The role of speech and language therapists (SLTs) within a multidisciplinary team (MDT) for acquired brain injury (ABI)

This guidance is to support health and social care and medicolegal professionals working with people with acquired brain injury (ABI) to understand the role of SLTs in ABI. The information in these pages should act as guidance only and is not exhaustive. Professionals should continue to use evidence-based clinical judgement alongside this document.

For general information about how speech and language therapy can support individuals who have had an ABI and their friends, families and/or carers, refer to the acquired brain injury public webpages.

Speech and language therapists (SLTs) working in ABI looking for clinical guidance should refer to the acquired brain injury clinical guidance webpages.

If you have any suggestions or feedback on these pages, please contact us.

1. Introduction

Acquired brain injury (ABI) can result in complex, long-term disabilities affecting communication, cognition, swallowing and social reintegration across the lifespan.
A multidisciplinary team (MDT) approach is essential for effective rehabilitation over the neurorehabilitation pathway (NICE, 2025).

ABI can cause significant changes in communication and eating, drinking and swallowing (EDS), resulting in:

- long-term impact on the lives of the individual and their loved ones
- reduced social interactions and social networks and increased isolation
- impact on families and/or carers
- loss of employment and/or education
- change to identity

- societal burden and economic cost
- reduced health-related quality of life (HR-QoL)
- health inequality
- poor mental health
- substance misuse
- added pressure on the criminal justice system
- homelessness
- decreased mental capacity and decision-making skills
- premature mortality.

Speech and language therapy plays a central role in assessing, treating and enabling communication and EDS as a core rehabilitation domain (NICE, 2025). Communication and EDS should be routinely explored at initial and ongoing rehabilitation assessments, with timely SLT screening offered whenever difficulties are suspected and comprehensive assessment provided where indicated, including re-assessment as needs change (NICE, 2025).

SLT-led intervention focuses on meaningful, functional communication change, supporting participation in everyday conversations, relationships, education and vocational goals.

SLT assessment and intervention should be delivered as part of a coordinated multidisciplinary neurorehabilitation across acute, specialist inpatients, community, vocational, educational and residential settings.

SLTs have a key role in providing education and training to families, carers, peers and professionals in effective communication strategies and ways to support conversation and participation. Education and training are associated with improved long-term communication outcomes and reduced social isolation, helping the MDT manage interactions more effectively and reduce negative impact (Christensen et al, 2023; NICE, 2025). Importantly, SLT input should not be withheld due to perceived gaps in evidence or staffing, as absence of evidence is not evidence of absence. Proactive, integrated SLT involvement is essential to holistic neurorehabilitation after ABI.

2. Impact on communication

The impact of an ABI on communication varies depending on the individual and type of brain injury. This impact involves a complex interplay between cognitive impairment, communicative activity and the communicative environment.

Nearly 100% of people with an ABI will have some sort of communication difficulty (MacDonald & Wiseman-Hakes, 2010).

Following an ABI, a person may experience difficulties with many aspects of communication. These can include some or all of the below.

2.1 Speech

This can be due to muscle weakness (dysarthria) and/or facial spasticity (increased tone) or difficulty in coordinating mouth movements for smooth speaking (apraxia of speech). This can result in unclear speech, changes in speaking speed, changes in volume, or monotonous speech.

2.2 Expressing themselves through language

A person may experience word-finding difficulties or may struggle to put together grammatically and/or semantically correct sentences (commonly associated with aphasia). This can occur in both spoken and/or written form (e.g. texting, typing or messaging).

2.3 Organising thoughts and ideas

A person may find it difficult to organise and express their ideas, thoughts or feelings. This means they may take longer to respond to or understand what has been said or written.

2.4 Understanding others

A person may find it difficult to understand abstract or complex language in large amounts, whether spoken or written. They may have difficulty following conversations, particularly with more than one person, and following instructions. They may have difficulty inferring meaning (e.g. from social media comments or when reading novels).

2.5 Communication and social interactions

A person may experience difficulties with following the rules of normal conversation. They may speak out of turn, interrupt others, talk excessively on one topic, change topics on

impulse, misinterpret or not interpret non-verbal cues, or lack self-monitoring (cognitive communication disorders). They may also struggle with humour, sarcasm or emotional responses.

2.6 Thinking and reasoning

A person may find it difficult to reason and talk things through.

2.7 Memory and attention

A person may struggle with holding onto information, which makes following and holding a conversation difficult. A person may have difficulty staying focussed on the conversation, particularly if there are other things going on around them.

2.8 Emotion and behaviour

Frustration, anxiety, depression, emotional lability and/or personality changes can impact a person's communication. Difficulties with communication and emotional processing can also lead to challenging behaviour.

2.9 Fatigue

Communication requires a lot of concentration and cognitive and/or physical effort. A person with an ABI may tire quickly in conversations.

2.10 Sensory changes

A person may struggle to access reading and writing if their vision has been affected. Or, if their hearing has been affected, they may struggle to follow a conversation and appear as if they have misunderstood.

3. Impact on eating, drinking and swallowing

Eating, drinking and swallowing (EDS) can be impacted by physical and behavioural changes following an ABI.

ABI can weaken or impair the muscles used for swallowing, making it difficult to eat and drink safely. This may lead to:

- coughing or choking when eating, drinking and swallowing
- increased risk of chest infections or aspiration pneumonia due to food, drink or saliva entering the lungs (aspiration pneumonia)
- malnutrition and dehydration.

Cognitive and sensory changes can also impact someone's EDS including:

- reduced appetite
- impulsivity leading to food cramming
- reduced insight leading to unawareness of when they last ate and whether they are hungry or thirsty leading to reluctance to eat or overeating.

4. The role of SLTs in ABI

SLTs are integral members of the MDT, working alongside medical, therapy, educational and social care professionals to optimise recovery and improve quality of life (QoL), with a focus on communication and EDS skills.

SLTs work within the WHO's ICF framework (2001) as a guiding principle within the context of multidisciplinary care using an interdisciplinary approach.

SLTs contribute to the broader understanding of the individual (holistic formulation) by providing insights into communication, cognition and functional abilities as part of a comprehensive neurorehabilitation plan supporting an individual to continue personal relationships and reintegrate into society.

4.1 Communication assessment and management

The role of SLTs includes:

- identifying and differentially diagnosing changes in speech production, comprehension and expressive language, involving observations and discussions with others
- supporting language recovery through therapy and alternative communication methods
- improving speech clarity, coordination and volume
- addressing issues with communication impacted by memory, attention, problem-solving and executive dysfunction
- coaching and collaborating with individuals in conversation skills, emotional expression and social interaction
- training family, friends and caregivers on how to support communication (ie communication partner training and providing a communication rich environment) and improve confidence and quality of life

- introducing alternative communication supports, such as speech-to-text apps, symbol boards, or electronic devices.

4.2 EDS assessment and management

This may include:

- EDS assessment through clinical assessment, observations and instrumental evaluations (e.g. videofluoroscopy or fibreoptic endoscopic evaluation of swallowing (FEES)
- dysphagia rehabilitation to improve strength, coordination and safety of swallowing
- dietary and texture recommendations – collaborating with dietitians and nursing staff to ensure safe eating and drinking
- risk reduction and acceptance to reduce the risk of aspiration pneumonia and malnutrition
- saliva management
- participation in mealtimes
- tracheostomy weaning.

4.3 Psychoeducation

This includes educating individuals, their family, friends, carers and any professionals working with the person around their specific ABI and its impact on communication and/or EDS as well as how to help and support.

4.4 MDT collaboration and training

SLTs work closely as part of MDTs on aspects including:

- joint goal setting: aligning communication and swallowing rehabilitation with e.g. physiotherapy, occupational therapy, neuropsychology and input from medical teams
- education for staff and carers: training on communication strategies, supporting EDS techniques and cognitive-communication interventions
- supporting transitions: assisting with discharge planning, return to education/work and social reintegration.

5. Impact of speech and language therapy

Speech and language therapy can:

- improve communication for independence and social participation

- reduce the need for hospital stays and hospital readmissions by reducing communication and EDS-related difficulties
- enhance cognitive-communication skills for daily functioning
- support a return to work or education and social life
- reduce burden on carers through training and support
- support supported decision making, expressing wishes to promote autonomy.

6. Who SLTs may work with

SLTs may work with a number of different specialists including:

- medical team of neurologists, GPs, neuropsychiatrists, rehab consultants and ear nose and throat (ENT) specialists
- nursing team
- occupational therapists supporting communication in daily tasks, cognitive strategies and adaptive technologies
- physiotherapists collaborating on support with posture, breathing and swallowing exercises
- neuropsychologists addressing cognitive communication and emotional wellbeing
- dietitians coordinating swallowing management and nutrition plans
- social workers and case managers ensuring access to rehabilitation services and family support, as well as supporting with ensuring communicative and cognitive needs are recognised
- carers, support workers, care agencies
- medicolegal and criminal justice system professionals
- third sector (voluntary) organisations including Headway
- education sector including special needs coordinators (SENCo), teachers and education staff
- drug and alcohol services
- homelessness organisations
- other therapists such as art therapists, play therapists and music therapists.

7. The SLT role across the rehabilitation pathway

7.1 Acute care setting

The role of SLTs in acute care is to:

- provide early assessment of communication and swallowing needs

- minimise complications (e.g. aspiration pneumonia, dehydration)
- initiate early therapy to maximise recovery potential
- support and educate friends and family.

7.2 Inpatient neurorehabilitation

In inpatient neurorehabilitation, SLTs:

- carry out comprehensive assessment
- contribute to holistic formulation of the individual
- provide intensive therapeutic intervention as needed, if indicated, within an agreed timescale, to address communication and/or EDS difficulties post-acute care
- work within an MDT to achieve agreed goals to support transition into a community setting
- support with goal setting and decision making
- provide education to family, friends and carers.

7.3 Community and outpatient settings

In the community and outpatient settings, SLTs:

- provide long-term therapy for speech, language, cognitive recovery and ongoing EDS needs
- support reintegration into daily life, education and/or employment
- provide family and carer training for ongoing support
- support local services such as gyms, cafés and community groups to be more neuro-friendly and to work with people with an ABI
- create spaces for co-creation and peer support opportunities
- provide expert witness and medicolegal contribution.

7.4 Vocational and educational neurorehabilitation

In vocational and educational neurorehabilitation, SLTs:

- enhance workplaces' or educational institutions' communication skills and strategies
- provide education for teachers and SENCOs around re-integrating a child with an ABI into school
- advise employers/educational staff on reasonable adjustments for a person with an ABI
- support pre-work skills
- facilitate return-to-work/education strategies

- support and advocate at points of transition.

8. How the MDT can help

Speech and language therapy is a vital component in neurorehabilitation. It is important to make a timely and appropriate referral to an SLT following an ABI and the individual should have a 'holistic rehabilitation needs assessment' (NICE, 2025).

No single screen is appropriate for identifying referral to SLT post-ABI. However, the Cognitive-Communication Checklist for Acquired Brain Injury (CCCABI) (MacDonald, 2024) is an excellent, free screening tool to help identify whether an SLT referral may be required.

8.1 Top tips for MDTs

- Raise awareness: many effects of an ABI (e.g. memory problems, fatigue, communication difficulties) are not immediately visible but still impact daily life.
- Be understanding: avoid assumptions and give the person time to express themselves.
- Encourage independence: support but do not over-assist; let the person do as much as they can.
- Ensure the person has understood.
- Provide written/physical strategies and appointments.
- Recap at the end of sessions.
- Seek clinical supervision from specialists in order to deliver an optimal service.
- Raise awareness and understanding among service managers and services about the complex condition.

See also RCSLT's communication after ABI top tips factsheet.

9. Referring to speech and language therapy

If you believe a person with an ABI may benefit from speech and language therapy, please refer them to the relevant service in your area, depending on the setting you work in.

To access speech and language therapy services through the NHS, ask the SLT in your team, or ask the person's GP, therapist, social worker or educator to make a referral to speech and language therapy.

If the person has worked with speech and language therapy in the community before, they may be able to make a re-referral themselves.

Individuals can access speech and language therapy at any point, as their needs and goals will change over time.

10. Resources

- RCSLT ABI public pages
- RCSLT ABI top tips factsheet
- RCSLT CCD guidance
- All Party Parliamentary Group on Acquired Brain Injury (APPG) (2018) Acquired brain injury and neurorehabilitation: Time for change
- Brainkind Brain injury screening index (BISI)
- Headway Communication problems after brain injury
- MacDonald, S. (2017) 'Introducing the model of cognitive communication competence: A model to guide evidence-based communication interventions after brain injury', *Brain Injury* 31(13-14), 1760-1780. https://doi.org/10.1080/02699052.2017.1379613
- MacDonald, S. (2024) *Cognitive-Communication Checklist for Acquired Brain Injury (CCCABI*) https://brainandcommunication.ca/cccabi/
- National Institute for Health and Care Excellence (NICE) guideline NG252 (2025) Rehabilitation for chronic neurological disorders including acquired brain injury
- The Neurological Alliance
- Professor Derick Wade blog All about rehabilitation: rehabilitation matters
- The Society for Research in Rehabilitation (SRR)
- Togher, L. et al (2023) 'INCOG 2.0 Guidelines for Cognitive Rehabilitation Following Traumatic Brain Injury, Part IV: Cognitive-Communication and Social Cognition Disorders', *Journal of Head Trauma Rehabilitation* 38(1), 65–82. https://doi.org/10.1097/htr.0000000000000835
- United Kingdom Acquired Brain Injury Forum (UKABIF)
- UKABIF (2025) The Cost of Acquired Brain Injury to the UK Economy: Right to Rehab: Time to Invest in Rebuilding Lives After Brain Injury

11. References

- Christensen, I., Power, E., Togher, L. & Norup, A. (2023) '"Communication Is Not Exactly My Field, but It Is Still My Area of Work": Staff and Managers' Experiences of communication with people with traumatic brain injury', *American Journal of Speech-Language Pathology* 32(2S), 827–847. https://doi.org/10.1044/2022_AJSLP-22-00074
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- World Health Organization (2001), *International Classification of Functioning, Disability and Health (ICF).* Geneva: WHO Available at: https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health (Last accessed May 2026)