistake* in 'the child is functional' factor). Later analysis involved refining the factors, whereby explanations led to some factors being combined with others (e.g., age proved to be a code that is not an independent factor because it does not lead to discharge without interaction with child characteristics, support, or potential for progress). Preliminary framework of factors is available in Roulstone et al., 2019.

Coding of subsequent data was carried out in Croatian by MK; new themes were discussed by the team. In order to validate the analysis, sections of the interviews were translated into English and analysed independently by the SR and CM. Factors identified from the interviews were confirmed, validated and extended by SLPs attending the focus group.

Ethics

The study was approved by the Research Ethics Committee of the University of the West of England and the SUVAG Polyclinic (REC REF No: HAS.17.01.085). All the materials for the participants were prepared in English, translated to Croatian and back translated to English. All participants gave informed consent.

Reflexivity

The make-up of the research team, consisting of both researchers and clinicians, monolingual English speakers and bilingual Croatian/English speakers, clinical practices in Croatia and England required collaborative reflexivity whereby the team engaged in frequent discussions regarding their interpretation of the data, both during the analysis of data and also in the paper-writing process. In particular the translation of interview data from Croatian to English generated multiple instances where MK and SR held discussions to clarify meanings and check assumptions.

Therapists' opinions depend on the system in which they work, so during the translation of interviews, analysis, and selection and translation of illustrative quotes, it was necessary to keep in mind the differences in service provision between Croatia and England. MK provided contextual information to the English members of the team in order to facilitate interpretation of data. Examples include:

- the concept of a therapeutic cycle in Croatia is (six months of therapy corresponds to the time-limit for claiming against a particular SLP report.
- the typical team of experts in schools (each school, depending on its size and the number of children with special needs, may or may not include one or more specialists, for example, speech therapists, pedagogues, psychologists or special educators)
- SLPs in Croatia work in health care, education, social care and private practice
- SLPs in the interviews often mentioned the age of six or seven or fifth grade as a decision point for intervention; this is related to the Croatian education system in which children start school at the age of six or seven and the first four grades correspond to primary school; grades five to eight correspond to secondary school.

During translation, certain terms used by SLPs posed a particular challenge in that translations did not yield a term that used in a similar way in English. For example, “razvodnjavanje”: this translates literally as “dilution”, and is used in Croatian to describe therapy that is starting to be less focused, less concise and less goal-oriented. The Croatian word “zasićenje” translates literally as “saturation”, but is used in Croatian to suggest that the child is fed-up with therapy, or that child is overwhelmed by information. The first level of translation was literal and, as such terms were identified with no direct equivalence in English, they were discussed within the research team and an English term that fit best with the intended meaning agreed.

Findings

The data collected in the interviews and focus group provided a rich description of the discharge decisions of participating therapists. SLPs’ responses gave evidence of the tacit nature of this decision and some of the difficulties in surfacing the decision. Nevertheless, our participants reported that it was a positive process which they found valuable. We briefly present quotes which illustrate SLPs’ reactions to the process and then move on to the findings from the main analysis which suggest a complex decision whereby four key case-related factors and one contextual factor are considered both individually and interacting.

Participants’ reflections on the task

The task gave rise to a number of comments which illustrate the tacit nature of the decision. Therapist’s comments suggest that the rationale for their decisions are not always easy to articulate, not only for clients but also for themselves.

“Uh, when you ask me like that... (silence) I need to think” (Int. 04)

“Well, I just knew.” Int 03.

Despite the clear challenge that this posed for participants, they were positive about the process as a whole.

“I hope it will be useful to you, it was to me!” Int 08.

“We don’t get the opportunity to talk like this. And we should”. Int.09

Four case-related factors

The analysis identified four overarching case-related factors that SLPs reported as influential: a) **plateauing** or lack of progress, b) **child’s achievements**, c) **motivation for the therapy** and d) **support** (Table 2). Our findings focus primarily on SLPs’ views and descriptions of these main factors. Additionally, SLPs talked about specific contexts that influence how a particular factor is interpreted and how different factors and subfactors combine to affect the decision-making process. Findings are reported with illustrative quotes.

a) **Plateau**: “Further than that s(he) would not go” [Int.01]

Plateau was described as the most important factor for discharge:

“... when for a long period you don’t move from some level. When the child came to some level, and you feel that you are all the time in the same place...” Int.09

“I need to stop in some moment when I see that really ... that the therapy is not making any progress (...) if the child doesn’t move forward, there are no bigger

movements, then the therapy is stopped because it has no point, coming here is starting to be redundant.” Int.07

*“That is a major clue, when I notice plateau If in those two **periods that repeats, that** we did not do what I expected, I don’t know, some goal that I have put, then that is a sign”. Int. 03*

“Now I said a lot of things, but to summarize, plateau, that’s the most important thing, how long is the child plateauing”. Int.10

When SLPs notice that the child's language skills are not improving, they try to stimulate progress in different ways, changing the way of working, introducing breaks, trying to motivate the child. They also pointed out that plateau is always monitored for a certain time.

“Well, now, if we are not moving forward and the child potentially has the capacity to progress, then something is wrong. The only thing that can be wrong is the way of working. Then I change the way or method...” Int.07

“... I give them for example three months. And then when I see they didn’t move a bit, then I start to announce the end.” Int.06

Even when the lack of progress is confirmed, therapists do not easily discharge the child. They explore and test possible explanations.

“... and then all those famous statements: we will let him rest, maybe maturation (will help), maybe he is fed up, he can’t anymore.” Int.09.

“If there were maybe situations, and there were that kind of situations, that something happens in the personal life of the child (when the child is not ready for the therapy)...” Int.03

When therapists feel that they have considered all the circumstances and exhausted all the all the possibilities to facilitate progress, they can finally reach a decision to discharge.

“I concluded that actually whatever we will do after this moment, we would be staying at the same, this level”. Int.01

b) Child’s achievements: “The child is functional” [Int.03]

(see Appendix for additional detail and supporting quotes)

At the point of discharge, a child’s achievements are often not at a level that is comparable to their typically developing peers. Several therapists reported that they are often not ‘satisfied’ when discharging the child with DLD:

Satisfied? I’m never satisfied with them. Int.06

This apparent discomfort with a pending discharge decision is mitigated by the idea that children have sufficient skills to participate in school and are "functional" in their environment.

Somebody who doesn’t know anything about the language disorder maybe would not even notice that language difficulties are still present. Int.02

However, it seemed difficult for therapists to specify the functional achievements that would trigger discharge; these were not identified through test results or published developmental norms. Instead, they linked them to the age of the child, the school the child

is attending, the severity and the type of the disorder, parent's and child's motivation and expectations.

Because sometimes the changes that I see are very small and standardized tests do not register them, but I do notice them in the way the child is functioning, and then that can be a sign that maybe I will discharge the child (...) in some cases a standardised test will just detect that the child has a language disorder, I'm aware of that (...), but if his functioning is now better, that is my goal. My goal is not to test him so he will achieve some score and get some diagnosis. I'm his therapist, which means that my goal is to make the child functional in the world. Int.03

One SLP suggested that a child's expected literacy level is made explicit in the school system, making it easier to assess whether a child is able to function within a school year/class. In contrast, for language development, the levels of functioning needed for each age group or school year level are not so clear making a judgement of the child's functionality more difficult.

"It would be easier to answer for example for reading. Because there I have some limit. With language disorder I don't have some limit, it's more about functioning of the child, but I'm definitively limited by the system where I work and our school system." Int. 03

The idea of functionality remained broad, difficult to capture and individually determined.

When asked about the criteria they use to assess a child's achievements – specifically, what they consider during evaluation – therapists mention not only the characteristics of the disorder but also the child's behaviour, parental support, and the context of the school the child attends (see table in Appendix). One therapist summarises this approach by stating

that they consider the child's entire life and all the circumstances the child encounters in their everyday environment.

"... achievements according to all the circumstances I have in my head for the child I have in front of me" Int.09

c) **Motivation for the therapy:** "Maybe the child is simply not willing to participate anymore" [Int.07]

SLPs considered motivation for therapy and the general attitude towards therapy to be an important factor in a discharge decision since it directly affects the plausibility of achieving therapy goals:

... his motivation or lack of motivation is one of the key signs showing what I will be able to do in the next six months. Int.03

SLPs feel that it is their responsibility to motivate the child and they try to increase the child's motivation in different ways: changing activities, changing procedures, methods, way of working, using activities and topics the child is most interested in, altering the schedule and dosage, considering the child's daily routine and activities. An apparent lack of motivation might be tested with a short break from therapy. Only when SLPs are certain that they have tried everything to re-motivate a child, does a lack of motivation lead to discharge.

SLPs seem to balance the influence of child and parent motivation. If parents are motivated, SLPs consider that the child is encouraged and supported in therapy; the absence of parents' motivation would be a negative influence to continuing therapy. Where parents are not motivated, the child's motivation would be critical: if a child is still motivated to engage

with intervention, then a therapist is more likely to continue therapy to provide that support that they perceive to be missing from the parents.

Well if I see that the child is left alone (...) and the child is motivated, willing, I'm more prone to continue the therapy... Int.08

d) **Support:** "It's a safety net" [Int.06]

Support is a complex and conflicting factor that interacts with other factors. When talking about support, SLPs mostly referred to the parents' involvement in therapy, but school services were also mentioned. For some SLPs, the lack of the support would prolong therapy; for others it would indicate discharge; for others the amount of support was not as influential.

When parents are interested in participating in intervention, SLPs consider that goals are achieved faster and more easily. Parents and SLPs set the goals together and parents are coached to work with the child; subsequently SLPs feel more confident to discharge the child since knowledgeable and motivated parents act as a "safety net" who can support the child. On the other hand, when that support is missing, the child is kept in therapy longer.

*... sometimes it exactly happens that it seems to you if that child had support I could discharge him. **But** this way you feel sorry for him because you know that at home nobody will work with him. **So** you think, yes in a way I'm here... Int.01*

Lack of support can also lead to discharge when it is combined with slow progress and with lack of motivation from both parents and the child. This seems similar to SLPs discussions of parents' motivation. However, SLPs distinguished between parents' motivation and parents' support and describe parents who are willing and motivated, but who simply lack the skills

to support the child. In those cases, SLPs keep the child longer in therapy, firstly to support the child, but also to train and strengthen the parent for the future.

For some SLPs, parents' support was not the critical factor in cases where the child had ongoing potential for progress; then it was the latter that determined whether or not the child is maintained in therapy:

There are parents who are asking me how much more. That is going to my nerves. I can't say that it demotivates me, but it makes me sad. (..) But that doesn't affect my decision. (...) I will not finish earlier with the child that did not achieve something that I find important just because they are lazy. (...) Criteria is the child, not his parents. Int.06

Not all therapists considered the support available from the child's school. Some mentioned the school's expert team that the school and the potential for cooperation. Others mentioned the size of the school and the sensibility of the teachers.

Insert Table 2 about here

Contextual factor: Resource constraints

Although the case-related factors are of prime importance, SLPs were clearly influenced by resource pressures even though these were not made explicit in the form of service prioritisation systems. This participant shows consideration of the case-related factors in the light of limited staffing resources.

"...did the therapy show progress or there is some stagnation, it depends on the age, and again, now we are coming to the involvement of the parents, were they coming regularly to the therapy, did they work at home with children, and how much interest did the show for

that entire story. In this kind of system where it's a few of us and a lot of children, I think those things are also relevant." Int.02

The pressures of waiting lists were in the mind of the SLPs, sometimes prompted by their supervisors but also always there in the background to be managed.

Interviewer: ... Does the system in some way affect the process of making (your) decision?

SLP: Well, it does affect in a way, that sometimes your superior will say, ok, revise your therapy list, children you have in therapy, to see to what extent is that therapy (is working) for them and to what extent are you just keeping the existing level. Of course, nobody ever said Well you need to discharge this child. Int. 01

" Sometimes it exactly happens that it seems to you if that child had support I could discharge him, but this way you feel sorry for him because you know that at home nobody will work with him, so you think, yes in a way I'm here... But, is that right thing to so, probably it's in the best interest of a child, but for those who are waiting on the list it's not."

Int. 01

"we also have other patients. And waiting lists. All that has some impact." Int. 04

Discussion

As one might predict, the overarching factors influencing discharge decisions that were identified in this study (plateau, child's achievements, motivation for therapy, and support), align closely with those outlined above from the professional literature. For example, the idea of 'plateauing' equates to ASHA's requirement that treatment is not generating 'measurable benefit'; the child's achievements reflects ASHA's 'optimal communication'; an

absence of motivation or support might be construed as ASHA's 'behavior that interferes with improvement'. Furthermore, SLPs evidenced a process of review of treatment and the support available to the child that mirror the steps outlined in ASHA's guidance ([Admission/Discharge Criteria in Speech-Language Pathology](#)). Although the main focus of SLPs' discussions was on the case-related factors that they considered, the influence of local resources was also evident; participants acknowledged this influence but did not spend much time talking about this. This possibly reflects the Croatian context where there was no explicit pressure on the SLPs to reduce waiting lists or to prioritise their resources. Wells et al. (2024) examined factors influencing access to paediatric speech-language pathology services from the family's perspective. Among several categories, resources (e.g., financial means, transport, time) and logistics (e.g., service policies, family structure, workload, workforce participation) were identified as central, reflecting the flexibility needed between families and service providers. These factors also emerged in our analysis but were not decisive. Instead, therapists considered them as contextual influences on the four main factors identified in our study. For instance, if low motivation stems from irregular attendance due to transport issues, therapists may adjust appointment times to address this. While Wells et al. (2024) highlight a mismatch between families and providers, our findings suggest that therapists actively work to minimize such mismatches in their decision-making. There are also hints in our data of the emotional and cognitive energy that is expended by SLPs and of the subtle pressure of waiting lists in balancing out the various factors and in testing SLPs' underpinning theories regarding the child's profile, reflecting the studies expounded in the clinical forum led by Hersh (2010).

Definition, descriptions and measurement of factors

In the literature review, we noted the difficulty of evaluating some of these criteria and this appears to be an ongoing challenge. Even though SLPs in this study provided rich descriptions about how factors might be recognized or interpreted in practice, their judgements were largely based on their tacit knowledge and were evidenced with **highly individualized criteria relevant to a particular case and would not necessarily be generalizable**. Such judgements would not always be made explicit to others such as family or in case notes. Explicit protocols for measuring associated factors could reduce the level of stress related to discharge decision and improve communication with parents. The process whereby therapists weigh up the relative impact of the different factors was particularly individualised and therefore difficult to summarise in any common heuristic. Nevertheless, this study has made a start: generating descriptions of the factors considered to be influential and showing how therapists use them in the decision-making process. However, there are ongoing challenges for therapists in the measurement and interpretation of the key factors identified in this study.

Plateau was considered to be the most important factor for discharge. This factor is also represented in the guidelines provided by professional bodies (e.g., ASHA, <https://www.asha.org/njc/decision-making-in-termination-of-services/>). However, progress in the child's achievement cannot be always observed or described utilising a standardised test measure. Evidence suggests that standard scores are not enough (Roulstone, Glogowska, Peters & Enderby, 2003) to make a decision about whether or not a child has reached a plateau. In this study therapists commented on the limitations of standardised testing and instead referred to criteria related to the child's ability to function in their own context. They noted how these are different for each individual child, but critical for therapists' decisions. These characteristics guide the entire process since the ultimate goal

of the therapy is to make the child “functional in his/her environment” (Int.01, Int.06). This is in line with the attempts to redefine discharge as the process of reintegration, as Simmons-Mackie (1998) suggests: “Rather than shift from treatment to no treatment, the client should experience a gradual transit down a continuum towards assisted community reintegration” (p. 236). Focusing on functioning rather than linguistic abilities where individual’s functioning emerges from the interaction between their impairment and their environment is in line with broader understanding of DLD and its impacts on different areas of child’s life (Jensen *et al.*, 2021). However, Bishop *et al.* (2017) remind us that we do not yet have adequate tools to measure functional communication. There is evidence that dynamic testing can be successfully used as a complementary method of diagnosis of language disorder in bilingual and multilingual children (review in Hunt, Nang, Meldrum & Armstrong, 2022), although structured dynamic testing is not widely used to assess progress. It is not unambiguously clear what skills should be measured at which age or stage of therapy and what would be the criteria when measuring how far the child is functional. This implies subjectivity which leads to greater responsibility for the SLPs.

Two other factors identified by therapists were support and motivation. There are difficulties in the objective measurement of these two interacting factors. Therapists provided examples of support (for example in school) or motivation (for example, a parent who is not interested); however, evaluations of these two factors are made at a tacit level and were hard for therapists to define. The justification of decisions on the basis of such factors must therefore be equally difficult to explain to others, particularly to parents.

Yet these aspects of the child's supporting context are likely to be critical to the potential of any therapy and therefore to the discharge decision. They have certainly been identified as part of other decisions in SLP. For example, Roulstone (1997) found that, in the selection of preschool children for intervention, SLPs were balancing the child's presenting symptoms with the facilitating potential of the child's context. These facets of context, that is a patient's, or parent's knowledge, skills and motivations, have been identified as 'activation' and found to be make a substantial contribution to healthcare outcomes (Hibbard *et al.*, 2013). Measurement of activation in the context of SLP has not yet been thoroughly tested, although Gibbard *et al.* (2024) reported the use of an adapted Parent Activation Measure (Parent Activation Measure-SLT -PAM-SLT-UK - Insignia Health, 2014) to evaluate the activation of parents who participated in a parent-based intervention. Overall, they found an increase in parents' activation at the end of the intervention. However, there was considerable variation in both the direction and amount of change. Such variation is not unusual in parenting programmes (Butler *et al.*, 2020; Mouton *et al.*, 2018; Lindsay & Totsika, 2017). There could be many reasons for this including the validity of the adapted measure, differences in parents' backgrounds and learning styles as well as the parents' own self-efficacy beliefs.

Implications and recommendations

This study has helped to make explicit the factors that are considered by SLPs as they make discharge decisions. Our findings are descriptive and not prescriptive – they do not give SLPs a recipe or guidelines for how to make the decision. Furthermore, the process of how the various factors are weighed against each other is still largely tacit.

Supervision for early-career therapists

Given that a professional's tacit knowledge is built up through experience, new practitioners will find this decision to be particularly difficult. Supervision, monitoring and validation of their decisions will be important not only for their learning but also for the safety and acceptability of their decisions. Reflecting on their own decisions in the light of the evidence from this study and through discussion with their more experienced colleagues will be an important way to develop their own confidence and expertise in making these decisions. Furthermore, discussion between more experienced practitioners about the factors they take into account, how they define and combine them to make decisions will not only support their less experienced counterparts but also increase consensus within the profession and lead to the emergence of explicit protocols.

Negotiating outcomes with children and their parents/carers

The development of ways to capture and measure factors that influence SLPs' decisions is an important aim for the field. Bishop *et al.* (2017) noted that facets such as the functionality of a child's performance are not yet described in a way that they can be reliably measured. Kwok, Rosenbaum & Cunningham (2022) showed that setting functional goals is difficult even when trying to rely on the framework of the World Health Organization's International Classification of Functioning, Disability and Health (ICF). They explored how SLPs conceptualize therapy goals for pre-schoolers with language difficulties and disorders within the ICF framework. While SLPs perceived that most of their goals addressed Activities and Participation, independent analysis showed a significantly lower proportion of goals aligned with these categories. This discrepancy suggests SLPs may overestimate their focus on participation. Thus, this remains an ongoing challenge, not least

because the contexts in which children need to function are specific to each child – their age, interests, capabilities and so on. **Understanding risk and protective factors can also offer valuable guidance. As Singer et al. (2023) note, identifying personal protective factors (being a preschool girl, reaching school age and being prosocial and personal risk factors (becoming a teenager or adolescent, having low socio-cognitive skills and experiencing comorbid mobility impairment or behavioural problems) helps clinicians better anticipate individual needs and tailor interventions.** To develop a single measure that can reflect the individual child's performance in their own important context may be unachievable. Instead, perhaps SLPs need to focus more on agreeing a priori outcomes with children and their parents/carers at the beginning of each period of intervention. These goals would need to be clear so that SLPs, child and family can be confident about when they have been achieved. Periodic renegotiation of such functionally meaningful goals would no doubt be necessary as everyone fine tunes their expectations of what can be achieved. Research on how specific speech and language goals or outcomes are related to functional performance would also be helpful.

Better understanding of activation and illness perceptions

Further investigation and development within the field of speech-language pathology of concepts such as activation (Hibbard *et al.*, 2013) and illness perceptions (Levanthal *et al.*, 1984; Moss-Morris *et al.*, 2002) which explores peoples beliefs about their health condition, could assist SLP's explicit discussions with families regarding their knowledge, skills, attitudes and confidence to work with their child with DLD. This may enable SLPs to fine tune the information and support that they provide which in turn may improve families' motivation and their children's response to therapy. Further research on the adaptation of

activation and illness perception questionnaires in SLP could improve our understanding of their value.

Strengths and limitations

This study focused on discharge decision making in a specific context: that of Croatian SLPs working in a health context. Given the variation in SLP services and approaches to care reported by Law *et al.* (2019) it would be reasonable to assume that practice elsewhere might differ from the practices reported in this paper. However, this is a qualitative study and not intended for generalisation to other contexts; rather the intention is to shed light on a particular decision in a particular context. By providing a rich description of a particular phenomenon in context, others can then examine its potential for explanatory power in their own contexts. There is similarity between factors that emerged in this context and the guidance given in some professional documents ([Admission/Discharge Criteria in Speech-Language Pathology](#)). This provides some evidence that the reports here will have explanatory resonances in other contexts. However, it also points to the need for similar research to be carried out in other contexts.

The initial conception of this study and application for ethics approval was developed first in English. In the reflexivity section above, we set out a number of the challenges of translation and interpretation. The possibility of inaccurate representation of the SLPs' meaning remains. However, the extensive conversations about nuances of meaning were valuable in the analytic process, providing additional exploration of SLPs' meanings.

Conclusion

This study suggests that the decision making around and preceding a discharge decision need further support in two ways: firstly, support and monitoring is needed for novice SLPs to facilitate their learning and the safety of such decisions; such discussions should be held in contexts where SLPs with a wide range of experiences share and reflect on their decision making in order to make explicit some of the tacit knowledge on which they base their decisions. A second focus should be on the further definition of concepts and the development of measures in order to provide evidence for SLPs in their decision-making and in their communication with each other and with parents. Thus, supervisory support, opportunities to reflect and to make explicit the processes and factors involved would be beneficial. There is also a need for measurement and evaluation tools that are more directly relevant to the decisions that therapists are facing in their daily clinical practice. Finally further research is needed to examine such decisions in other contexts.

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Table 1. Participant experience

Average years experience (range)	Phase 1. Interviews	Phase 2 Focus Group
Preschool	n=4 16 (6-30)	n=10 112 (2-27)
Primary	n=9 14 (3-29)	n=7 9 (2-18)
Secondary	n=2 12 (6-19)	n=5 12 (6-18)

Table 2. Summarizing factors leading tom discharge

Factors leading to discharge	Explanation of the factor
Plateau	Child's language skills are not improving over certain period, although SLPs tried to stimulate progress in different ways.
Child's achievement	Although child's achievements are not at a level that is comparable to their typically developing peers, SLPs consider child's skills to be "functional" in their environment.
Motivation	Child's motivation to participate in the therapy. This factor is considered as both, affected by parents' motivation and independent of it.
Support	Support system which can help the child after discharge, such as family ad school services.

Appendix. Criteria used by clinicians to support discharge decisions when “a child is functional”

EVALUATION CRITERIA	Indicators	Influencing factors	Decision making process	Supporting quotes
Speech and language are never perfect, but the level of functioning is satisfactory.	Number, frequency and type or the remaining difficulties	Child's environment	Child's language is sufficient for the child to participate in his/her environment and improve > likelihood discharge	<p><i>She would notice the error, detect it alone and even correct it. And the frequency of errors was much smaller. (...) Somebody who doesn't know anything about the language disorder maybe would not even notice that language difficulties are still present. Int.02</i></p> <p><i>Those errors can happen to any child his age. To the child who never came to the speech and language therapy (...) we know that is expected at that age, it's developmental. Int.08</i></p>
Comprehension as “conditio sine qua non”	Test results	Disorder type	<p>Comprehension difficulties > longer therapy</p> <p>Test results are not always decisive for children with receptive DLD:</p> <p>poor test results > longer therapy</p> <p>BUT good/poor test results after longer therapy > both discharge or longer therapy</p>	<p><i>First of all, comprehension, because that is an alarm, if comprehension is affected, then for sure I can't discharge the child. Int.02</i></p> <p><i>... for sure I would not discharge a child who is, who has in Trog for example 1.5 standard deviation below, I would not discharge him, for sure. Int.06</i></p> <p><i>Because sometimes the changes that I see are very small and standardized tests do not register them, but I do notice them in the way the child is functioning, and then that can be a sign that maybe I will discharge the child (...) in some cases a standardised test will just detect that the child has a language disorder, I'm aware of that (...), but if his functioning is now better, that is my goal. My goal is not to test him so he will achieve some score and get some diagnosis. I'm his therapist, what means that my goal is to make the child functional in the world. Int.03</i></p> <p><i>If my decision would be driven only by the test score, I</i></p>

				would keep them in therapy forever. Int.09
Remaining difficulties are not new, but repeating.	Persistent and consistent errors despite targeting in therapy	Duration of therapy Supportive parents	Longer duration > likelihood discharge Parents able to continue work on error > likelihood discharge	<i>He was already longer in therapy, those things are not seen for the first time, but they were repeating. So I thought that parents already knew enough about it and now they can take over and follow it at home. Int.07</i>
Achieving the level where the child can cope with the school system.	Autonomy in language tasks, and school assignments e.g. self-monitoring, self-correction, use of self-help strategies and independence. Child's coping strategies with the disorder and attitude towards difficulties	School demands	Teachers who understand child's difficulties > likelihood discharge Child has some support in the school > likelihood discharge Smaller, less demanding schools > likelihood discharge	<i>When the child can do what is required in the school, do the tasks, homework, comprehend what is needed, has some compensation mechanisms for the difficulties. Int.01</i>
Child is functional beyond speech and language	Child as a partner in communication Ability to use language to learn and grow	Personality of the child Cognitive abilities	Child is confident and sociable > likelihood discharge Better cognitive abilities > faster learning > likelihood discharge	<i>... in the moment when the child is brave enough to talk about the difficulty he has, and how he sees it, and he is asking for help, that is a sign that he is ready to cope with the things (...) when he is capable to openly talk about what is actually happening. That means he is ready to cope with his environment. Int.09</i>