Clinical Guidelines for Speech and Language Therapists: Bilingualism

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Bilingualism - Guidance

Unlike other clinical guidelines, which provide SLTs with guidance on specific clinical populations, this document highlights the needs of bilingual clients and their families.

Bilingualism is not a clinical disorder, but a typical human attribute, central to the bilingual person's identity. These guidelines may therefore apply to any clinical population encountered by SLTs.

Key Points

- The RCSLT is committed to supporting bilingual individuals and their families, recognising bilingualism as the norm.

- Bilingualism is an advantage in a person of any age. This is regardless of the specific combination of languages and/or dialects spoken by the bilingual person.

- Bilingualism is an advantage regardless of the presence of a speech, language, or communication disorder, or feeding and swallowing difficulties.

- Bilingualism does not cause, or contribute to, a speech, language or communication disorder.

- Working with interpreters is a core skill for speech and language therapists, including bilingual SLTs.

- Services should allocate at least double the time for bilingual clients and their families in order to achieve the same positive outcomes as monolingual clients, and therefore deliver an equitable service.
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Bilingualism - overview

Any person presenting with a speech, language, communication or feeding and swallowing disorder may also be bilingual. This is because bilingual people are as likely to encounter these difficulties as monolingual speakers (Winter, 2001:465; Stow and Dodd, 2003; Mennen, Stansfield and Johnston, 2005).

Bilingualism does not cause or contribute to any of these difficulties. However, for a bilingual person and their family, accessing services and their experience of services can be hindered by well-meaning, but misinformed professionals. Many highly negative myths are associated with bilingualism, and these are still regularly encountered by bilingual communities.

As evidence-based professionals, speech and language therapists are committed to relating the research on both typical bilingualism and bilingualism in the context of speech, language and communication disorders to clinical practice. In combination with the informed views and beliefs of the client, and our clinical experience (Sackett, Gray, Haynes & Richardson, 1996) it is possible to deliver effective and supportive care in a language one does not share with the client.

The key role of interpreters and bilingual staff makes this possible, and they should be considered valued members of the team. Despite long-standing professional guidelines, monolingual SLTs and other professionals are sometimes hesitant to work alongside professional interpreters, or find this relationship challenging (Palfrey, 2013; Zendedel, Schouten, van Weert and van den Putte, 2016), with many ‘getting by’ in English (or other mainstream language) with the help of ad hoc interpreters such as friends, relatives and even children in the family (Wu and Rawal, 2017).

SLTs should ensure that professional interpreters are involved in all aspects of assessment, providing: advice, assessment, intervention, and multi-disciplinary meets and any decision-making in partnership with the client and family. Financial considerations of working with interpreters are overridden by legal requirements to provide equitable services (Equality Act, 2010; United Nations Convention on the Rights of the Child, Article 2)"

A huge barrier to working with bilingual clients in the past was the availability of information about other languages, such as phonological inventories, descriptions of syntax, grammar and morphology and cultural knowledge.

Much research has been directed into these areas and there are now data available on many languages, including resources specifically for speech and language therapy in languages other than English. There is still much to do in this area, but the practitioner no longer needs to work from a blank slate for most families encountered in the UK.

Societal and individual attitudes to bilingualism are often crucial factors in clients and families valuing their home language(s). Many bilingual communities are resident in the UK. Some communities have been established for many generations and are UK citizens, while other communities are new arrivals in the UK.

Politicians have often linked ethnicity with language use, reiterating the myth that speaking a home language is a barrier to acquiring English. Speech and language therapists are well placed to advocate for home language use and explain the benefits, while debunking the myths. There is strong evidence that associating high status with home language promotes its use (King, Fogle and Logan-Terry, 2008).
For some bilingual communities, the negativity and prejudice of the past has been replaced with optimism and a new found high status. Welsh language use has grown, and Gaelic and Welsh medium schools are now desirable educational routes for many families.

Speech and language therapists through their training have professional communication skills at their highest levels. For instance SLTs have the skills required to support a person with aphasia to recall words in English and home language following a stroke, to explain thickening food and drink to a carer with an interpreter, or working on phonology with a child in home language.

Working in a language one does not share with the client can be challenging, but the outcomes for the client and family are both clinically and professionally rewarding.

**Main Learning Points**

- Bilingualism is an umbrella term, which includes the concept of multilingualism, and multi-modal language use such as sign language.

- Collaborating with professional interpreters should not be viewed as optional, and must not be restricted by budgetary constraints.

- The main aim of assessment is to differentiate diversity from disorder.

- Assessment and intervention must always be carried out in both/all languages.

- The main aim of intervention with bilingual clients is to maintain, restore or achieve bilingualism.

- Professionals in the UK are committed to providing equitable services to all individuals (Equality Act, 2010) and not to discriminate based on language (United Nations Convention on the Rights of the Child, Article 2)

- The World Health Organization International Classification of Functioning, Disability and Health (ICF, WHO, 2007) can be effectively used to aid the practitioner in factoring multilingualism into the clinical reasoning process.

- If there is a communication disorder, then it will be present in both/all the languages that the individual understands and uses.

- Speech and language therapists should never recommend abandoning the home language(s) in favour of additional language learning.

- Services with a high level, i.e. 5-10% or more of bilingual people in the local population, should consider developing a specialist bilingual service.

- Services should ensure that all staff working with bilingual clients/patients have access to training on typical bilingualism and speech, language and communication disorders in the context of bilingualism.
Bilingualism in the UK

Bilingualism and multiculturalism are common in the majority of countries around the world and can be observed across all ages and societal status. The ongoing need to experience new interactions, education, job opportunities, immigration and relationships encourage the need to communicate in other languages besides the mother tongue (referred to as ‘home language’ in this guidance).

The advantages that bilingualism offer may extend further than just a linguistic addition; it is thought by some researchers that bilingualism positively improves cognitive abilities as well.

“It is sometimes assumed that ‘English is enough’, but in global terms only 6% of the population are native English speakers and 75% speak no English at all” (Multilingual Britain report, British Academy and Cumberland Lodge, 2012).

There are no reliable figures on the number of bilingual speakers living in the UK. Although the National Census asked about language for the first time in 2011, respondents were asked about their ‘main language’. Unsurprisingly, the overwhelming majority reported: English as their main language (92% or 49.8 million), and of the remaining eight percent (4.2 million) who had a different main language, the majority (3.3 million) could speak English well or very well. (Office for National Statistics, 2013).

The question ‘hides’ the bilingual speakers who may use English for work and everyday activities, but regularly use another home language or languages.

Indigenous languages of the British Isles:

- **English** is the most widely spoken language of the United Kingdom with 92% (49.8 million) speaking English as their main language, and of the remaining eight percent (4.2 million) who had a different main language, the majority (3.3 million) could speak English well or very well. (Office for National Statistics, 2013). English is a high status language with English used for the internet, scientific journals, teaching, business and popular culture, including films and popular music. English is the language in which most speech and language therapy degrees are taught in, and as a result, the majority of speech and language therapists are English speakers and until recently, assessments and therapy packages in languages other than English were rare.
- An estimated 700,000 people speak **Welsh** in the UK, the official language of Wales. Welsh is a language of mainly Celtic origin, although there are influences from Latin, French and English (Davies, 2014: 180).
- An estimated 1.5 million people speak **Scots** (i.e. Germanic language variety spoken in Lowland Scotland and part of Ulster) in the UK, which is a sister language of English.
- An estimated 15,000 people living in England and Wales, reported themselves using **British Sign Language** as their main language.
- An estimated 73,804 native speakers in Ireland (2016) speak **Irish** also known as **Gaelic** or the **Irish Gaelic**.
- An estimated 57,375 people in Scotland speak **Scottish Gaelic** which is classed as a indigenous language.
- **Angloromani** is spoken in the United Kingdom and refers to the use of Romani origin words within English conservation.
- An estimated 300-400 people in Cornwall speak **Cornish**, which is a Southwestern Brittonic Celtic language. Cornish is currently recognised as a minority language in the UK.
- **Shelta** is a language spoken by Irish travellers. The exact number of speakers in the UK is hard to determine.

### Migration in the UK

The fast changing demographics in the United Kingdom is influenced by migration. According to the Office of National Statistics around 1 in 7 (14%) individuals were born abroad, with Poland being the most common non-UK country of birth (an estimated 911,000 residents) as of 2016.

Likewise, the Migration Observatory at Oxford University (Feb 2017) reported that Poland, India and Pakistan are the main three foreign countries of birth. There are also about 141,000 Chinese speakers and other pockets of smaller groups.

“Looking at the distribution of foreign-born by age, including children (those aged 0-15), youth (aged 15-25), adults (aged 26-64), and retired (aged 64+), the vast majority of foreign-born people are adults (70.9%), while 9.4% are children, 9.9% are youth, and 11% are retired” (Vargas-Silva & Rienzo, 2017).

This change in demographics creates a challenge for speech language therapists to meet the needs of speakers of languages whose first language is not English in the delivery of services.

![Figure 1. Top Ten Languages in England and Wales, 2011 Census.](source: Census - Office for National Statistics)
It is noteworthy that the census highlighted that ‘Half (10,800) of those who reported Pakistani Pahari (with Mirpuri and Potwari) as their main language lived in Birmingham’. Pakistani heritage languages including Mirpuri, Punjabi and Urdu are thought to be the third most widely spoken home languages after English and Welsh.

These languages share a large proportion of lexical items but have different grammar (See Pert, 2007 and Stow, 2006 for an overview).

These data and other surveys should be considered after considering the definition of ‘language’, and ‘dialect’, as both terms may cause significant confusion and lead to errors of language reporting and therefore the work of speech and language therapists when trying to match a family with a suitable interpreter, or when seeking information on a language.

The National Association for Language Development in the Curriculum (NALDIC) publish information from the School Census in England. The 2012 census indicated that there are 18 languages spoken by more than 10,000 pupils.

This provided similar results to the census, but with Punjabi and Urdu being the most popular after English:

<table>
<thead>
<tr>
<th>Language</th>
<th>Pupils</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>5,570,335</td>
<td>84.1%</td>
</tr>
<tr>
<td>Panjabi</td>
<td>116,350</td>
<td>1.7%</td>
</tr>
<tr>
<td>Urdu</td>
<td>109,215</td>
<td>1.6%</td>
</tr>
<tr>
<td>Bengali</td>
<td>87,945</td>
<td>1.3%</td>
</tr>
<tr>
<td>Polish</td>
<td>53,915</td>
<td>0.8%</td>
</tr>
<tr>
<td>Somali</td>
<td>42,215</td>
<td>0.6%</td>
</tr>
<tr>
<td>Gujarati</td>
<td>40,490</td>
<td>0.6%</td>
</tr>
<tr>
<td>Arabic</td>
<td>39,135</td>
<td>0.6%</td>
</tr>
<tr>
<td>Portuguese</td>
<td>24,305</td>
<td>0.4%</td>
</tr>
<tr>
<td>Tamil</td>
<td>24,605</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

*Table 1. School census January 2012 language data nationally and by local authority*

Statistics for Schools in Scotland 2016 suggested 39,342 pupils as having EAL and that 2011 census data suggests 150 languages other than English used across Scotland.

The following guidelines provide information and guidance on working with bilingual clients and their families. Bilingual clients can often be amongst our most vulnerable, and the loss of home language can have severe negative lasting effects on an individual. These guidelines are designed to support, maintain and promote bilingualism, even when individuals have very limited communication.

**Further reading**

- [Multilingual Britain](#)
- [Office for National Statistics](#)
Terminology - Adults

Definition of bilingual and bilingualism

People are considered bilingual when they need to communicate in two or more languages. ‘As language is a dynamic, complex social tool developed over extended time periods’ (Kohnert, 2013, p. 17), bilingualism does not have a straightforward definition.

There is substantial variability amongst bilingual and multilingual individuals as it includes different levels of proficiency, competency and fluency which can vary over the lifespan of the individual.

An adult can be bilingual from childhood or become bilingual by acquiring another language(s) late in life due to social interests, working related activities, or migration. Grosjean (1982) has explained that with time, an adult can become as bilingual as a child but an accent may be present, and this is not an indicator of proficiency or competency.

The inhibition control model proposes (Kroll, Bobb & Misra, 2008) that neurotypical healthy bilingual adults can speak either in L1 or L2, thus separating both languages if necessary.

This is known as monolingual mode. It is important to note that the non-targeted language in the monolingual mode is not completely deactivated (Kohnert, 2013). Both languages remain active to a certain extent with no signs of interference.

This indicates a healthy pattern of the neurotypical brain (and an advantage of being bilingual) as it is successfully using cognitive resources to resist interference (Kohnert, 2013). In a bilingual mode both languages are active and code switching appears more regularly, if appropriate.

With age, it is normal to present with increased interference and code switching between two or more languages (Ardila & Ramos, 2008). An older adult may choose, or need, to use just one language despite having used two or more languages regularly in younger years.

Adults who are sequential language learners will reflect in their acquired language (L2) skills differences which may be influenced by their first language system. It is important for the speech and language therapist to consider this this matter and its impact when assessing the adult.

Other typical processes experienced by bilingual adults are:

<table>
<thead>
<tr>
<th>Terminology</th>
<th>Key words</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acculturation</td>
<td>Children Adults Culture</td>
<td>Cultural process that allows a person to move from monoculturalism towards biculturalism. This is usually a process that allows individuals from minority cultures to adopt traits of the majority culture.</td>
</tr>
<tr>
<td>Additive Bilingualism</td>
<td>Children Adults</td>
<td>Is a process in which the acquisition of a second language does not occur at expense of maintenance and development of the native language.</td>
</tr>
</tbody>
</table>
**Table:**

| **Attrition** | **Normal process** | **Children** | **Adults** | **Language loss**, which is the decline in previously attained language ability and skills. L1 or L2 are susceptible to environmental opportunities. Note: Language shift occurs in language communities and SLTs should be aware of any relevant research on the particular community the individual is from, and the effects of language contact generally. |
| **Assimilation** | **Culture** | **Adults** | **Cultural process that correlates with **subtractive bilingualism** as it is the loss of a person’s traditional/original culture.** |
| **Cross Language Generalisation (tag)** | **Adults** | **Intervention** | **As both languages are active in a bilingual mode, then supporting one language will result in changes in all languages.** |
| **Cognitive Reserve (tag)** | **Adults** | **Advantage** | **Ability the brain has to withstand and or resist neuropathology before cognitive function is affected. Bilingualism is thought to be a contributing factor to increase it.** |
| **Language Interference (tag)** | **Adults** | **Children** | **Normal Process** | **Is the effect of language learners’ first language L1 on their production of the second language L2. It means L1 influences L2. It can be positive if one language aids in developing skills for a second language or negative effects if it hinders it.** |
| **Language Proficiency (tag)** | **Adults** | **Children** | **‘refers to skill or ability in a particular linguistic code, with no a priori standard or benchmark. Proficiency is a noun that requires a modifier to fully appreciate its meaning. High proficiency, native-like proficiency, or minimal proficiency can all be used to describe the relative level of attainment in a particular language’ (Kohnert, 2013: 21).** |
| **Passive Language Skills** | **Adults** | **Children** | **Refers to the ability to have a good understanding of a language with very little ability to express using it.** |
| **Subtractive Bilingualism** | **Adults** | **Children** | **Is the loss of the native language as a result of acquisition of the second language. Subtractive bilingualism often results in monolingual proficiency in the majority language.** |

**Terminology - children and young people**

**Typical bilingualism**

The following sections provide an overview of typical bilingualism. This includes essential information and terminology, which the reader needs to be familiar with prior to considering speech, language and communication disorders in a bilingual context.

**Definition of bilingual and bilingualism**

Bilingualism is the ability to understand and/or use two or more languages. The term therefore encompasses ‘multilingualism’, which is the knowledge and/or use of several languages.

The languages in question may be spoken languages, sign languages, or a combination (Lillo-Martin, de Quadros, Pichler and Fieldsteel, 2014). To be bilingual an individual does
not have to have equal fluency in both languages, or mastery of both languages. (Baker, 2000, Meisel, 2004, Myers-Scotton, 2006, Romaine, 1995).

A bilingual person may routinely use their languages in different contexts and for different purposes, such as home life and education or work. The bilingual person may therefore not have the same communicative skills in both their languages (Rowland, 2013). Any individual with knowledge of more than one language should be considered bilingual, regardless of the relative proficiency of the languages understood or used.

Bilingualism is not a disorder and there is no evidence that bilingualism causes or contributes to any speech, language or communication disorder (Hampton, et al, 2017)

Language is core to a person’s identity and culture. The use of other languages should be valued, respected and encouraged, as the impact of language loss on an individual or community can have a serious negative impact on concepts of identity, self-respect, and heritage culture and these effects are often permanent.

Bilingual people and communities are the majority in the world and bilingualism is the natural state of human beings (Mennen, Stansfield and Johnston, 2005). Bilingualism is often viewed with suspicion and negatively by majority language speakers, with unfounded concerns that exposure to more than one language may confuse or otherwise negatively affect the child’s development.

Such misconceptions must be challenged with the extensive research evidence showing that bilingualism is an advantage in children and adults (Wei, 2000).

**Home language, Mother Tongue, and Our language**

Terminology for languages is problematic, as for simultaneous bilingual children there is no clear L1 and L2. Most children in the UK arrive at bilingualism by speaking one language at home and another for education (sequential bilingualism) and so L1 is the home language and L2 is typically English, Welsh or Gaelic.

‘Home language’ therefore reflects the typical scenario in the UK for minority ethnic families, who constitute the largest group of bilingual children. ‘Mother tongue’ is the term adopted by the World Health Organisation which reflects the fact that mothers tend to be the primary caregiver in a family, and hence provide the language input for infants. This has the downside of excluding same-sex male couple, single parents who are male, or gender non-binary, and adoptive single parents and other carers.

**Language, dialect and accent**

Both the UK National Census and the Schools Census report languages which seem to match political borders (countries), or regions. Language reporting is fraught with complexity, making the statistician’s work more challenging. Language and identity are closely linked. This means that ideas of national and regional identity, and social status may affect the language label reported by a particular speaker (Grosjean, 1982; Stow, 2006, Pert, 2007).

The situation may become even more complex if there are several forms of the language. Each language has at least two variants, a standard or high status form and a non-standard or lower status form. The high status form is often associated with power and influence, and used by those in politics, the media and the wealthy.
Consider English. The ‘Received Pronunciation’ or ‘BBC English’ form is considered to be the ‘correct’ or ‘clearest’ form by many English language speakers, even if they do not use that form themselves (Hughes, Trudgill and Watt, 2013).

Other ‘accents’ or ‘dialects’ are often judged to be ‘incorrect’ or less desirable. Speakers of the non-standard form are often judged more negatively.

A dialect is ‘...a language variety distinguished from other varieties by differences of grammar and vocabulary. Standard (British) English is therefore a dialect of English, just as the other standard dialects of the language (Standard Scottish English, American English, etc.) are, and all non-standard dialects of the language too. Accent...refers just to variations in pronunciation.’ (Hughes, Trudgill and Watt, 2013: 3).

In the same way, different varieties of related languages are perceived as being associated with high or low social status speakers. In a review of speech and language therapy referrals, Stow (2006) found that only 45% of bilingual children had their language correctly identified on the referral form. Parents often reported ‘Urdu’ (a high status language) for children speaking Mirpuri and Punjabi.

Mirpuri, Punjabi and Urdu, were considered so different by the service that different bilingual co-workers were employed, and speakers reported that they were not mutually intelligible.

The use of the term ‘dialect’ is therefore subjective and speech and language therapists need to consider that if ‘dialects’ are functionally different, then they should be treated as functionally separate languages.

Different variants of a language may also have the same label which can confuse those who are not aware of this, e.g ‘Kiswahili’, the higher status form spoken in Tanzania and Kenyan ‘Kiswahili’ are different variants.

**Monolingualism**

Monolingualism is the use of only one language. This is the typical only for a minority of humans. However, monolingualism is mistakenly considered the ‘nature’ or ‘normal’ state of human beings by speakers of high status monolingual communities. Early research into bilingualism considered bilingual language acquisition as a threat to the successful acquisition of the majority language (typically English).

This misconception was reinforced by the focus on the majority language capability and ignoring the person’s ability in their home language.

**Majority language**

This is the language spoken by most people in a community. This language often has associations of high status as it is the language of education, work, law, and the media. For this reason, the majority language is often viewed as essential and the only correct form of communication.

Other languages are often compared unfavourably with the majority language. In the UK, high status languages used in these contexts include English, Welsh and Gaelic.
Minority language

In contrast to the majority language, minority languages are spoken by a small number of individuals or communities. Minority languages are used by people who may or may not also speak the majority language.

Minority languages may be seen majority language speakers as unhelpful, due to misguided beliefs that the use of a minority language is a barrier to speaking the majority language.

The English language spoken in the UK represents a dominant cultural context, where one language i.e. English is most widely used by the majority of the population. Many factors impact upon the acquisition of a heritage language in the context of a dominant language environment.

Within this context, a bilingual’s languages may be viewed as languages in contact, which are often altered because the two languages influence each other. Studies have shown that the languages spoken by bilinguals may differ from that within a monolingual speech community (e.g. Trudgill, 1974a). Social pressures may be perceived by the bilingual that reinforce the acceptability (or otherwise) of one of their languages in a particular domain e.g. Pagett (2006) investigated codeswitching in bilingual children in the classroom and found that many had a clear preference for speaking English at school and were reluctant to use their home languages, even when encouraged to do so.

Language contact outcomes are determined by economics, politics and demographics as well as by social relations among populations (Sankoff, 2001).

Additional language

English as an Additional Language (EAL) is a commonly used term in education in the UK. Analogous terms such as Welsh as an Additional Language (WAL) or Gaelic as an Additional Language (GAL) are similarly valid as these reflect the use of these languages as the language of education.

Additional language is therefore a term which recognises that many children encounter the language of education on entry to school.

Some children are monolingual in a language other than the majority language prior to attending an educational provision, while others may have had limited exposure to English (or Welsh or Gaelic or other language of education).

The terminology should be used with caution by speech and language therapists, as it does not evaluate the child’s abilities in their home language. It is common for children to be labelled as EAL, only for it later to emerge that the child has a language impairment and that the parents only used English with the child.

See the EAL Framework for further information.

There is often an assumption that children from families where English is not the home language have acquired their parent’s home language to expected levels.
This may not be the case and speech and language therapists should always assess the home language to check such assumptions and discuss the child’s language skills with the parent(s)/carer. To fail to do so and to allow such children to be treated as learners of an additional language may risk failing to identify children with serious speech, language and communication difficulties.

It should be noted that it is not the role of SLTs to teach additional language. If a child has acquired their home language then they have demonstrated that they have all the mechanisms in place to analyse and acquire a language. Such children, with sufficient exposure will acquire the additional language without specialist intervention.

Language learning (both home language and additional language) may be negatively affected by other factors unrelated to bilingualism, most significantly poverty. Children and families living in areas of high socioeconomic deprivation may need interventions at the universal level and such approaches should include valuing bilingual families’ home language use.

Other factors include medical, cognitive (learning difficulties), sociolinguistic, including length of residence in the country, language status and attitudes, and affective such as motivation and anxiety.

**Categorising children who speak two or more languages**

Bilingual, Additional Language (EAL, WAL, GAL etc.), receptive bilingual, and other labels can make it difficult for the speech and language therapist to know how to discuss children who are using, or are expected to use two or more languages.

**Aspects of bilingual language use**

By studying bilingual language use, it is possible to hear how a bilingual person uses their two (or more) languages. The literature has terminology which describes the interface between two languages, which is described below.

**L1**

This is the speaker’s first language. It is usual for speakers to have a concept of a ‘first’ or ‘main’ language. This is generally the mother tongue or home language. Most bilingual speakers in the UK learn an L1 in the home environment from birth and then acquire a second or additional language on entry to a care or education setting.

However, a smaller proportion of bilingual speakers will learn two languages at the same time. This is much rarer, but even in this circumstance there will not be a perfect balance between the two languages.

**L2**

This is the speaker's second or additional language. It is often the language of education, encountered when the child enters nursery or mainstream education.

**Code switching: different aspects of code switching**

Linguists study two different aspects of code switching. The first is when the speaker switches language (or code) between spoken sentences. This language alternation is known
as intersentential code switching. This is usually interpreted as a signal of in-group membership (Grosjean, 1982: 153). This is therefore a social pragmatic function.

Switching between languages in the same conversation, or even in the same sentence (code-switching), is a common behaviour for bilingual children and adults and is indicative of linguistic competence.

The reasons why children and adults code-switch are numerous and systematic and include, but are not limited to, assessment of the listener's language knowledge (switching to a language the listener knows better), the (non-) existence of translation equivalents across their two languages (an idea may be expressed better in one language than another), and lexical gaps (switching because you know the word in one language not another) (Genesee, Nicoladis and Paradis, 1995; Ribot and Hoff, 2014).

**Intersentential code switching**

The use of language alternation between spoken utterances. That is, speakers use a spoken sentence in one language, and then a spoken sentence in another language. However, ‘sentence’ is not strictly correct; bilingual speakers may change language when there is a new phrase.

Conjunctions such as ‘and’ allow a code switch to occur such as “Sometimes I'll start a sentence in Spanish Y TERMINO EN ESPAÑOL” (and finish in Spanish) (Poplack, 2000: 235).

**Intrasentential code switching**

The use of a bilingual or multilingual spoken sentence or utterance. This is not thought to be a random ‘mix’ of words and morphemes from different languages. The sentence is formed using rules and is predictable.

Myers-Scotton (2002) proposed that one language forms the morphosyntactic frame, and that content may be drawn from the other language and embedded in the frame.

For example, “girl chair uper beh-ti vi” follows the Mirpuri phrase/word order, the monolingual version being “kuri kursi uper beh-ti vi” (girl chair on sit-ing+female is+female). Note that the speaker has simply inserted English nouns as if they were synonyms.

English can also form the morphosyntactic frame, e.g. “A dzanani is cooking some chavel” (a woman is cooking some rice). This time the English frame sets the phrase/word order.

This type of code switching is thought to reveal how all spoken sentences are produced, the presence of two languages (or codes) simply allow us to ‘see the join’. This is evident in monolingual speech from ‘slips of the tongue’, where content is inserted into the frame, but in the wrong ‘slot’, e.g. ‘Fancy getting your model renosed’ (Azuma 1993: 1072).

Code switching in sequential bilingual children is established by 3 years 6 months and increases with age, with almost all multi-word utterances conforming to the monolingual morphosyntactic frame (Pert, 2007).

For this reason, children from bilingual communities who code switch are demonstrating linguistic sophistication, with the ability to integrate two languages and observe language
rules. Those children who cannot code switch in this way are likely to have Developmental Language Disorder (Pert, 2007). This evidence reverses the myth that code switching is a sign of linguistic confusion.

**Code switching: Bilingual utterances**

A code is a language. A bilingual speaker therefore has access to two or more codes. A bilingual speaker can choose to:

1. Use an L1 spoken utterance
2. Use an L2 spoken utterance
3. Use a spoken utterance using elements from L1 and L2

This assumes a verbal language mode. Sign language users have the option not only to use their signed language, but also to use verbal and signing simultaneously.

Code switching is common in bilingual communities and is most frequently observed in bilingual-to-bilingual communication. This is because bilingual speakers are often aware which languages a person speaks and will adjust their language use to suit their interlocutor, according to the cooperation principle.

Code switching was once thought to be proof that children were ‘confused’ by bilingualism; the use of bilingual sentences seen as an inferior form compared with monolingual sentences. Parents were encouraged to use the one-person-one-language approach to avoid such confusion.

This advice has been shown to be invalid, not least because bilingual parents are often unaware when they code switch.

Bilinguals often comment negatively about their code switching behaviour due to the perceived ‘purity’ of monolingual utterances. This is despite the fact that almost all bilingual speakers employ code switching (Romaine, 1995).

Code switching is also known as ‘code mixing’. However, this implies that there are no syntactic or grammatical rules and that the utterance is a random mixture of elements from the two languages.

Rather than being a random selection of elements, code switching is constrained by rules. There is debate on the exact nature of these constraints. However, Myer-Scotton (2006) proposed a model, informed by the data provided by bilingual speakers. This complex linguistic model is summarised below, although those interested in analysing language samples from bilingual speakers should undertake further reading.

It is thought that all spoken utterances are formed in the same way. With monolingual speech, we can only see the way this operates when the speaker makes an error, such as a slip of the tongue.

For bilingual speakers, the fact that content may be drawn from either L1 or L2 means that we can more easily see how the spoken utterance has been formed.

When a speaker produces a spoken utterance, the elements can be thought of as a sentence frame which is selected first. The frame is cohesive and includes all the elements
required for that particular language. The frame sets the word/phrase order and important obligatory settings such as gender agreements.

The frame is then filled with content words. These content word may be drawn from either the L1 or L2.

**Borrowing**

Borrowing contrasts with code switching, in that words which have been adopted into a language from another are completely integrated. This includes the phonology of the word. Borrowed words are used by monolingual speakers who may have no knowledge of the donor language. Grosjean cites words such as ‘interview’ and ‘jeans’, which French speakers now use as a part of their French lexicon (1982: 292).

**Equitable versus equal**

The terms ‘equitable’ and ‘equal’ are often thought to be synonymous. Services should aim to provide an equitable service (see Stow and Dodd, 2003).

This means, a service which is designed to ensure that bilingual children and their families have the same outcomes as monolingual families.

To achieve the same task will take more time (at least double when compared to the same task for a monolingual client) and more resources than when the child and/or family do not share a language with the speech and language therapist. Examples include:

- More time for assessment, reporting and discussing the implications of assessment results, giving advice and/or training and providing therapy. This is due to the time to assess and treat multiple languages required for the interpreter to translate the speech and language therapist’s utterances and then the family’s answers back to the therapist, time for language samples to be translated for the client record, time for discussion between the speech and language therapist and the interpreter on how to assess or model language structures which are not expressed in the same way in the client’s home language. This is not an exhaustive list.
- The funding of interpreters for all parts of the care pathway, including triage, assessment and therapy/intervention.
- Time for advice leaflets, assessment findings, reports and therapy/intervention programmes to be verbally translated for clients. For many bilingual families verbal translation is preferable to written translation, as literacy levels may be low in the community and some language have no written form, e.g. Mirpuri, a Pakistani heritage language widely spoken in the UK.

Services should not be provided which are equal, i.e. the same amount of time and resources allocated to monolingual and bilingual clients/patients. This would be contrary to professional clinical guidelines and legislation on equality (Equality Act, 2010).

Failure to assess, intervene and support a client in all the languages they speak is a failure to meet all their health needs (World Health Organization International Classification of Functioning, Disability and Health (ICF, WHO, 2007) and may be considered discrimination on the basis of language.

**Language development and becoming bilingual**

**Mother tongue and home language**
‘Mother tongue’ is a commonly used term for the language spoken as the main or first language. The term reflects the most common route of language learning, i.e. from mother to child. Since most child rearing involves the mother as primary carer, this term is still widely understood. ‘Home language’ is used throughout this clinical guideline to avoid gender bias where the father, or other carer is involved in child rearing.

Routes to bilingualism

Some researchers have placed emphasis on the manner in which children have become bilingual. The following terms are widely used in the literature and are concerned with the timing of exposure to two or more languages.

Simultaneous bilingualism

This is when two or more languages are spoken to the child, usually from birth. This is of interest to speech and language therapists as, it is often claimed that such children have slower rates of language acquisition than monolingual children (Hoff et al. 2012; Hurtado, Marchman and Fernald, 2008).

Simultaneous though does not mean equal amounts of exposure in each/all languages. Even if children are exposed to two languages from birth, exposure may be very uneven in the two languages. Research investigating early lexical acquisition in bilingual infants has repeatedly reported a positive association between maternal talkativeness and vocabulary size (See Hoff et al. 2012, and Hurtado, 2008)

Meisel (2004) points out that ‘Although some researchers report that bilinguals tend to begin to speak late, i.e. after the age 2;0...the observed delays are well within the range of what counts as a normal rate of language development for monolingual children.’ (95). Inappropriate assessment can also contribute to the myth of later language development, such as if the child’s words are only counted in one language and not both.

Sequential bilingualism

Sequential or successive bilingualism is where one language is acquired and then a second (L2) or additional language introduced later. Although this is the dominant route by which children become bilingual in the UK, relatively little research has been conducted into the experiences of these children compared to simultaneous bilingual children (Meisel, 2004: 105). There is growing research into these children (see Chondrogianni in Miller et al., 2018).

Parental strategies

Baker (2000, xvii) identifies three types of family bilingualism:

1. Each parent speaks a different language to the child. This is often called the ‘one person-one language’ strategy.
2. The parents speak one language to the child who acquires a second language outside the home. This often occurs in Language minority situations.
3. Both parents speak both languages to the child.

Parents are often advised to use the ‘one-person/parent one-language’ approach (OPOL) to avoid the child becoming ‘confused’. This is where one parent uses one language exclusively, and the other parent another exclusively, with both languages introduced from birth.
This is based on negative views of code switching, which was thought to be undesirable (Romaine, 1995: 122) and evidence that the child could not differentiate his/her languages.

Research has debunked these myths. Dewaele and Li Wei (2013) found that attitudes to code switching were linked to many factors, including personality. Emotionally stable people were more positive about code switching.

Younger age groups were not as appreciative of code switching as older speakers; less educated people were more positive about code switching than highly educated speakers; and those growing up in multilingual and ethnically diverse environments more positive about code switching than those who had not.

Kabuto (2010) found that a bilingual toddler’s middle class parents used code switching as a tool to help children engage with reading, develop biliteracy, and language skills.

The OPOL strategy has been successful with middle-class parents where, crucially, both languages are of high status and the parents are highly motivated (Cunningham-Andersson and Andersson, 1999). However, most bilingual children in the UK speak a lower status language at home.

Romaine (1995: 186) highlights that ‘A very common outcome of the ‘one person-one language’ method was a child who could understand the languages of both parents, but spoke only the language of the community in which they lived (e.g. English).

This language separation approach also assumes that there are two parents, excluding single parent families.

Genesee, Nicoladis and Paradis (1995) showed that children as young as two years of age could differentiate their languages, and that parents, although they reported using one-parent one language strategy, did use code switching with their children.

Bilingual parents may have negative beliefs about code switched sentences, and be unaware that they code switch. However, there is no reason to separate languages in this manner, as no harmful effects have been reported from code switching language input from parents. There is very little research on the relationship between caregiver CS and children's lexical development. Only very few studies have explored the effect that CS might have on children's vocabulary development (Bail, Morini and Newman, 2015, 2015; Byers-Heinlein, 2013; Hodd et al. 2013; Place and Hoff, 2011).

Speech and language therapists should therefore discuss the parent(s) concerns about family strategies and reassure them that different strategies work for different families. The main consideration should be the total input time for each language, as well as the status of activities in a particular language, with avoiding language loss in mind.

Practical methods such as buying games, movies and TV programmes, music and books in home language and the language of education will ensure that neither language is seen as negative.

**Silent period on first exposure to L2**

Children who speak a home language entering education for the first time are plunged into an environment where the adults, and often other children, do not share their language. A
new language (English, or sometimes Welsh or Gaelic) is the language of the classroom. At this point, children may go through a silent period. This is pragmatically appropriate, as the adults the child is encountering often do not share their home language.

Children realise that communication in home language is not possible, and begin the process of second language or additional language acquisition. The silent period is therefore an entirely normal stage in second language acquisition.

The challenges for the speech and language therapist are:

1. How long is the silent period ‘typical’, before we should be concerned about the child’s communication skills?
2. Do we need to do anything proactive during the silent period to facilitate communication?
3. How can the silent period be differentiated from Selective mutism?

It has been suggested in the literature that if the silent period lasts longer than one month, then there should be concern. However, Bligh (2014) found that a small but significant proportion of children experienced a silent period of six months, and sometimes a year (3).

Others have highlighted that Selective Mutism is more prevalent in bilingual children. Certain factors may contribute to Selective Mutism in children exposed to a new language, including a social anxiety disposition, family immigration status, and developmental delay. (Toppelberg, Tabors, Coggins, Lum and Burger, 2005).

Children who have a prolonged silent period or over a month should therefore be assessed for these risk factors and monitored. If active management is not implemented, children with serious language disorder or selective mutism may be missed.

**Language loss**

‘Language loss’ or ‘Language attrition’ ‘...is a phenomenon where an individual’s abilities—usually measured expressively—in his or her L1 are diminished, presenting patterns of production that do not correspond to a typical monolingual speaker of the target language’ (Anderson: 1999: 4).

Children from minority groups, especially where the home language is considered low status are particularly vulnerable. Patterns of loss reported in the literature include the following four main patterns:

- Progressive reduction of inflectional morphology, with a corresponding less flexible word order
- Leveling of grammatical distinctions, so that irregular patterns become regularized
- Preference for coordinated sentences, with a corresponding reduction in embedding; and
- Transfer of L2 syntactic structure to L1

(Anderson, 1999: 5).

It is possible that language loss may be confused with Developmental Language Disorder (DLD).

**Avoiding language loss**

Language loss can be rapid in both individuals (occurring within a few months) and in a particular language community, with a shift from L1 to English in as little as one generation (Anderson, 2001). This tends to occur when children speaking a home language with a
perceived low status is in contact with a high status language. For example, Mirpuri speaking children entering an English medium school setting.

This may have a profound impact on the family, with the child speaking English to a parent who cannot understand the language well enough to communicate and maintain strong parent-child bonds. Parent(s)/carers should therefore be supported to insist on home language use until the child settles into a bilingual usage pattern.

Teachers should be encouraged to ‘... promote additive bilingualism over subtractive, multiculturalism over assimilation in their classrooms by providing multicultural students’ a welcoming environment, and helping them in expressing and overcoming their feelings of anomie, acculturation and assimilation’ (Unganer, 2014: 354).

Smith-Christmas (2016) highlights that ‘Perhaps not surprisingly, children who receive more minority language input tend to be more productive bilinguals than children who receive less minority language input’ (3).

Speech and language therapists should explain to parent(s)/carers that abandoning home language is an irreversible step, and that children will not be able to acquire the home language without sufficient exposure. Parents may be disappointed when, having opted for English (or language of education), the child goes on to lose their home language, and then need to learn their home language at a later stage as an additional language. This may lead to reduced mastery of their home language.

Parents often express dissatisfaction at the competence and phonological accuracy of such language use. It is best to ensure that potentially bilingual children retain both languages in the first instance.

One way to present this to parents is to ask if the child should be monolingual or bilingual when they are an adult. Most parents opt for bilingualism. This focus on outcomes is far more helpful than thinking about English for educational purposes.

It is important to note that language loss may occur to the L1 or L2 depending on the amount of input a child receives. Flores (2015) reported the case of a nine year old bilingual child losing L2 German, when returning to Portugal. Loss was extremely rapid, with significant difficulties with German after only a few months and the child not even able to remember common German words such as ‘house’ after 18 months.

Flores concludes that ‘...bilingual children need uninterrupted exposure to both languages in order to retain their bilingual competence.’ (587).

**Differentiating language loss from language disorder**

The patterns of language loss are strikingly similar to Developmental Language Disorder (DLD). The key to differentiating language loss from language disorder is the exposure the child has to their home and additional languages.

If home language input has been reduced (e.g. because the child has started school and is using English, setting up a cycle of parents and siblings switching to English), then home language will be lost within months. Restoring sufficient exposure to both/all languages should resolve the language loss, whereas DLD will not spontaneously resolve in this case.
Ethnicity and bilingualism

Stow and Dodd (2003) highlight that there are complex issues associated with ethnicity and language use, as well as cultural identity. These areas not always overlap, and terminology may be problematic for a range of reasons.

‘White’ (a census term), does not, for example, differentiate between monolingual English speakers, traveller communities, different religious groups and bilinguals who may speak a European language. Assumptions that a white family are monolingual risks missing bilingual children, and all families should be asked if they speak another language during the parent/carer interview following referral (case history).

The 2011 Census only asked respondents what their main language was. This may mask many speakers who use English for work and education, but use a home language regularly as well.

Stow and Dodd (2005) found that ‘Only 45% of bilingual children had their language correctly recorded on the referral form.’ (10).

It appears that families may accept a language with a well-known label. For example, Pakistani heritage families may agree that they speak Urdu or Punjabi, when they actually speak Mirpuri. Mirpuri is often labelled as ‘Pakistani Pahari’ or ‘Potwari’, and this language is widely spoken in the UK, with over half living in Birmingham (Office for National Statistics, 2013).

To avoid mis-reporting of languages, speech and language therapists should be familiar with the local dialects and languages used in their area. Families should be offered a choice of language, e.g. ‘Which languages do you speak at home? Do you speak Mirpuri, Potwari, Pahari or Punjabi?, Or another language?’ rather than being asked ‘Do you speak X?’ Telephone triage can also assist in the identification of the correct language.

Refugees, asylum seekers, Immigrants and Multicultural communities

A refugee is a person fleeing conflict or persecution (UNHCR, 2017). Refugees may apply for asylum in the UK. Such an application is legitimate under international law, and if granted, asylum seekers become legal citizens of the UK.

Such individuals are likely to have had little time to adjust to British society and may have had little or no opportunity to learn sufficient English. Many refugees are traumatised by their journey to the UK.

Finney and Peach (2004) note that ‘The media, particularly the press, in the UK has covered asylum issues in a hostile and inaccurate way’ (79) and that ‘there is a great deal of concern and hostility towards incomers’ (28).

Working with interpreters may bring additional challenges when working with asylum seekers. Vostanis (2017) reminds us that ‘interpreters coming from the same community, often being refugees themselves, thus both being important role models and functioning outside their health or social professional remit; these boundaries need to be clear and monitored’ (74).
In other words, SLTs need to be extra vigilant to ensure that untrained or partially trained interpreters are supported, and that any disclosures from a child or young person are dealt with appropriately.

There is also some risk that interpreters do not understand the concept of confidentiality, or families may feel extremely vulnerable, especially when a very small community exists. Discussing confidentiality together with the client and interpreter and making plain the consequences of ignoring confidentiality may be necessary to establish trust with the family.

An immigrant is a person who has moved to another country to take up permanent residence, usually for reasons of employment, education or family connection. Immigrants have legitimate status in the UK. Illegal immigrants are people who have moved to the UK but do not have the relevant government authorisation and accompanying documentation.

Multicultural communities include all the above, but the majority of people with a cultural heritage that is not exclusively British are UK citizens because they were born in this country. This is why Britain is often referred to as a multicultural society. British citizens speak many languages, have different religions and cultural practices.

The term ‘Heritage’ may be applied to a person who is British, but has roots to another country or culture.

For example, a Pakistani Heritage child would be a British citizen whose parent(s), or grandparent(s), or even great-great grandparent(s) originated from Pakistan. Such communities often have strong cultural, religious and linguistic ties with the Heritage country, and may visit relatives there.

Language is a vital component of the transmission of culture. Without an understanding of home language, children and young people may have difficulty understanding the nuances of concepts, beliefs and ideas associated with a particular culture.

Pahl (2015) highlights that ‘Notions of place and space are disrupted when possessions are left behind, and language is all there is left to recreate lost objects in old spaces...Home cultures can be understood in this context as “traveling” (304).

Speech, language and communication disorders in a bilingual context

The impact of bilingualism on speech, language and communication disorders

The role of the speech and language therapist with bilingual children is to:

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<td>This means recognising the difference between core, central disorders which affect both/all languages, and the normal, unconcerning effects of acquiring two or more languages. In order to do this, speech and language therapists should be familiar with concepts relating to normal bilingual speech and language development and develop skills and knowledge around working with bilingual families through Continuing Professional Development (CPD) activities.</td>
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2. **Provide all aspects of the care pathway in the home language(s)** to address speech, language and communication disorders, and feeding and swallowing disorders.

a. All aspects of care should be provided in home language. This includes telephone triage, assessment and therapy/intervention. Referrals should have a section to indicate the home language(s) and efforts should be made to verify which language and specific dialect is required before the family attend. This may include using a telephone interpreter service to contact the family and check this information.

Providing care exclusively in the majority language or language of education (such as English, Welsh or Gaelic) will have multiple negative effects of the outcome for clients/patients, unless this is specifically requested by the client/carer and parent(s)/carer, and where the family is aware of the effects of only using the language of education.

b. On a basic level, families require interpreters who are able to support them in order to understand the highly complex terminology and concepts relating to their child’s difficulties. Families with basic majority language skills can often ‘get by’ in day-to-day circumstances, only to experience severe difficulties when trying to understand their child’s needs. To fail to provide home language support risks uninformed consent and poor outcomes for the child.

c. Other negative outcomes of a majority language only approach include failure to resolve difficulties in the home language and increasing the likelihood of the loss of the home language through the promotion of the majority language as the ‘correct’ and only acceptable form of communication. It is recognised, for example, that treatment of phonological disorders in English does not generalise to the child’s home language.

3. **Advise parents, carers and the multi-professional team on bilingualism**

Advise as well on how to support families to address their child’s needs without risking the loss of the home language.

4. **Advise parents, carers and other professionals on the negative consequences for the child of abandoning the home language in favour of the majority language** (typically English, Welsh or Gaelic).

Parent(s) and carers should never be advised to abandon home language in favour of the majority language (typically English, Welsh or Gaelic) under any circumstances. Such an approach is not supported by the evidence base and leads to poor speech, language and communication outcomes for the child, and poor social outcomes for the child, family and wider community.

5. **Speech and language therapy leaders (managers, team leads, advisers) involved in designing services for local populations have a key role in promoting the needs of bilingual communities by advising commissioners and supporting their teams to deliver equitable services.**
It is not the role of the speech and language therapist to teach the majority language in the absence of a speech, language or communication disorder. This role lies with education.

The speech and language therapist may have a role in advising teaching staff on how to provide a language rich-environment, but this would be in the context of preventative or universal level practice, applicable to all children attending a provision, and not at the individual level.

The speech and language therapist has a key role in challenging misconceptions about bilingualism and supporting individuals, families and communities.

It is not the role of the speech and language therapist to teach the home language if the parent(s)/carers have chosen to abandon the home language and use the majority language with the child, i.e. provided a monolingual majority language home environment.

In these circumstances, parent(s)/carers should be advised to consider formal language teaching classes. It is the role of the speech and language to support parents to avoid this situation arising by providing advice that reinforces that the use of the home language will not interfere with the acquisition of the majority language.

Speech and language therapists should consider that they risk invalidating their indemnity insurance if they fail to adhere to these clinical guidelines and agree to providing services exclusively in the majority language, risking harm and poor client outcomes, contrary to the evidence base.

The Royal College of Speech and Language Therapists recognises that bilingualism in a child, young person or adult is an advantage.

Language disorder in a bilingual context

Children’s language development is highly variable (Ukoumunne et al., 2011) and establishing which children will experience long-term language difficulties such as Developmental Language Disorder (DLD) is a challenge in the monolingual context (Bishop, Snowling, Thompson, Greenhalgh, 2016).

The bilingual context introduces a new layer of complexity for the speech and language therapist, who must endeavour to differentiate typical bilingualism from a central, core disorder, affecting both/all languages.

Speech development

Speech consists of the physical act of making sounds (articulation). This is the tool by which meaning is transmitted to the listener. The sounds, or phones are physical sound waves produced by the manipulation of air in the vocal tract. As a speaker only has one vocal tract, articulation disorders affect both/all languages.

The rules by which meaning is encoded into speech is known as phonology. Different languages encode meaning using different lexical items and a different set of phonemes. Phonological disorders are difficulties mapping meaning onto the sound system.

These underlying deficits produce similar, but not identical error patterns in each language. Phonological errors must therefore be viewed as a function of that particular language, and
therapy in L1 will not carry over to L2, since that language will not map meaning in the same way.

See also *Interventions for speech disorders in bilingual children*.

**Bilingualism and disorders of fluency**

Fluency disorders (stammering or stuttering). Fluency disorders are no more likely in bilingual than monolingual children (Stow, 2005:9 and Uljarevic, Katsos, Hudry & Gibson, 2016). The presence of a home language/bilingualism should not be viewed as an additional 'load' (Stow and Pert, 2015:6).

Children presenting with a fluency disorder should not be advised to give up their home language(s) in order to enhance fluency. SLTs should be aware that people with a stammer often report varying degrees of fluency in different languages and that goals may be different for different languages.

**Bilingualism and autistic spectrum conditions**

Bilingualism and neurodevelopmental disorders/intellectual disability such as autism are present from childhood and often have an impact on the development of speech, language and communication skills. Many people mistakenly believe that bilingualism may be 'too much' for children with such needs.

However, a recent review found no evidence to support this view (Uljarevic, Katsos, Hudry & Gibson, 2016). In the case of autism in particular, a positive effect of bilingualism on communication and social functioning has been observed in the few studies available and many UK families with autistic children who took part in a survey reported that they value the fact that their children can use two languages (Hampton, Rabagliati, Sorace, Fletcher-Watson, 2017)

**Financial restrictions to providing a service**

Providing an equitable service is the best way of meeting the requirements of the Equality Act 2010 ([Legislation.gov.uk](https://www.legislation.gov.uk), 2010). Race is one of the eight protected characteristics. Since language is closely associated with minority ethnic groups, to withhold services in home language, knowing that this results in the client/patient achieving poorer outcomes, would be discriminatory and would be open to legal challenge.

Discrimination based on language is also explicitly prohibited by the United Nations Convention for Child Rights (UN CRC) and would be open to legal challenge too (Uljarevic et al., 2016). Moreover, the ICF WHO proposes the consideration of health needs from integrated biological and socio-cultural perspectives, which includes language.

For all these reasons, professionals in the UK are expected to commit any resources required to provide equitable service and avoid discrimination.

In the NHS, rationing and service delivery has become commonplace. Bilingual families are particularly vulnerable to cuts in services such as translators or access to home language assessment and intervention, as they may be unfamiliar with speech and language therapy services, unsure how to navigate complaints procedures, and have difficulty using spoken and written English in order to complain. For this reason, speech and language therapists have a role to advocate for bilingual children and their families.
Since outcomes for clients/patients are improved with home language interpretation and support, it is false economy to attempt to cut such services. Services should provide access to home language for all parts of the care pathway. This includes:

- Access to interpreters or bilingual coworkers, or a bilingual speech and language therapist with language skills carefully matched to the language of the client and family for all stages of the care pathway, including:
  - Triage (e.g. by via telephone interpreting service)
  - Assessment
  - Therapy/Intervention
  - When providing advice, training or information
  - Case conferences and other meetings to decide entry/changes to placements or provision so that full informed consent is obtained
  - At discharge

- Raising awareness of speech and language therapy services to communities who may not know the role of the speech and language therapist, including:
  - Promotion using posters in home language depicting people from the local minority community/communities
  - Appearing on local community radio
  - Visiting community centres, religious settings and other community forums, as appropriate
  - Websites including verbal as well as written translations of referral information and help and advice
Characteristics

- Bilingualism is the ability to understand and/or use two or more languages. Individuals can be considered bilingual, regardless of the level of proficiency they have in either language.

- Bilingualism in a child, a young person or an adult is a linguistic, social and possible cognitive advantage. Bilingualism promotes the ability to develop and maintain relationships with family and community. It provides a secure and strong sense of self-identity rooted in culture as well as increasing confidence as a communicator in both/all languages spoken. Bilingualism therefore contributes to an individual’s sense of wellbeing. The benefits of bilingualism include wider employment opportunities, easier additional language learning and possible cognitive gains.

- **Bilingualism is not a disorder.** Bilingualism does not cause or contribute to a speech, language, communication or feeding and swallowing disorders.

- Some individuals, especially children and people who have just arrived in another language community may be monolingual in another language and will be expected to become bilingual with sufficient exposure to the additional language.

- Bilingualism is the most common human state, and monolingualism is more unusual globally.

- In the UK, the majority of speech and language therapists and professionals are monolingual speakers, and it is common and recommended practice to overcome the language barrier by the employment of professional interpreters and translators.

- Bilingualism is not associated with any cognitive disadvantages in individuals with speech and language disorders and may in fact be an advantage. This is the case for any combination of languages used by a client (Uljarevic, Katsos, Hudry & Gibson, 2016)

- Bilingual speakers may experience rapid home language loss if not supported in home language. Language loss / first language attrition is the decline in previously attained language ability/skills i.e. loss of home language/mother tongue or second language loss- both depending on environmental opportunities and/or contexts, e.g. exposure, education, socialisation and other factors.
Vulnerability and risk issues - adult

- Bilingualism is both a linguistic and a potentially cognitive advantage and does not cause or contribute to communication disorders. Extensive research and body of literature has falsified the belief that bilingualism might have a detrimental impact for an individual.

- Bilingualism does not have a straightforward definition. There is a substantial variability amongst bilingual and multilingual individuals. Therefore, an individualised and thorough ethnic/linguistic profile of the individual is crucial in order to avoid misdiagnosis and also properly discern differences vs disorder.

- Bilingual individuals are vulnerable to misdiagnosis where diversity is mistaken for disorder. Having a clear understanding of normal bilingual language use i.e. interference, code-switching, language loss/attrition is crucial in order to avoid identifying these processes as a language difficulty. If linguistically and/or culturally inappropriate assessment tools are used to reach a diagnosis an incomplete picture of their skills will emerge.

- Formal assessments aimed at monolingual English populations should not be directly translated and applied to bilingual clients/patients, unless they are significantly adapted for the target population, and used descriptively. Standardised assessment scores should not be quoted for bilingual individuals.

- Bilingual clients require bilingual assessment and therapy. Where this is not provided, bilinguals are at risk of subtractive bilingualism. This is the loss of the minority language, in an environment that fosters only the majority language. A majority language-only approach also risks isolating the bilingual client from their native or heritage culture, which will negatively impact their sense of identity and well-being.

- Bilingualism does not cause or contribute to stammering/stuttering and there is no evidence that bilingual individuals stutter more than monolinguals. It is important to highlight that pseudo-stuttering behaviours in bilingual individuals can be observed as part of word retrieval rather than clinical stuttering.
Vulnerability and risk issues - children

Late referral or failure to refer

Bilingual children may be missed and referred at a later stage (Stow, 2006: 74). This is especially true of children with speech sound disorders.

In contrast, the same study found that bilingual children were much more likely to be referred for language delay or disorder than monolingual children.

Stammering (dysfluency) was the same for both monolingual and bilingual children, suggesting that this disorder is easily recognisable regardless of language spoken.

Under- and over-representation on the caseload

Although there are dangers of over-referral, mistaking typical bilingual language acquisition for disorder, Winter highlights that ‘Over-representation may be a ‘safer’ option than under-representation where clients might be at risk of missing out on necessary therapy. In the ideal situation there is perhaps always slight initial over-representation at the referral stage as a therapist is needed to differentially diagnose borderline cases.

Over-representation at further stages of therapy, however, drains resources which could be being used in a more effective way and wrongly equates bilingualism in a child with special educational need, also potentially affecting his/her self-esteem.’ (1999: 87).

Incorrect language identified for the family

Identifying the home language accurately is essential in order to book the appropriate interpreter and for accurate assessment of language skills. The incorrect language was recorded for 55% of referrals on a typical paediatric community caseload (Stow, 2006: 69).

Generic terms relating to the heritage country such as ‘Pakistani’ and ‘Chinese’ are often cited, and the wrong dialect, variant or form of language may be quoted. Where several variants of a language exist, the speech and language therapist should become familiarised with the differences between languages.

The language should always be checked and confirmed by a professional interpreter or trained bilingual speech and language therapy assistant (Bilingual co-worker), as mistakes can occur when matching by ethnicity or country alone (Isacc, 2002: 102).

Confusing speech, language and communication disorders for Additional Language Learning Needs

Typical code switching, where children may be using English words but word order and morphological markers from their other language(s) cause practitioners to think that the child have severe language disorder.

Pert and Letts (2006) found that children used code switching by three and half years old and, using a Pakistani heritage language, they inserted approximately 25% of words and tokens as English words.
Sentences, where the Subject-Object-Verb construction of Mirpuri was used, but English words inserted, led to spoken sentences such as “DADDY tolja nal at WASH kar-na pijā”. This is a perfect Mirpuri sentence, with content words inserted from English. A speech and language therapist less familiar with code switching might find this behaviour confusing.

Speech and language therapists should recognise that code switching is normal, frequent in bilingual-to-bilingual speech, and provides the best examples in terms of complexity of the child’s expressive language.

Similarly, children who have just started to acquire an additional language do not necessarily find language learning problematic. The absence of satisfactory English (or the language of education) is no reason to diagnose a language delay or disorder. If a child has a language delay or disorder, this would be apparent in both/all the language spoken. A language history is therefore crucial to establish the level of input a child has received, as part of the diagnostic process.

Cummins’ model of Basic Interpersonal Communication Skills (BICS) and Cognitive Academic Language Proficiency (CALP) is useful here (Cummins, 1981). BICS takes around two to three years of exposure to the additional language.

This can make the listener feel that the speaker is fluent. However, the bilingual child requires much more exposure and interaction in the additional language before that language can be used for thinking and learning (CALP). Older learners, whose L1 CALP is better developed may acquire L2 CALP more rapidly and successfully. (Cummins, 1981).

**Language loss/attrition**

There is a high risk of home language loss for bilingual children who are treated in English (or the language of education), rather than their home language. The risk increases for low status language speakers. Language loss is rapid, occurring in a few months and is often irreversible.

Speech and language therapists should therefore offer home language intervention, prior to therapy in the language of education (English, Gaelic or Welsh), especially for sequential bilinguals. (See Language loss).

**Providing services in the mainstream language only**

Providing an English-only service (or the language of education) is ineffective, leads to poor outcomes for the child, and potentially isolates them from their parent(s)/carers, extended family and community.

The impact on the self-esteem and identity of the child are severe and traumatic. An English-only service is a form of discrimination and therefore illegal and should be strongly challenged.

Similarly, services cannot provide one part of the care pathway in English-only. For example, providing interpreters for the assessment phase, but only offering treatment packages in English. The outcomes are similarly negative and avoidable.

Funding issues cannot be used as justification for providing an English-only (or mainstream language only) service. Funding for interpreters should be sought from the Trust, NHS body, or central organisational funding, rather than the speech and language therapy budget.
Commissioners should be informed of their legal obligations to bilingual communities in their area.

**Over- and under-referral**

See Under- and Over-representation on the caseload.

**Recommending ceasing home language use to support Additional Language Learning**

Languages are not an additional ‘load’ on the child’s linguistic system (Malakoff and Hakuta, 1991: 141). This is true for children with dysfluency (stammering) (Stow and Pert, 2017), and for children with severe and complex language difficulties. Grosjean highlights that suggesting it is an extra load is widespread and erroneous (2009). Even code-switching, where two languages are actively accessed and used by bilingual speakers does not incur in additional processing costs (Gullifer, Kroll & Dussias, 2013).

Home language validates the family language usage and ensures that child achieves the best possible outcomes; that is, being able to communicate with their parent(s)/carer, siblings, extended family and community.

**Populations: Social deprivation, racism and discrimination**

Social deprivation is often ‘the elephant in the room’. Rather than bilingualism, socio-economic deprivation can often be the main cause of speech and language difficulties in children.

Many (but not all) minority ethnic populations live in deprived areas. In these circumstances, the bilingual aspect may be blamed for a child’s difficulties, when actually the deprivation is the major contributing cause.

Almost a third of the UK population experienced poverty in at least one year between 2010 and 2013, or approximately 19.3 million people (Office for National Statistics, 2015).

Although poverty rates have fallen for all ethnic groups, more than half of people from Bangladeshi and Pakistani ethnic backgrounds still live in income poverty (Kenway and Palmer, 2007: 10). Studies have found that 50-84% of children living in areas of social disadvantage start school with language delay (Hartshorne, 2009).

Minority ethnic parents see home language as central to their identities. Home language is seldom available in schools. It is estimated that 85% of South Asian students are bilingual to some degree, and yet ‘The provisions for the teaching of minority languages in British schools have been very paltry indeed’ (Ghuman, 2002: 55).

Contrast this with the promotion of European languages in schools. The message appears to be that some languages are more valued than others.

Speech and language therapists should promote home language use. The use of home language is still viewed negatively by monolingual speakers and parents may abandon home language due to these negative messages. Speech and language therapists are aware of the evidence-base supporting home language use.
Staffing in bilingualism (all age groups)

A post with a special interest in bilingualism should be considered especially where other equivalent clinical specialist posts exist. Posts which aim to meet the needs of bilingual clients and their families may include:

- Specialist speech and Language Therapist - Bilingualism
- Highly Specialist and Consultant Speech and Language Therapist - Bilingualism
- Consultant Speech and Language Therapist - Bilingualism
- Bilingual Speech and Language Therapy Assistants (sometimes known as Bilingual Co-workers).

Staffing in bilingualism - adults

Speech and language therapists will face the challenge to provide services to bilingual and/or multilingual adults. Therefore, working efficiently and appropriately with interpreters and other bilingual staff is a crucial professional competency.

Collaborating with Interpreters

- Not all bilingual individuals can be interpreters or translators just because they can speak more than one language, unless formally trained. Interpreters have a professional background that fulfill the duties required during a significant communication exchange with a bilingual client (e.g. confidentiality, social rules).
- The main aim when collaborating with an interpreter is that the clinical information provided or requested by the therapist is conveyed in an equivalent manner. Culture will impact on the use and understanding of SLT diagnosis and therefore the interpreter will act as a “bridge”, supported by the therapist.
- SLTs should:
  - Avoid using professional jargon and focus on key concepts and terms
  - Check with the interpreter that the individual/family has understood the message
  - Employ the B-I-D model proposed by Langdon and Cheng (2012):
    - Briefing: Discuss aim of session, adult’s background, areas of interest, recording of information
    - Interactions: The therapist actively interacts with the adult and or family (sustain eye contact, if appropriate), while the interpreter takes care of conveying the message.
    - De-briefing: Discussion takes place with the interpreter about outcomes, including misunderstandings or problematic areas. It is useful to gather from the interpreter culturally and linguistically appropriateness of interactions and samples.
- The interpreter needs to be familiarised with the aim of the session which will include the importance of confidentiality and a non-judgemental behaviour regarding the information exchange. It is important to gain knowledge of salient cultural features and communication styles.

Resource:

*Working with Interpreters* (PDF document - see webpage) and *Working with Interpreters Checklist* (see webpage)
Collaborating with Bilingual Co-workers and Bilingual SLT Assistants
Staff members in our working environments can provide invaluable support when alongside a speech and language therapist, including working with clients on a one-to-one basis, assisting in group therapy sessions, clerical and administrative work or advising on culture and language differences.

Resource:
The policy statement explains the commitment that the NHS outlines in providing a equitable, effective and high quality healthcare to all patients:
Principles For High Quality Interpreting And Translation Services - NHS
Staffing in bilingualism - children

Bilingual speech and language therapists

There are currently no figures on the number of bilingual speech and language therapists working in the UK. The majority of speech and language therapists are white women (McKinson, 2007). Although this tells us nothing about SLTs bilingual or monolingual status, it does suggest a lack of diversity, which does not reflect the communities we aim to serve.

Although it cannot be assumed that ethnicity equates to language use, there are likely to be few bilingual speech and language therapists practising in the UK (Stow and Dodd, 2003: 354).

This is not to minimise the expertise that such individuals bring to the profession. Bilingual speech and language therapists will have a personal insight into the importance of bilingualism, as well as cultural and linguistic knowledge of the languages that they speak.

From a service delivery viewpoint, it is important to ensure that bilingual speech and language therapists are not automatically allocated all bilingual clients within a service. Such individuals may have an interest in other specialist areas, and may not have the cultural and linguistic knowledge to work with clients outside the communities of which they are a part.

Mennen, Stansfield and Johnston (2005) found that 77% of paediatric speech and language therapists had bilingual clients on their caseloads, with eighteen languages other than English spoken by the children in one city.

It is unlikely that any one person would speak this many languages. This makes it inevitable that all speech and language therapists will need the skill of working alongside an interpreter.

Bilingual speech and language therapy assistants / Bilingual support workers / Bilingual co-workers

Bilingual speech and language therapy assistants are highly valued, integral members of the team. They may be employed directly by a service, or work in the wider team, such as in a school or other setting.

They may work alongside an SLT or deliver agreed procedures and interventions. The speech and language therapist is responsible for ensuring that the bilingual speech and language therapy assistant is trained in all procedures, and has discussed the tasks prior to delivery.

Monolingual speech and language therapists

Most speech and language therapists in the UK are monolingual. This does not exclude them from working with bilingual clients and their families. Monolingual speech and language therapists should work closely with professional interpreters and other informants in order to deliver a service in the client’s home language.

Monolingual speech and language therapists can develop knowledge of languages by undertaking courses and cultural competence by engaging with families and local communities.
Monolingual speech and language therapists should ensure that they do not rely on their knowledge of one language (typically English) and compare other languages with English. English is not the only language, and should not be considered the standard by which to compare other languages.

**Specialist / Highly Specialist / Consultant Speech and Language Therapists**

There are few speech and language therapists with a special interest in bilingualism (Law et al. 2000), despite growing numbers of bilingual children. Specialists have a key role in raising awareness of the needs of the caseload and increasing referrals (Stow and Dodd, 2003). The lack of specialists in bilingualism is surprising compared to other clinical groups.

The role of the specialist includes:
- Developing a specialist service for bilingual clients and their families
- Delivering direct services
- Advising the service manager and commissioners
- Devising policies and procedures with equity in mind

(RCSLT Specific Interest Group in Bilingualism, 2007).

Specialist/ Highly specialist and Consultant speech and language therapist roles should be considered in areas where there is a high proportion of bilingual children (RCSLT Specific Interest Group in Bilingualism, 2007:7). The lack of such specialists will likely lead to poor practice and inconsistent service delivery across the area served.

Although ethnicity cannot be equated with bilingualism (e.g. Polish families are ‘Other White’ but likely to be bilingual), the Office for National Statistics (2012) reported that 86.0% of the population of England and Wales was ‘White’. The largest minority groups are Indian heritage (2.5 %) and Pakistani heritage (2.0%).

Any population with 5-10% minority ethnic population or more, are likely to encounter a very large number of bilingual families, especially as differential birth rates mean that there are often more children and young people as a percentage of that age group, than for the total population.

It is therefore recommended that any service for a local population of 5-10% or more appoint one or more of the following posts:
- Specialist SLT / SLT with a special interest in bilingualism
- Highly specialist SLT
- Consultant speech and language therapist post.

Detailed statistics may be located via the Office for National Statistics, Local Statistics website: [https://www.ons.gov.uk/help/localstatistics](https://www.ons.gov.uk/help/localstatistics)
Interpreters

Interpreters have knowledge of the client’s language and the professional’s language, acting as a facilitator across the language barrier in real time. The difference between an interpreter and a translator is that an interpreter translates *spoken language*, while a translator translates *written language*. (Langdon, 2002). For speech and language therapy services, interpreters will be expected to act as both interpreter and translator.

The interpreter is likely to also understand the cultural heritage of the family and advise the speech and language therapist.

**Children under 18 years of age, other clients, carers and the child’s siblings, family and untrained volunteers should never serve as interpreters** (National Council on Interpreting in Health Care, 2011). Similarly, staff unrelated to the appointment/meeting activities (such as reception staff) should not be recruited at the last moment.

Working with an interpreter should always involve planning time, and a de-brief. Time to translate recorded language samples (always retaining the client’s untranslated sentences in transliteration) is also required.

Interpreters should not be asked to interpret at the last minute; planning is crucial. This allows the interpreter to understand what is required of the client, and to check any technical terms or changes caused by translation. For example, some languages do not have different lexical items for ‘word’ and ‘sound’, or parts of the body such as ‘vocal cords’. Such terms may need explaining with pictures and diagrams and examples should be given to assist in understanding.

Interpreters should not be asked to interpret standardised assessments, as surface language structures are different from language to language, and normative scores will not be valid. Phonology assessments obviously change the target word and so cannot be interpreted and must be re-designed for each language.

Everyone should direct their speech to the client. Never speak to the interpreter during the session with phrases such as “Can you ask…?”. The interpreter should act as your voice. Sitting in a triangle, with the interpreter to your side will allow the client and family to see everyone’s face. Interpreting and speech and language therapy are both complex and skilled roles. Training on collaborating should be provided for both groups (Hwa-Froelich and Westby, 2003: 84).

Failure to provide interpreters is discrimination (Stow and Dodd, 2003) and illegal under the Equality act (2010).

**Translating written materials**

Written translations of documents, including appointment letters, reports and advice leaflets require careful consideration and planning. In many cases this is not the best use of resources, as many languages have no written form, and/or clients may have had limited access to education and no or poor literacy as a result. Only clients who have confirmed literacy in their home language should have written information interpreted. Other clients would benefit more from verbal translations of the text. This may be face-to-face, or through hi-tech means such as audio and video recordings.
See *Working with Interpreters (see webpage)* and *Working with Interpreters Checklist (see webpage)*.

**The wider team**

Children with speech difficulties are mainly referred to speech and language therapy services by Health Visitors, Teachers and parents (Broomfield and Dodd, 2004). Awareness of bilingualism and dispelling myths is therefore particularly important for these groups.

Agreeing care plans and intervention aims may also include Allied Health Professions (AHPs) such as Physiotherapists and Occupational Therapists, as well as Special Educational Needs Coordinators and Inclusion Managers.

The wider team may meet to discuss referrals, a potential diagnosis, progress with clients and discharge. The team should always ensure that there is an interpreter involved in these meetings and that everything is translated for the family. Team decisions made without a translation may mean that informed consent has not been given.

**Traveller Services**

The term ‘gypsy’ is recognised as racist term with negative connotations. The umbrella term ‘travellers’ has come to be used for a range of nomadic groups.

Irish travellers were recognised as an ethnic group in 2000 following a High Court case (Foster and Norton, 2012: 87). Irish travellers speak “Gammon” or “Cant”, historically known as “Shelta”; however, Travellers do not use this latter label (Bakker, 2006).

‘Roma’ is another umbrella term in European Union policy including the Roma, Gypsies and Travellers. The Roma are culturally and linguistically distinct from Irish Travellers. The Roma speak Romani, which in common with other heritage languages with perceived low status such as the Pakistani heritage language Mirpuri, has no written form (Pnevmatikos, Geka and Divane, 2010).

Children from traveller communities are extremely vulnerable, with 9 out of 10 experiencing racial abuse. ‘Roma also lack familiarity with the NHS and face language barriers and this can make it difficult to access health services’ (Lane, Spencer and Jones, 2014: 42).

Local authorities may have a Traveller Service to support traveller communities. Speech and language therapists should make every effort to offer services to these hard to reach communities by visiting Traveller sites along with Traveller Services. Communities may be wary of professionals due to previous discrimination.

**Ethnic Minority Achievement Team (EMAT)**

Local councils in England may have an ethnic minority achievement team who aim to raise the achievement of minority ethnic pupils in partnership with schools and other organisations. These teams often have specialist teachers who are skilled in assisting pupils with additional language learning.

If the speech and language therapist identifies that a child or young person has good home language skills, but poor additional language (the language of education), then liaison and referral to the Ethnic Minority Achievement Team would be indicated. Training for the
specialist EMAT teachers from the SLT service may also support appropriate referrals and joint working.

**Early years and education staff**

Early intervention has been identified as key to effective child development and engagement with education. Poor language development is strongly associated with socioeconomic deprivation and in some areas, up to 50% of children started school with language difficulties (Nicholson and Palaiologou, 2016).

Early Years staff are therefore key in promoting language development. Speech and language therapists should ensure that Early Years staff are positive about bilingualism, and that they do not promote an English-only (or Welsh-only, or Gaelic-only) approach to enhancing language development.

Training for such staff should be seen as an essential part of the role of the speech and language therapy service.

Other commentators go further, and argue for ‘safe spaces’ where bilingual staff can facilitate additional language learning, while supporting home language (Conteh and Brock, 2011).
Education and training

Bilingual clients are vulnerable due to the poor understanding of typical bilingualism and also poor understanding of speech, language and communication needs, and feeding and swallowing difficulties in a bilingual context. Due to this high risk, it is recommended that a member of the team with a specialist post leads training for the whole team, including SLTs, Bilingual assistants and interpreters on a continuing basis, and at least annually on bilingual issues.

Such a specialist should also routinely offer training to the wider team/workforce, including referring agents and those delivering care to clients. This may include, but not be limited to, health, education and social services staff.

Training for speech and language therapists

Speech and language therapists are highly likely to encounter bilingual clients. It is the role of the SLT to have access to research and updated clinical knowledge to be able to dispel the myths associated with bilingualism. All staff should therefore access regular training on bilingualism, and cultural competence. This may also include training on equality and diversity issues. Training may include:

- e-Learning
- Attendance at Clinical Excellence Networks (CEN)
- Appropriate Continuing Professional Development (CPD) courses
- Personal or formal study, including higher degrees such as Masters level study, PhDs and other qualifications.

Training for interpreters and speech and language therapy assistants/Bilingual Co-Workers

Interpreters and speech and language therapy assistants (also known as Bilingual Co-Workers) will require training on:

- The role of the speech and language therapist
- The role of the speech and language therapy service
- How to interpret, providing the SLT’s voice
- How to highlight cultural barriers
- How to interpret complex ideas, theories and technical terms, such as
  - Body parts in the vocal tract, e.g. ‘Vocal cords’
  - Theories, such as phonology versus physical explanations of speech disorder
  - Diagnostic labels, including acquired conditions such as Dysphasia, Dysphagia; and developmental conditions such as Developmental Language Disorder etc.
- How to follow the Translation protocol (Pert, 2003), or similar recording system, so that the client’s expressive language and/or production of words is recorded in assessment recording forms and the casenotes, and never just the translated version of the client’s responses.

Training for pre-qualification speech and language therapists

All Higher Education Institutions (HEIs), which deliver pre-qualification training programmes in speech and language therapy, including degree and master’s level programmes should include education on working with bilingual clients. HEIs should consider using bilingual case studies for case-based learning, as bilingual perspectives often illustrate theory to practice for all clients.
Please see RCSLT’s Curriculum Guidance for further information.
Audit and service evaluation

Speech and language therapy services should identify key statistics of the number of people who do/are likely to speak languages other than the main languages in the UK (i.e. languages other than English, Welsh and Scottish Gaelic). Since there is no definitive data sources on the number of bilingual speakers in the UK, this may involve National Census data, Local Council data, School language census data and other sources.

Differential birth rates, age profiles and ageing of the adult population should be considered. This may lead to higher numbers of anticipated bilingual speakers by age group, e.g. more children as a percentage of 0-16 years than adults, or the community as a whole.

The presence of other contributing factors which put such communities at a higher risk or speech, language and communication needs, or feeding and swallowing disorders should also be considered, including poverty, and associated difficulties such as poor diet, lack of access to educational and employment opportunities, exercise etc.

Speech and language therapy services should carefully examine referral and caseload figures to ensure that they are meeting the needs of the local community. Any over- or under-referral by clinical group should be investigated. Service planning should always consider the needs of bilingual clients, with an equitable service in mind.
Guidelines on assessment and management - adult clients/patients

An actual communication disorder will affect all languages that the individual uses. The speech and language therapist performing the assessment will have to consider not only the presence of normal processes in language acquisition, but the individual’s language history including frequency of use, language dominance and language loss over the years, especially in adults.

Key points

- Having a clear picture of premorbid language skills is crucial to correctly gathering and interpreting language outcomes in adult clients/patients.
- Using a language questionnaire will provide the therapist with most the information needed to assess a bilingual adult.
- Using an interpreter to assist with the evaluation and assessment is crucial to ensure an equitable service.

Language Questionnaire/Case History for Adults

The first interview with a bilingual adult or family/carer member is crucial to establish rapport and gather functionality aspects of the use of the mother tongue (L1) and exposure to the mainstream/majority language (L2), or any other languages used. This will include;

- Length of exposure to each language (L1, L2, or any additional languages)
- Dialectical information of each language used, if appropriate
- Immigration background, when appropriate
- Language of choice when communicating in different contexts (e.g. work, home, social, with extended family, with friends)
- Language linked to education background

Resource: Language experience and Proficiency Questionnaire (LEAP-Q)

Assessment Tools

- Norm-referenced testing is not appropriate for use with bilingual adults unless the normative sample involves the client’s cultural and linguistic background. See cultural competence.
- It is not ethically or professionally appropriate to translate a standardised test as it will not provide an accurate linguistic profile of the bilingual adult. In additions, languages vary greatly in syntax, lexicon and grammar.
- In order to gain an accurate profile of the bilingual adult, modifications and suggestions to assessments are a possible solution. In doing so, SLTs must acknowledge that this will invalidate the test used, and the outcomes will be for reference only. The cultural and linguistic background of the individual must be taken into account for any adaptations.
- A language sample is a unique and useful tool to assess a bilingual adult. The sample should be elicited in both/all the languages that the adult has been exposed to. The use of interpreters is crucial in this task, and once the sample is gathered it...
is important that it is analysed acknowledging that the bilingual adult may present with an array of skills across their languages.

**Assessment Bias**

Assessment bias will affect the management decision of providing services to a bilingual adult. Developing **Cultural competence** is crucial to decrease assessment bias. Kohnert (2013) explained the different types of bias that can contribute to an inaccurate diagnosis:

- **Content bias**, which can occur when the bilingual adult is assessed with resources or methods that are not culturally familiar tasks. Therefore the individual’s performance will not be reflective of his/her previous experiences.

- **Linguistic bias** can occur when there is a discrepancy between the adult’s language experience and the language or dialect utilised in the evaluation process. The more common case of linguistic bias is when an adult is only assessed in English and compared to English performance scores.

**Tip**: in order to reduce linguistic bias, getting familiarised with the adult’s culture and linguistic background before the assessment process begin is advised. Also analyse a detailed language questionnaire that will provide accurate information especially on dialects and or language differences.

- “**Bias in the interpretation** of collected data occurs when measurement standards are not consistent (Kohnert, 2013: 150)” with the adult’s background are utilise to assess his/her outcomes.

**Tip**: learnt the normal processes bilingual adults experience and investigate the adult’s linguistic and ethnic background with emphasis on the community characteristics.

Aphasia is the impairment in the ability to decode or encode linguistic elements for the purpose of listening, speaking, writing or reading (Darley, 1982). Bilingual adults with aphasia are challenged to use two or more languages.

As the bilingual brain processes both or more languages in the same hemisphere (dominant hemisphere-left side), we can predict that all languages will be affected to some extent.

The type of the aphasia (receptive, expressive or mixed) will involve both/all languages previously learnt. This means that the characteristics of the type of aphasia will be observable across the adult’s linguistic profile. **The intrinsic features of the languages affected will dictate what linguistic errors will look like.**

In a language in which grammatical markers are essential to denote gender or tense, an agrammatic production, will look quite different than in a language in which the context provides this information (Centeno and Anderson, 2011). For example, in highly inflected languages (Spanish, Italian) omission of verb conjugations for instance will alter the adult’s meaningful production significantly.

**Resource**: [Bilingual Aphasia Test](#)

**Bilingualism and Stuttering**

Research has shown that language dominance appears to influence the severity but not the types of stuttering behaviours in bilingual individuals who stutter (Lim et al., 2008). In
addition, it was also found that usually in the less developed language system or L2, the function words get more affected by the stuttering in contrast to content words in the more proficient language or L1.

Therefore assessment of fluency needs to take place in all languages. It is common to assess reading, monologue and conversation although 'reading' may need to be omitted for languages which are not written. Words for 'stuttering/ stammering' are common in other languages and SLTs should familiarise themselves with the most likely ones used in their locality as well as common opinions of causation in order to support their clients.
Guidelines on assessment and management - Children

Referral

Referrals should include a space to indicate the language(s) of the child and family. It is best to have the most frequently encountered languages listed as tick boxes on the form to facilitate accurate identification of languages spoken.

Triage

Correct identification of the child and their family's language(s) is crucial to ensuring good relationships with the family and reaching any diagnostic decisions. Telephone triage is therefore an essential component of working with bilingual families prior to booking face-to-face interpreters.

Telephone interpreting services should be used to check that the language on the referral form is accurate. Generic terms such as 'Chinese' instead of a specific language such as 'Cantonese' or 'Pakistani' instead of 'Urdu' should alert the speech and language therapists that the referring agent is either unfamiliar with the languages of the local community, or has not sufficiently checked the family language. High status languages are often reported, when the family may speak a related but less well known language.

Any reference to 'dialect', 'accent' or 'slang' should be treated with caution; all language are equally complex, but not all languages hold the same level of status. Stow and Dodd (2005) found that 'only 45% of bilingual children had their language correctly recorded on the referral form.' (10).

Drop-in sessions

Parents who do not speak the language of education (typically English, Welsh or Gaelic), or who have only conversational ability are less likely to attend a drop-in session.

Parents may fear that professionals will blame bilingualism for their child’s lack of speech and language development, or they may have no or limited understanding of the role of the speech and language therapist.

Raising awareness of the role of the speech and language therapist by providing short talks for parents and carers, taking along interpreters for the most commonly spoken languages can help to reassure parents that they will be supported in home language if they attend.

Assessment

Prior to the assessment, the interpreter should be booked. The correct language should have been checked with the family in advance (see Triage). The planning stage will involve discussing the reason for the appointment, the questions that will be asked and which assessment tasks will be undertaken. The interpreter and speech and language therapists should work together to identify any cultural or linguistic issues which may arise.
**Introductions and purpose of the assessment**

Each person in the room should be introduced, and their role explained. This has two functions; from the parent(s)/carer’s perspective they can hear what to expect during the session.

Asylum seekers and refugees may be particularly suspicious of professionals and revealing personal information due to prior traumatic events. From the SLT’s viewpoint, the identity of the adults attending the appointment can be confirmed and recorded. Specific reassurance should be given about confidentiality and safeguarding.

Ground rules about interpretation and translation can be set, establishing that anything said in the room will be interpreted, no matter how trivial. This builds trust with the family and reassures them that they will not be discussed in English without their knowledge.

**Parent(s)/carer interview (Case history)**

This will be similar to any other parent interview. However, the speech and language therapist must be aware that there may be different cultural practices and child rearing beliefs. Speech and language therapists need to develop cultural competence for the communities they work with, and apply this to their interactions with clients.

**Language exposure and usage (Language case history)**

Attitudes to the home language and the language of education should be discussed. Parents may have absorbed myths about bilingualism, or feel that education in the majority language is more important than maintaining home language, without considering the negative impact that may have on the child and the family.

First generation immigrants may be proud of their additional language learning, and not aware that their children may fail to maintain their home language if they are only exposed to English (or the language of education).

Where a parent has poorly developed additional language skills, or is just beginning to develop them, it is important that they are encouraged to use the best language model they can provide for their child. Poor quality input may lead to poor language development. This is another reason to recommend home language for sequential bilingual families.

For families of simultaneous bilinguals, the family language strategy should be discussed. Have they considered the relative exposure to the languages? Who spends more time with the children? What attitudes have the child and the family to the different languages?

**Formal assessments and the use of normative data**

Speech and language therapists must not use standardised assessments to assess bilingual children, or they should be considered supplemental as descriptive assessments (Hegde and Maul, 2006: 348). This is because standardised assessments have been proven to be inadequate for the diagnosis of language difficulties in bilingual children (Caesar and Kohler, 2007: 191).

Standardised assessment tables are composed of data collated from monolingual children. To compare a bilingual child’s English to a monolingual child is simply unfair and biased.
Monolingual children have been exposed to English all their lives and so, of course, perform better on such assessments than a bilingual child who has had less, or different exposure.

In addition to the language input difference, there are also cultural reasons that bilingual children do not perform as well on standardised assessments. Children may fail to recognise objects, foods, activities and even people if they do not resemble these things from their everyday life experience. For example, even small differences such as US versions of popular assessments were changed for the British population. Children may also be unfamiliar with being tested in a formal setting and unfamiliar with the clinical environment.

The difference between a child growing up in a household where there is a different language and culture is likely to be even greater. Hegde and Maul state that ‘...standardized tests tend to be culturally and biased and yield results that may be totally or partially invalid for culturally and linguistically diverse children.’ (2006: 348).

As there are such huge differences between monolingual children and bilingual, bicultural children, in terms of language exposure and cultural experience, speech and language therapists must not quote age equivalents, standard scores, percentile ranks, or other similar normative data derived from monolingual English speaking populations.

The evaluation of a bilingual child’s linguistic performance and competence must be conducted within the context of an evidence base. Knowledge of typical phonological development is essential for this, to enable differential diagnosis of delay or disorder. Much of the data available on language acquisition and phonological development has focused on monolinguals.

However, even in normal development there are differences between monolinguals and bilinguals and it would be inappropriate to assess a bilingual child on the basis of monolingual norms (RCSLT, 2006). Bilingual children may underperform their monolingual peers (Paradis and Kirova, 2014).

Similarly, changing or adapting an assessment means that the validity of that assessment is compromised. That is, it is no longer the same tool which has been used with the cohort of monolingual children to which the results refer. Any adapted assessments should therefore be re-standardised.

This is unlikely in the context of clinical practice, and new assessments are too time consuming and costly to produce unless funded as part of a research study or publication.

For the speech and language therapist, or team, culturally and linguistically valid tools are far more achievable and valuable. Such assessments aim to profile the child’s strengths and needs, and identify therapy aims.

Excellent examples of such assessments are now available, where teams have saved over 80% preparation time by devising resources as a team (see Functional Language Across Countries, FLAC, Millar-Wilson, 2014). These are screening tools and further assessment will be required if children present with difficulties.

Research by Cattani et al (2014) showed that ‘Bilingual toddlers who received 60% exposure to English or more performed like their monolingual peers on all measures’ (of standardised assessment). This finding is in keeping with prior research, that children who use a majority language are likely to become more and more monolingual, unless home language is supported.
Children with such a high level of English exposure are likely to experience home language loss, unless the home language is a) high status and b) strenuously supported and used in the home. This is not the case for most bilingual children in England, who are sequential bilinguals and speak a low status language.

Speech and language therapists must therefore provide advice on maintaining bilingualism by encouraging home language use. In conclusion, even for children with high levels of English exposure, the use of standardised assessments is not recommended.

**Alternatives to standardised assessment: Unbiased, child-centered assessment**

Formal assessments are familiar to speech and language therapists, assist in diagnosis and compare the child to their peers (De Lamo White and Jin, 2001: 616). Selecting an alternative may be stressful for speech and language therapists unfamiliar with bilingual children and informal or child-centred approaches.

Research shows that, despite a large and increasing array of suitable tools and methods for assessing bilingual children, speech and language therapists still rely heavily on English standardised assessments (Ebert and Pham, 2017: 43). This must be addressed by the profession.

Barriers such as lack of interpreters and time to carry out appropriate assessment should be supported by team leads and service managers, with the aim of equity of outcome (rather than equality of time allocation). Any non-evidence based barriers such as lack of funding should be vigorously challenged and commissioners informed and educated on their legal duty to deliver equitable service.

In the United States, awareness of professional standards has led to an increase in the use of appropriate assessment methods, and less reliance on standardised assessments (Arias and Friberg, 2017).

Speech and language therapists should not rely on standardised assessments, but seek a full and holistic view of the child's language abilities. This means:

- Assessing both/all languages - to determine whether a language learning difficulty exists, to capture skills in both languages and to assess code switching, which is likely to provide the longest and most representative language samples (Pert and Letts, 2006). This requires bilingual-to-bilingual communication and so an interpreter is essential for language assessment.
- Observation, interviews evaluation and collaboration with teachers (Aris and Friberg, 2017: 11). This is especially true for comprehension, where parents' and teachers' views are likely to be more accurate than assessment, especially for younger children. This can provide a profile over both/all languages.

**Language assessment: Verbal comprehension**

Many UK speech and language therapists are familiar with the Derbyshire Language Scheme and the concept of Information Carrying Words (ICWs), whereby one piece of contrasting information is allocated to a word in an instruction (Masidlover and Knowles, 1979).
This was one of the first manualised assessment and intervention schemes and is discussed here due to the large impact on the conceptualisation of verbal comprehension in the UK.

Although the concept of ICWs may work for English, which, at sentence level has a very ‘bare’ morphological structure, the concept of ICWs breaks down for most other languages.

For example, in Urdu, the question ‘Who’s running?’ cannot be said neutrally, one must say ‘Who is running + male?’ or ‘Who is running + female? In addition, the assessment uses items that some communities would not readily recognise.

To address this, there are Punjabi and Mirpuri-Punjabi versions of the Derbyshire Language Scheme assessment materials, The Rapid Screening Test and The Detailed Test of Comprehension (developed by the Nottingham Community Health Trust’s Speech and Language Therapy Service) which address vocabulary differences and cultural aspects.

Many speech and language therapists continue to rely on the scheme due to its suitability for children who may not have the comprehension and attention skills to complete a more challenging formal assessment. However, new theories of language acquisition such as constructivism, place more emphasis on the pragmatic context of language learning.

Alternative approaches include informal assessment, dynamic assessment and standardised assessments which include multilingual adaptations. The New Reynell Developmental Language Scales (NRDLS) ‘...includes a Multilingual Toolkit, which gives guidelines for adapting the test or parts of it to languages other than English.' (Letts, Edwards, Schaefer and Sinka, 2014: 107).

This is a rare example of a standardised assessment providing utility beyond monolingual English normative data tables.

**Language assessment: Expression**

Bilingual children are more likely to draw on both of their languages when speaking to another bilingual speaker. Assessment should therefore be delivered by the interpreter or other bilingual professional.

Code switched multi-word utterances represent children’s best utterances, and mean length of utterance (MLU) measures are comparable to monolingual children at the early stages of language development.

**Language assessment: listening/receptive vocabulary and naming**

UK speech and language therapists are familiar with standardised assessment of vocabulary. However, there are few assessments available with bilingual norms. The British Picture Vocabulary Scales (Second Edition only) (Dunn, Dunn, Whetton and Burley, 1997) had an additional English as an Additional Language (EAL) normative ‘Supplemental’ set of tables. Subsequent (colour) editions do not have this supplementary data.

Mahon and Crutchley (2006) found that a sample of bilingual children performed differently than these norms suggested, with children aged four to six years providing a relatively poor performance. The children ‘catch up’ with age, but bilingual children did perform differently until they were older. This study compared raw scores and not standard scores.
Communicative Development Inventories (CDIs) are parental reports of listening and naming vocabulary, which have been developed for a range of languages as well as English (Law and Roy, 2008: 202). These are aimed at children aged 8-16 months, and up to 30 months. (See O'Toole et al., 2017).

The advantage for bilingual children, is that parent(s)/carers can be encouraged to indicate if the child has the item in either language, making the assessment of the number of concepts possible, rather than surface word labels (how many things, activities etc. the child can label or describe, rather than words which may or may not be replicated in both languages). Core et al. (2013) compared total and conceptual scores in Spanish-English bilinguals from 22 to 30 months. They found that the total score was more comparable to monolingual norms on the CDI, compared to conceptual scores. For this reason, it’s probably best clinically to look at total scores, at least in young children.

However, the CDI relies on carer/parental literacy skills, unless a team member helps the parent(s) to complete the word lists. Stow (2006) found that parents from the local bilingual community had relatively low levels of accuracy when reporting on their child’s language (284).

A descriptive approach, where the child’s vocabulary is mapped across both/all languages, with the assistance of interpreters or trained assistants, together with informal assessment and observation seem to be a more robust approach than either questionnaires, parent reporting or formal assessment in isolation.

Language skills and phonological short term memory can now be assessed in a range of languages using Language Impairment Testing in Multilingual Settings (LITMUS) tools (Armon-Lotem, de Jong & Meir, 2015).

Language tools such as LITMUS-Sentence Repetition (SR) and LITMUS-Nonword Repetition (NWR) were designed to identify DLD in bilingual children by tapping specific linguistic skills known to be particularly difficult for children with DLD, e.g., clausal embedding for SR and consonant clusters for NWR.

(See Armon-Lotem and Meir (2016); Chiat et al. (2013); Chiat and Polišenská (2016); de Almeida (2017), Dos Santos and Sandrine (2016) and Fleckstein et al. (2016).)

Cross-linguistic Lexical Tasks have now been developed. Although not yet available with normative data, they are available in a range of languages and assess both receptive and expressive vocabulary. See Altman, Goldstein and Armon-Lotem (2017); Gatt, Attard, Łuniewska, and Haman (2017). Haman et al. (2017) and Khoury Aouad Sailby et al. (2017).

Speech assessment: Categories

This clinical guideline employs the Dodd classification of speech disorders.

Speech assessment: Articulation

Articulation disorder

Is defined as:

‘...an inability to produce a perceptually acceptable version of phones due either to a physiological condition such as dysarthria or mislearning of the sounds’ motor program (e.g. lisp) (Dodd, 2011, 98). That is, a physical, rather than a psycholinguistic problem.'
Broomfield and Dodd (2004) found that 12.5% of children with speech difficulties presented with articulation disorder. Since these are physical difficulties, any child with an articulation disorder will exhibit these difficulties across both/all the languages they speak. This has been observed in bilingual children (Holm, Dodd, Stow and Pert, 1996-1997: 57).

Assessment for articulation disorders is by testing stimulability. Speech errors in the context of words cannot be assumed to be articulation errors. These errors may by phonological errors (see below).

The only way to be certain that a speech error is caused by an articulation disorder is ask the child to imitate the sound in isolation, i.e. the SLT says the sound and the child attempts to replicate it as a single sound.

If the same error is made when producing the single sound, then this confirms an articulation disorder. If the error is different, or the sound is acceptable/on target (the sound is stimulable), then the child is likely to have a phonological disorder underlying the error.

Children should be asked to imitate all sounds produced in error in the context of words as single sounds, i.e., a stimulability assessment. This applies to both monolingual and bilingual children.

**Speech assessment: Phonology**

Phonology is the interface between meaning (language) and speech (the means of transmitting words via speech signals).

Phonemes are the minimal unit of meaning and contrast with other phonemes in a particular language to provide a comprehensive system whereby meaning may be transmitted. Phonemes are conceptual units. They are realised by producing sounds or phones.

Bilingual speakers provide strong support for phonological theory. They show that different errors may be made in each language. This is because such errors are not caused by physical difficulties.

**Phonological delay**

Is defined as ‘...characterized by all errors being accounted for by a phonological error pattern (e.g. cluster reduction and fronting) that occur during typical speech development at a younger chronological age level.’ (Dodd, 2011: 98).

57% of children with speech difficulties present with phonological delay, and hence this is the most common category of speech disorder encountered.

**Phonological disorder**

Children who use one or more error pattern that are atypical of normal development have phonological disorder. This category may be further subdivided into *Phonological disorder - Consistent* and *Phonological disorder - Inconsistent*.

Children who make the same errors each time, or most of the time are considered consistent. This presentation was found in 20.6% of children with speech difficulties. Such children may also present with delayed phonological error patterns, but the label includes delayed patterns, as long as at least one atypical error pattern is observed.
Children presenting with inconsistent phonological disorder produce different error forms on at least 10 out of 25 words (when words were assessed three times within one assessment session)(Dodd, 2011: 98). This presentation was found in 9.4% of children with speech difficulties.

**Bilingual presentation of speech difficulties**

Bilingual children are no less likely to experience speech sound difficulties than monolingual children. However, there is a risk that referring agents who do not share a home language with the child may fail to identify speech errors, leading to a lower rate of referral to speech and language therapy, or referral at a later age (Stow, 2006).

Holm, Dodd, Stow and Pert (1996-1997) found that all categories of speech disorder were found in bilingual children. Separate phonological systems exist for the two languages, and a single articulatory system is used for both languages (57).

The underlying difficulty will result in the same type of errors in both languages, but not necessarily the same error (61). For example, HK presented with phonological disorder, with backing, devoicing, not releasing final consonants, final consonant deletion, stopping and weak syllable deletion observed in Urdu.

HK presented with backing, final consonant deletion, not releasing final consonants, final consonant deletion, stopping, and assimilation. Note that not all errors are observed in both languages.

**Speech assessment**

A speech systems examination should be undertaken to examine the vocal tract and identify any structural deficits, such as a bifid uvula or cleft palate. Appropriate referral to a regional cleft lip and palate specialist service should be made if there are any concerns following such an examination.

Any assessment of a bilingual child’s speech must include assessment of both languages. Due to the presence of two phonological systems, one for each language, assessment of one language will not necessarily identify all the errors present in the other language.

Assessment should also include an assessment of sound stimulability to differentiate articulation disorder from phonological disorder; and word/lexical production to assess consistency of production at the lexical level, in order to identify or rule out inconsistent phonological disorder.

This is essential, as consistent phonological disorder and inconsistent phonological disorder require very different therapeutic approaches, and misdiagnosis will lead to poor outcomes for the client.

A motor assessment is also informative, although inconsistent phonological disorder should be ruled out prior to diagnosing Developmental Verbal Dyspraxia / Childhood Apraxia of speech (Stringer, Nicholson and Stringer, 2012). Core Vocabulary therapy may act as a diagnostic therapy in such cases (Dodd, Crosbie and Holm, 2004).

**Intervention for speech disorders in bilingual children**

Please see the International Expert Panel on Multilingual Children’s Speech (2012).
Speech disorder: Articulation disorder intervention

Articulation is a physical difficulty and not linked to meaning or any one particular language system. This means that articulation therapy may be carried out in any language. It is recommended that the language selected is one of the child’s language where s/he can understand detailed and specific instructions.

Imitation, mirror work side-by-side the client in a landscape oriented therapy mirror are recommended. Clients may benefit from therapy pictures that do not refer to a particular word (as these are language dependent). Articulograms such as the Bigmouth Sound Pack pictures (Hughes and Ramsay, 1994) are universal and show the child where to relate their articulators.

For this reason, they are more appropriate than systems of pictures where the child has to have prior knowledge of the words used.

Articulations are typically distortions of phones. Articulation therapy is characterised by a ‘traditional approach’. Van Riper’s approach focuses on drill work. Following stimulability (the child is able to produce the sound on request as a single sound), this is then stabilized.

The child is asked to practice using the sound in isolation, in nonsense syllables, then words and sentences (see McLeod and Baker, 2017, 485-499 for an overview of articulation therapy). N.B. This approach is not suitable for children with phonological delay and disorder.

Speech disorder: Phonological delay intervention

Bilingual children are thought to have a separate phonological system for each of their languages. For this reason, therapy aimed at a phoneme or error process in one language will not generalise / carry over to the child other language(s). This is because meaning and sound mapping are different across languages.

A lexical item in English has different phonemes to the same word in another language, e.g. ‘chair’ is ‘kursi’ in Mirpuri. If the child has therapy to change their deaffrication of the first segment in ‘chair’, it won’t generalise to ‘kuri’ as it has different phonemes. It also won’t generalise to other affricate words in Mirpuri, as the therapy won’t have used the meaning to trigger changes in those words.

Practical application: Therapy focusing on a particular phoneme or error process/phonological process will need to be carried out with lexical items in both languages.

For example, minimal pairs therapy would need to be implemented in both languages, using minimal pairs from both languages. Minimal pair therapy in English only is likely to resolve the child’s error process in English only, with the home language process persisting.

Speech disorder: Phonological disorder (Consistent) intervention

See above. Intervention for consistent phonological disorder,

Speech disorder: Phonological disorder (Inconsistent) intervention
Core Vocabulary therapy (Dodd, Crosbie and Holm, 2004) is the recommended intervention for inconsistent speech disorder. The aim of the approach is to develop **lexical consistency** of production, *not* the consistent production of a particular phoneme. This is because children with inconsistent phonological disorder need a corpus of lexical items on which to construct a set of phonological rules.

It is therefore not appropriate to comment that a child *inconsistently* produces a particular phoneme, as inconsistent phonological disorder means that the child does not have predictable phoneme substitutions, and there is a great deal of variability in production at the word level.

Once lexical consistency is established, the child is likely to respond well to minimal pair work and other interventions aimed at phonological delay and (consistent) disorder.

**Phonological awareness**

Phonological awareness is the ability to detect, isolate, manipulate and convert sound units at the syllable, onset-rime and phoneme level (Dodd, Crosbie, McIntosh, Teitzel and Ozanne, 2000). Word analysis can be at different levels, including:

- Syllable segmentation, e.g. ‘bu.tter.fly’, ‘di.no.sa.ur’
- Rhyme awareness, where the rime of the word is identified as the same as in other words, when the onset is discarded, e.g. ‘cat’, ‘mat’, ‘sat’
- Alliteration awareness, where the first segment is detected, isolated and compared, e.g. ‘table’, ‘tin’, ‘tap’
- Phoneme isolation
- Phoneme segmentation
- Letter knowledge

Phonological awareness is developed through exposure to alphabetical forms of literacy. The PIPA assessment has normative data from both the UK and Australia and these differ. This is thought to be because children in each country are exposed to literacy at different ages. Lack of literacy knowledge can make even segmenting words into syllables difficult (Sailaja, 2007).

Some languages are pre-literate (Stow, 2006) and have no written form. Other communities may have a language with a written form, but limited access to education. Some languages are syllabic and use a system not related to the sound-symbol correspondence of an alphabet.

The presence of tones in a phonological system in languages such as Cantonese mean that phonological awareness is not as simple as considering segmental aspects. Culturally, some communities have a literary tradition where rhymes and poems are for an adult, religious or other select group, and not therefore aimed at children.

Bilingual children with phonological skills in English may transfer some of their phonological skills to their home language, if that too is an alphabetic language (Yusun Kang, 2012).

**Practical application:** Phonological awareness skills are culturally based and unlikely to be well developed in children who speak languages other than English who are not literate.

Rhyme may be unfamiliar to children from other communities and so recommending nursery rhymes may simply encourage additional language learning, since rhymes aimed at children may not be available in home language.
Assessment of play and parent-child Interaction

Pretend play is often assumed to be critical to child development. However, despite a long history of research, the evidence for this is sparse. Lillard highlights that ‘Pretend play might be useful because it is a setting that can facilitate positive adult-child interaction’ (27).

UK culture has valued play and adult participation in play since at least Victorian times. The concept of childhood has developed since then. Prior to this, children were seen as ‘mini adults’ and often required to work from a young age. In modern society, adults are expected to initiate and facilitate play with their children.

For some British Asian communities, older siblings are more likely to be the play partners of children than parents (Stow, 2006:40). Parents’ interactions may be more directive than facilitative. For this reason, observing children playing may be more naturalistic if observed with his/her siblings or or friends.

Children from communities with different clothes, cultural practices and food, dining traditions from the mainstream culture may be at a disadvantage when their play is assessed. Children will not recognise items they do not use. For example, Pakistani heritage children may be unfamiliar with cutlery.

It is important to recognise when there is cultural bias in the play, assessment and therapy materials selected. With the widespread availability of online picture and photograph resources, and digital cameras, creating appropriate materials should be relatively simple.

Parent-child interaction (therapy) (PCI or PCIT) has been widely used by SLTs and is seen as a key way of developing language skills, with changes seen in mean length of utterance (Falkus et al. 2016). Most of the evidence around this approach was collected with white middle class families. However, non-English speaking communities may have very different interaction styles with their children.

Vigil and Hwa-Frolich (2004) comment that ‘Specific behaviours, including directing a child’s attention, producing imperatives and directives, and teaching and manipulating objects during play, have a basis in the cultural values of interdependence, high power/distance, and strong uncertainty/avoidance...Professionals might use a more directive style and group-oriented activities when working with preschool and school-age children from such cultures. (124).

This is echoed by Awde (2009) who concluded that ‘...in many Asian minority communities, directing the child’s lead, attention directing and teaching explicitly prevail, meaning that therapist’s recommendations can interfere with the family dynamics and may encourage parents to interrupt therapy’ (14).

UK SLTs working with British Asian (Pakistani and Bangladeshi heritage families) have reported that Parent-Child Interaction Therapy groups were unsuccessful due to cultural reasons, and that direct interventions were generally more acceptable (Pert and Stow, Personal Communication, 2018).

Practical implications

In order to avoid cultural bias, SLTs should consider the culture and home life of the child, to ensure that children can recognise people, dress, objects and foods etc. relevant to their everyday experience (see Norbury and Sparks, 2013).
Direct language groups, storytelling using objects and culturally appropriate pictures, may be more appropriate than PCI/PCIT approaches, which conflict with the natural interaction styles and culture of some communities.

**Assessment of facial expression, eye-contact and non-verbal communication**

‘Body language’ or nonverbal pragmatic language skills are important in maintaining social interactions. These include:

- Maintenance of eye contact
- Physical distance maintained during communication (proxemics)
- Gestures
- Facial expression
  - (Hegde and Maul, 2006: 14)

This is an important area to consider when assessing children, as children with language disorder and autistic spectrum conditions may have different behaviours and ability to attend to, identify and react to nonverbal signals than typically developing children in one or more of these areas (Stagg, Linnell and Heaton, 2014).

Children from English speaking countries such as the UK and USA are expected to maintain direct eye contact during discourse, as this signals that the listener is attending to the speaker. In Asian cultures, direct eye contact is a sign of disrespect, especially when being chastised (Hegde and Maul, 2006: 341).

Facial expressions are thought to be universal across all human populations. The seven basic emotions include:

- Happy
- Surprise
- Contempt
- Sadness
- Fear
- Disgust
- Anger

Despite this, there are cultural differences in this basic behaviour. If a person is in the presence of another, they may adjust their facial expression due to social expectations. This is known as ‘display rules’. For example, researchers found that Japanese participants exhibited the same facial expressions as Americans when viewing a film alone, but were more likely to smile when a high status male experimenter was present.

Collectivist cultures such as Hong Kong, Russia and Indonesia were more likely to be less expressive in the company of others, than more individualistic cultures such as the USA, Canada and Australia (Hwang and Matsumoto, 2015: 48-50).

**Practical implications**: It is inappropriate to diagnose a language disorder because of lack of eye contact (Hegde and Maul, 2006: 352).

**Assessment of pragmatics**

Myers-Scotton (2006: 146) describes pragmatics as having two parts:

1. There is a gap between decoding words and sentence structures and what is actually meant to be communicated; and
2. The gap can be filled in by inference, a process driven by the certainty that the message can carry intentionality in addition to the dictionary meaning of words and their combinations.

Pragmatics is highly dependent on context, and combined with semantics (word and sentence meaning), provides the full message in the communicative act.

Skilled bilinguals can code switch to add additional meaning to their utterances. Bilinguals can also assess very quickly if their conversational partner is likely to be able to speak their home language or only the mainstream community language.

Pragmatics is a complex area, and a full discussion is beyond the remit of these guidelines. However, speech and language therapists need to be aware of cultural and linguistic difference, which may be relevant to language use, and hence how to evaluate if children are acquiring these rules.

Also see *Assessment of facial expression, eye-contact and non-verbal communication*.

**Delivering intervention in home language or additional language**

To avoid the risk of rapid language loss, sequential bilingual children should have all their therapy targets set in home language, prior to their additional language.

Children who are supported in home language are likely to acquire their additional language through subsequent exposure to the additional language (English, Gaelic or Welsh), once they have established their home language skills.

The advantage of this approach is that parent(s)/carers can use their home language to work with their child. The home language is likely to be the parent’s or carer’s best language, with a higher level of proficiency than their additional language. Home language is therefore the best language model, providing high quality language input for the child.

Children with speech, language and communication difficulties may have missed early opportunities to acquire their home language, when a disorder interfered with early development.

Therefore, a high level of input or treatment intensity in home language will assist in their ability to remember, analyse and acquire language structures and concepts, as well as learn home language vocabulary.

Sequential bilingual children of school age may also benefit from targets delivered in home language by a bilingual teaching assistant to ensure that a suitable therapy intensity is achieved, e.g. on a daily basis.

Parent(s)/carers, teaching staff, and other professionals may express the concern that a child needs the language of education (e.g. English) in order to achieve academic success.

The establishment of home language skills is not a barrier to the acquisition of English (or Welsh or Gaelic), and children are unlikely to acquire their home language if input in home language is at a low level.
The myth that children should only receive input in the language of education for educational success must be robustly rejected by SLTs, and training offered to professionals who espouse this view.

Children who are simultaneous bilinguals will benefit from carrying out therapy aims in both/all their languages. The SLT should carefully consider the amount of input the child receives in each language, especially if one of the child’s languages is viewed more negatively than the other.

Language exposure is key to developing competency in a particular language, and so factors such as time exposed to each language, the type of activities carried out in the language, the person who will deliver the therapy programme and their language skills must be considered.

Ultimately, the language(s) of therapy must be discussed and agreed with parent(s)/carers. However, parents must be supported to understand the risks of abandoning home language in favour of the language of education, and the likely outcomes, i.e. the rapid loss of home language skills, or receptive skills only in the home language.
Cultural competence

Speech and language therapist will have to overcome linguistic, cultural and communication barriers that may adversely influence suitable assessment and intervention in order to provide equitable (tag link to Equitable vs Equal) access to all patients.

Within any culture, there is an extensive range of beliefs and behaviours. Consequently, generalisations of cultural features may not be always accurate.

It is the responsibility of the speech and language therapist to become culturally competent by ongoing awareness of how his/her own cultural biases towards an individual may affect the service. In other words, the process of cultural competence originates with each of us - we all have our own culture which will impact on practice.

Adapting practice by constructing cultural knowledge and frequent self-assessment is indispensable to fully comprehend how values may affect our interaction with others.

In addition, the speech and language therapist needs to get familiarised and/or gain information regarding the different communication styles and salient features of the individual’s cultural background as well as the degree of assimilation (tag) and acculturation (tag). These two processes will impact the individual’s cultural profile making it unique.

Working with multicultural families entails forming an environment of trust and reciprocated respect.

Considering and appraising family beliefs towards any communication disorder will allow the speech and language therapist to: comprehend parental/carer’s involvement and acceptance of therapy services, select most suitable intervention model as well as increase knowledge of how cultural attitudes and beliefs may impact treatment outcomes (Schenker, 2013).

A client’s cultural beliefs will influence:

- Definition, symptomatology and severity of health/communication problems
- How long they attend intervention and with whom
- Success and or failure of outcome

Hofstede (2011) identified 6 cultural dimensions which influence all aspect of communication from nonverbal behaviours such as body language and the way we talk to verbal behaviours such as discourse.

For example, a family that identifies themselves with a masculine culture background, the father will be leading most of the conversations with the therapist and will manage appointments or main decisions while the mother will embrace the emotional support.

Strategies to increase Cultural Competency

- Be aware of your own cultural beliefs (including assimilation and acculturation) and how they might influence your interpretation of other cultures.
- Explore and become aware about the client’s cultural approach and attitudes towards topics such as disability, impairment and health in general.
- Develop knowledge about the local populations, communities families and individuals (e.g. social greetings).
• Form a trustworthy and cooperative rapport with the client’s support system (e.g. family, carer, partner etc.) by validating their cultural views.
• Avoid stereotyping and recognising individual differences from recognised cultural practices.
• Create resources such as leaflets, handouts or information packages in different languages (commonly spoken languages in your area of service) in order to support understanding about related topics of speech and language therapy.
• Gather information, when appropriate and available, from interpreters and cultural alike community members about appropriateness of social routines / practices.
• Create a directory of bi/multilingual interpreters and staff facility member that may be able to assist during clinical sessions.
• Include bilingualism and cultural principles in the policy making, planning, assessment and service delivery process.
• Select culturally sensitive material, resources and activities for both assessment and intervention.
• Respect beliefs, religion and cultural norms, while still providing clear and evidence-based advice, assessment and intervention. Highlighting and problem-solving where there are conflicts in these areas, to deliver an acceptable and accessible service (tag to Equitable vs Equal)

**See Cultural Competence Checklist**, gather evidence and add it to your CPD log.

For more on cultural competence, please the following:

- [Cultural competence – Flying Start NHS](#)
- [NICE – Cultural Competence](#)
- [The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence](#)
Safeguarding, Child Protection and Vulnerable Adults in the Context of Bilingualism

Bilingual clients and patients may be at particular risk, since they may not be able to express their concerns, due to a language barrier, often combined with a speech, language or communication difficulty. In addition, bilingual clients may be unfamiliar with the role of professionals and the range of services available to assist them.

Religious and cultural practices and beliefs should never be prioritised above the welfare of the client/patient.

Disclosure of anything which puts a client/patient in potential harm, physically, emotionally, sexually, or financially should be reported to the appropriate services. Please refer to Child Protection and Vulnerable Adults policies and procedures, and any other relevant safeguarding procedures.

Should a bilingual patient/client make a disclosure in home language, the interpreter or bilingual co-worker must be involved in reporting the disclosure in their capacity as a professional.

Interpreters or other suitably qualified bilingual co-workers should be involved in all stages of safeguarding procedures, to ensure that the client/patient’s disclosure is understood and that they are kept informed at all times, as appropriate.
Policy England

Here you will find links to relevant national legislation, policy and frameworks.

Please note that this list is not exhaustive. Please contact paul.omeara@rcslt.org if you have any suggestions.

- Health and Social Care Act 2012 children, young people and their families are always involved in decision about their care (which includes every ethnic/minority background)
- Children and Families Act 2014 children and young people with special education needs and disabilities (which includes every ethnic/minority background)
- SEND Code of Practice 0-25 years (which tackles joint planning and commissioning) The Code of Practice is clear that “Difficulties related solely to learning English as an additional language are not SEN.”
- Black and minority ethnic (BME) pupils identified as having SLCN Dec 2012 Part of the Better Communication Research Programme
- Black and minority ethnic (BME) pupils identified as having SLCN, Dec 2012 Part of the Better Communication Research Programme
- Mental Capacity Act 2005

Policy Scotland

Here you will find links to relevant national legislation, policy and frameworks.

Please note that this list is not exhaustive. Please contact paul.omeara@rcslt.org if you have any suggestions.

- Ready to Act for Scotland
- Children & Young People (Scotland) Act 2014

Policy Wales

Here you will find links to relevant national legislation, policy and frameworks.

Please note that this list is not exhaustive. Please contact paul.omeara@rcslt.org if you have any suggestions.

- Welsh Language (Wales) Measure 2011
- Mesur y Gymraeg (Cymru) 2011
Policy Northern Ireland

Here you will find links to relevant national legislation, policy and frameworks.

Please note that this list is not exhaustive. Please contact paul.omeara@rcslt.org if you have any suggestions.

There is currently no Irish Language Act in Northern Ireland.

Policy UK

The UK has ratified the United Nations Convention on the Rights of the Child (CRC) which states that human rights are for all children and particularly mentions both language and disability as characteristics which should not be used as a basis for discrimination and denial of rights (Article 2). Rights to culture, language and religion are enshrined as rights for all children (Article 30) and all children have rights to media and appropriate books in an accessible language (Article 17).

References

(please see separate PDF for full reference list)