

GOOD PRACTICE FOR SPEECH AND LANGUAGE
THERAPISTS
WORKING WITH CLIENTS FROM LINGUISTIC MINORITY
COMMUNITIES

Endorsed by:
THE ROYAL COLLEGE OF SPEECH AND LANGUAGE
THERAPISTS

Prepared by the RCSLT Specific Interest Group in
Bilingualism

October 2007

1.	Introduction	4
2.	Speech and Language Therapy Managers	5
	2.1 Client Demography	5
	2.2 Needs	5
	2.3 Policy Making	6
	2.4 Resources	8
	2.5 Bilingual Speech and Language Therapy Co-workers	9
	2.6 Specialist SLT Post for Linguistic Minorities	9
	2.7 Training	10
3.	Speech and Language Therapists	10
	3.1 Linguistic and Cultural Background	10
	3.2 Assessment	11
	3.3 Formal Assessment and possible special educational needs	12
	3.4 Working with Special Needs	12
	3.5 Feedback to SLT Managers	12
4.	The Specialist Post	13
	4.1 Defining the Brief	13
	4.2 The Post Holder	13
5.	The Bilingual Co-worker	14
	5.1 The roles of the Bilingual Co-worker and Monolingual Assistant	14
	5.2 Independence	15
	5.3 Recruitment and Training	15
	5.4 A Good Working Relationship	15
	5.5 The Same Language, Culture, Sex and Age	16
	5.6 Briefing and Debriefing	16
	5.7 Linguistic Analysis, Assessment and Therapy	16
	5.8 Areas of Work	16
	5.9 SLT role with co-worker	17
	5.10 Role within the Department	17
6.	The Assessment and Therapy Process	17
	6.1 The First Interview	17
	6.2 Clinical Case History Taking	18
	6.3 Client Management	18
	6.4 The Language of Therapy and Intervention	18
7.	The Way Forward	20
	Bibliography	21
	Appendix 1. Assessments appropriate for use with bilingual clients	23
	Appendix 2. Members of the Committee of the SIG in Bilingualism	24

Notes:

- 1) We appreciate that there are Trusts where there are no Speech and Language Therapy Managers. The SLT service may be organised by a Speech and Language Therapy Adviser or by a generic locality manager. In these cases, we recommend that this document is drawn to the attention of whoever has responsibility for managing the SLT services.
- 2) Please note that the term "co-worker" is used in this paper and is meant to be inclusive of all terms currently used to describe this role including:
 - Bilingual Co-worker
 - Bilingual Assistant
 - Bilingual SLT Assistant
 - Technical Instructor
- 3) This paper contains a set of guidelines. It is in no way meant to be prescriptive. It aims to outline good practice which should be interpreted according to local models of delivery. Some Trusts operate a service that is purely consultative, some operate a centralised service and others operate a mixture of the two. We would support the use of any model of service delivery which takes account of the principles contained in this paper and which can be shown to meet the needs of the local population.
- 4) The RCSLT covers SLTs working throughout the UK. Within this document the word 'English' has been used to signify the language spoken by the majority of the population. It is recognised that in some areas of the UK other languages (such as Welsh or Gaelic) are in fact spoken by the majority of the population and are the medium of education. In such cases the name of the appropriate language should be inserted in place of the word English.
- 5) Readers requiring support/advice for specific issues are advised to access Specialist Advisers who can be contacted via the Royal College of Speech and Language Therapists www.rcslt.org

1.0 **Introduction**

1.1 This paper sets out guidance for good practice for Speech and Language Therapists (SLTs) working with clients from linguistic minority communities. These clients may be bilingual, have the sociolinguistic expectation to become bilingual, or be monolingual in a language other than English. They may be adults or children and may present with any speech and language pathology.

1.2 'Bilingualism can be defined as individuals or groups of people who acquire communicative skills in more than one language. They acquire these skills with varying degrees of proficiency, in oral and /or written forms, in order to interact with speakers of one or more languages at home and in society. An individual should be regarded as bilingual regardless of the relative proficiency of languages understood or used' (Communicating Quality 3; Royal College of Speech and Language Therapists 2006: 268).

1.3 ***Legislation***

The Race Relations Act (1976) makes it unlawful for a person to discriminate on racial grounds against another and defines racial grounds as including race, colour, nationality or ethnic or national origins.

The Act was strengthened in 2000 and it has been widened to include:

- i. A statutory duty to promote race equality; and
- ii. Extend the bill to cover direct as well as indirect discrimination by central government and public authorities (including those responsible for health planning and provision).

Discrimination therefore includes victimisation and harassment (Commission for Racial Equality, 2007). Failure to provide interpreters in health care contexts for a minority group that is unlikely to speak English is also an example of discrimination (Stow & Dodd, 2003).

1.4 59% of SLTs working in generic paediatric settings work with one or more bilingual clients (Winter, 1999). This finding sets the context for interpreting this guidance into practice.

1.5 Some SLTs working with this client group may feel that their clinical competence is challenged by the linguistic and cultural differences which confront them. While acknowledging that the principles of assessment and management of speech and language problems remain the same, it is clear that their application must be adapted. A guideline of this size cannot hope to cover all the areas and issues involved in any great depth and clinical detail. For a detailed presentation of the issues, discussion of therapy models, relevant theoretical background, and recent research, the reader is referred to the bibliography at the end of this guideline. Readers may also be interested in this paper: *Providing an equitable service to bilingual children in the UK': a review* (Stow and Dodd 2003). It gives a comprehensive review of the need for providing an equitable service and factors impeding its delivery. It covers challenges faced in assessment and intervention when working with linguistic minority children and has good appendices for resources.

1.6 One of the most optimistic findings which comes from recent literature is that bilingualism in a child or adult is an advantage and rarely the cause, or exacerbating feature, of any language difficulty. (Juarez 1983, Duncan and Gibbs 1989, Leung 1996, Rodby 1998, Cummins 2000.) Thus, the SLT must use both (all) the languages which clients use or are exposed to in their daily lives to differentially diagnose the language difficulty and to counsel and intervene. A decision not to use the facility of the client's two (or more) languages and possibly work in the client's less developed language because it is the one shared by the therapist, is clinically less preferred. In

some cases working through one language, for example the one shared by the therapist, may be a strategy to transfer communicative skills to the client's preferred language. Clinical compromises which are induced by economic rationalisations should be recognised and every effort made to overcome them.

1.7 In this guideline it is the recommended and clinically preferred practice to utilise the languages of the client's daily repertoire, with the client and for supportive work with spouse, parents and family. Parents and family should be empowered to use their home language. In circumstances where parents, family or spouse opt to exclude their home language from the therapy process the SLT needs to discuss with them the implications of their choice for the client's therapy.

1.8 To this end the paper offers advice for:

1. speech and language therapy managers
2. SLTs,
3. specialist post holders and
4. bilingual co-workers

It will also be of interest to Commissioners for Children and Commissioners for Education and Social Care

2.0 Speech and Language Therapy Managers

2.1. Client Demography

Statistics need to be collected on client demography in the Trust across clinic, pathology, age and language. This should be repeated at regular intervals, e.g. annually. Collection of client demography information is sensitive and must not be used in any negative way; the positive benefits to the linguistic minority communities must be stressed. Without information on client/language demography no case can be made for fundamental resources, such as a bilingual co-worker, or a specialist post, which will help members of these communities, with language disabilities, to benefit more from the speech and language therapy service. Speech and language therapy (SLT) managers need to take responsibility for ensuring that language information is collected for the service. For example, they could ensure that an item for "home language" is a feature of all client data collection, and particularly for SLTs information about spoken and written forms noted.

The SLT Manager may also wish to collect data on some wider issues such as a picture of socio-economic circumstances of wards and deprivation, circumstances and experiences of migration, profile of religious beliefs and cultural influences in order to strengthen the case for resources

2.2. Needs

Every effort should be made to assess the needs of those who have a language disability in the linguistic minority communities in the Trust.

This can be done in a number of ways:

- a. through contact with community leaders, to assess public perception of speech and language difficulties and speech and language therapy
- b. through contact with other Trusts and speech and language therapy services with similar linguistic minority populations and to share good practice
- c. through contact with other professionals involved with the client group, such as the referral agencies, e.g. health visitors, school health practitioners and teachers, and to become involved in programmes for raising awareness of different cultural expectations about language development
- d. through contact with the National SIG Bilingualism for discussion about particular issues
- e. by analysing the Trust statistics of client demography.
- f. through patient and public involvement (PPI) groups/consultation

2.3. Policy-making

The SLT manager and the department must draw up a policy statement about how their service will meet the needs of their clients in linguistic minority communities in the Trust. The fundamental principle of equality of service across diverse communities must orientate this policy, as it does with all SLT service policies. Thus, assessment, therapy and other aspects of client management should be offered in the languages used by the client in the communities in which he/she moves. The policy should clearly state these aims and offer strategies for developing the service and coping when and where there is a shortfall between the ideal and the real. Aspects of existing good practice need to be identified and ways of building on them developed. The following headings aim to help form policy.

1. **Define level of need:** develop criteria based on actual client demography bearing in mind potential demographic changes; e.g.
 - (1) the potential for referral of bilingual/non-English speaking clients to the speech and language therapy service exists in all Trusts and strategies and resources need to be considered about meeting this need when it arises;
 - (2) less than 10% of clients across the Trust would be a low level of need, or a moderate need if occurring in one area - geographical or pathological, such as the "stroke" population;

- (3) between 10% -30% of clients across the Trust would be a moderate level of need or a high level of need if in one area;
- (4) more than 30% of clients across the Trust would be a high level of need.

2. Actions

- (1) **Low level of need:** explore links with neighbouring speech and language therapy departments and with other disciplines within the Trust so that resources may be shared.
 - (2) **Moderate and high levels of need:** develop specialist posts for SLTs and bilingual co-workers.
3. **Number and size of linguistic minority communities:** develop posts or shared resources which are language-specific. Where it may not be feasible to support home language in assessment or intervention, consider developing a consultative or information advisory role on aspects of general management which would be the responsibility of the specialist post holder.
4. **Bilingual assessment, counselling and remediation:** aim to establish this practice wherever possible, by developing human and material resources.
5. **Exceptions to (4):** identify the instances where English only or home language only would be the *clinically recommended* option, that is, the SLT's clinically preferred option is modified by the clients' wishes, or bilingual therapy is not yet appropriate. The language preferences need to be explored before decisions can be made. Some examples are:
- (1) an adult or adolescent who stammers or is dysphonic makes known both a preference and a dislike;
 - (2) older school learners may have developed more English than home language, particularly in literacy, and assessment and intervention for "high level" language functions or literacy difficulties can only take place in one language;
 - (3) the English-speaking therapist may give advice in English about activities which stimulate language which the bilingual care-giver will carry out in the child's home language;
 - (4) work with alternative communication systems and signing systems may be possible up to a certain point in one language, e.g. the mother tongue, and then the other language, e.g. English, will need to be introduced to meet the communication needs of the client;
- The SLT needs to make parents, family and spouse aware of the potential implication for the client if a strong preference for only one language is expressed by them. This should then be clearly documented in the case notes.
7. **Training:** draft a programme of in-service training for SLTs, bilingual co-workers and bilingual "casual" personnel and seek advice and support from the RCSLT advisers in bilingualism and National SIG Bilingualism. Also explore and strengthen links with the local authority, including educational psychologists, teachers and ethnic minority support services.
8. **Staffing:** draft a programme of service development staffing, e.g. specialist post holder, bilingual co-workers, "casual" bilingual personnel supplied through links with community agencies. Consider alternatives to funding these staff, e.g. converting the funding for a speech and language therapist post into a bilingual co-worker/assistant post.
9. **Pay and conditions for bilingual co-workers and "casual" bilingual personnel:** these should be developed in line with the national profiles contained within Agenda for Change. Ensure scope for development by negotiating appropriate KSF outlines for the post.

10. **Lines of accountability:** specialist (bilingualism) post holders may be accountable to the Team Leader or to the Trust manager of the speech and language therapy service. Bilingual co-workers and bilingual "casual" personnel may also be accountable to them or to the specialist post holder.
11. **The role of bilingual relatives:** It is imperative that bilingual relatives should not be used as translators. Therapists need to define the role of bilingual relatives in the management process of bilingual/non-English speaking clients so that it is in line with the role of relatives of English speaking clients and is different from the role of bilingual personnel. The key difference is that their role is supportive rather than primary. It would be useful to establish guidelines within speech and language therapy services to show how the therapist can facilitate the session in the presence of (i) the interpreter and (ii) the relative.
12. **No mother-tongue resources available:** In some Trusts there are a large number of languages such that SLT departments cannot be expected to meet the home language needs of all their clients. Departments need to consider identifying their "minimum standard" of management in terms of assessment, intervention and support when home language resources are minimal or not available. These cases need to be audited because they will be time consuming for the therapist and an argument could be made for more effective resourcing through a bilingual co-worker.
13. **Review of non-take up of service:** As part of the department's auditing process there needs to be monitoring and regular review of factors which affect the non-take up of speech and language therapy services by the linguistic minority population. Modifying these factors should form part of future policy statements.
14. The Trusts' SLT manager must ensure that policy statements are disseminated as widely as possible, and their implications, such as bids for specialist posts, are appreciated not only by health service colleagues and managers but also by interdisciplinary colleagues, such as educational and social services staff.

2.4. Resources

1. The Trust's SLT manager and the SLT department may have to put a strong argument to the Trust management for an increase in resources to meet the needs of bilingual/non-English speaking clients. This argument should include:
 - a. A theoretical and clinical statement supporting the case for equality of speech and language therapy services of speech and language therapy to the bilingual speaking population in the Trust. This should also include legal requirements e.g. Race Relations Amendment Act, 2000, Human Rights Act.
 - b. within-Trust /area demographic statistics of population groups;
 - c. the increase in time and resources needed, e.g. In the development of new assessment processes and materials to meet the needs of bilingual clients;
 - d. the potential adverse effects of the failure to meet positively the needs of this client population e.g. drop-out of SLTs from the department and failure to recruit, impact on children's educational attainment
2. Organising the resources to meet the needs of this client group should take into account the following points:
 - a. establishing a specialist SLT service for work in this field, including therapists and co-workers
 - b. sharing initiatives in this field with other disciplines within the Trust, e.g. community link workers, advocates and interpreters, as well as colleagues in education
 - c. finding out about initiatives in SLT departments in neighbouring Trusts and exploring avenues for working together
 - d. contacting the National SIG Bilingualism about resources

- e. contacting the RCSLT's advisers on bilingualism
 - f. investigating funding possibilities from a range of sources;
 - g. identifying trust priorities within the bilingual service, e.g. developmental language information, professional development, research.
3. Clear funding/purchasing arrangements should be made when bilingual staff or materials from other departments are used on a regular basis by SLTs within and across Trusts.

2.4. Bilingual Speech and Language Therapy Co-Worker

1. All aspects of co-workers' posts need to be regularly reviewed, in line with KSF outlines. The bilingual and bicultural skills of the co-worker should be recognised and developed by training, which means that adequate and appropriate training is built into the early stages (at least the first year) of the bilingual co-worker's work.
2. As an interim measure to establishing the post of bilingual co-worker, other bilingual resources in and outside of the Trust could be investigated, e.g. social services, education, as well as other bilingual health co-workers.
3. The extent of independent work to be carried out by the bilingual co-worker should be carefully negotiated on the basis of the service needs, the training received by the co-worker/assistant, and KSF outlines/remuneration levels. Section 5 discusses this point further.

2.5. Specialist SLT Post for Linguistic Minorities

Some Trusts have established specialist SLT posts in the field of bilingualism, which are graded in line with other specialist posts within the Trust. There are considerable advantages to the service in developing this specialist post, both for colleagues and for clients. In addition, the manager of the SLT service should ensure that:

1. s/he and the department are actively involved in the development of a whole Trust SLT service for linguistic minorities, e.g. across types of client groups, age groups, education groups, community language groups;
2. the post holder is responsible for advising on the delivery of service district/area-wide to clients from linguistic minorities, as well as having direct client contact ("hands-on" therapy).
3. there is regular and frequent exchange of information between the manager and the post holder concerning, for example, the implementation of policies, and demands on resources;
4. the establishment of such a post promotes rather than discourages departmental in-service training about bilingual language difficulties.

2.6. Training

It is recommended that the manager of the SLT service would arrange for an initial phase of in-service training as well as continuing professional development for therapists who are joining the department with either some or no previous experience of working with linguistic minority communities. For example:

1. Initial Training:
 - a. Becoming familiar with the linguistic demography of the Trust, across locations and client groups
 - b. Developing knowledge of linguistic analysis and the cultural background of the main community groups in the Trust
 - c. Introduction to assessment and resources
 - d. Introduction to working with bilingual co-workers and bilingual personnel.
2. Continuing training:

- a. How to monitor and report changes in the Trust demography of linguistic minority communities across location and client groups
- b. Linguistic analysis of less frequently spoken languages in the Trust
- c. Specialist training in one clinical area e.g. special needs, dysfluency, aphasia
- d. Working with bilingual co-workers/assistants and personnel.

The agenda for continuing professional development would be set by the needs of the staff and the client group.

3.0 **Speech and Language Therapists**

3.1. Linguistic and Cultural Background

Culture is the distinctive way of life of the group, race, class, community or nation to which an individual belongs. It is the first and most important frame of reference from which one's sense of identity evolves. (O'Hagan, 2001) SLTs should develop the ability to maximise sensitivity and minimise insensitivity in the service of culturally diverse communities. In order to do this they should be willing to learn about other cultures and should develop their own self-awareness of their own cultural beliefs (see Isaac 2002).

SLTs should inform themselves of the linguistic structure and use of the languages they are likely to encounter in their clinical caseload. This will improve the SLT's clinical practice with the client groups in several ways. For example, knowledge of the language enables the SLTs to judge that they have obtained accurate linguistic information about the languages spoken by client and family and they will be in a position to make an informed choice about the resources they and their clients will need. Developing this knowledge may be done through professional courses, such as in-service training in the department. SLTs may also approach for advice their SLT manager and/or the specialist post holder if there is one in the Trust. They may also wish to approach RCSLT advisor in bilingualism as well as local and national SIGs. They may also take a teach-yourself approach, such as obtaining linguistic texts or commercially available CD ROMs, on the relevant languages.

3.2. Assessment

1. The main aim of assessing children referred with possible speech and language difficulties, from bilingual communities is to draw as full a language profile of the (emerging) bilingual child as possible. This will help the SLT to differentially diagnose between a language acquisition difficulty affecting all language learning and a difficulty affecting the acquisition of an additional language. Making this distinction is a challenging and problematic process for SLTs and bilingual co-workers. Helpful guidance is offered by several sources such as Hall et al (2001) and Isaac (2002) and a special issue of Child Language, Teaching and Therapy (2003).
2. SLTs should ensure that they have the appropriate language assessment materials for assessing both/all of the client's languages across the various language systems, e.g. phonology, vocabulary and syntax, as well as fluency and social communication skills. This may well prove to be an almost impossible criterion for the range of languages in some Trusts, which in turn is an issue to be addressed in the policy statement on the "minimum standard" of management of certain referrals.
3. There are some standardised assessments available for English/Panjabi bilingual children (see Appendix 1). Where standardized assessments are not available SLTs should make use of informal assessments and observation.
4. This inventory of bilingual assessments (Appendix 1) must be seen as only a beginning reference. Since it is lacking in so many quarters the SLT must be guided by the "minimum standard" advised by the Trust, and by the following guidelines:
 - a. Language assessments for one language must NOT be translated into other languages. They may be substantially modified and re-standardised. The linguistic structures being assessed in one language will change across languages. The cultural bias of the assessment will need modification to the different cultures of the other languages. The standardisation norms will no longer apply to different language populations using a much modified test instrument.
 - b. The norms from first language English norms tables must NOT be quoted for results from additional language English performance because they are

different linguistic populations.

- c. If first language English assessments are used for additional language English performance results may only be quoted in a descriptive way.
 - d. Work with trained personnel when administering an assessment in another language. It is NOT recommended to use friends, relatives or neighbours of the client. It may embarrass the client, but more important, it is failing to recognise the skills needed in test administration. It is an unjustified lowering of professional standards.
5. In the case of a referral for assessment of a client whose first language has only a few speakers in the Trust area, the SLT should refer for guidance to the Trust manager of the SLT service, the specialist post holder (if there is one) and the department's policy statement.

3.3. Formal assessment of possible special educational needs

Following from the Education Act 1996, SLTs should bear in mind when writing a report that contributes to a possible statement of the child's special education needs that information about both/all languages should be included. If information is not available about the child's languages other than English then this should be stated and its importance emphasised. The 2001 Code of Practice (DfES, 2001) for children with special educational needs supports the full assessment of all languages spoken as well as the use and proficiency of those languages. It also states that those children will need help in expressing, comprehending and using their own language where English is not the first language. Any report written is likely to be qualitative rather than quantitative given the lack of standardised data for this client group.

3.4. Working with special needs

The linguistic minority child/adult with communication problems and additional special needs, e.g. sensory impairment, or physical or learning difficulties, presents further challenges to the SLT. There is a growing body of documented practical experience (see Duncan 1989; Chapter 10) which will inform SLTs and their departments in drawing up good practice guidelines. For example, Cline (1997), Martin, Colesby and Jhamat (1997), Cline and Frederickson (eds) (1996), and Frederickson and Cline (2002).

3.5 . Feedback to Speech and Language Therapy Managers

SLT managers depend on information from clinical therapists in order to organise service delivery. It is important that therapists give feedback on:

- a) demographic information of client caseload in terms of language and pathology,
- b) problems accessing or working with bilingual resources, e.g. Co-workers, materials, language information,
- c) need for training in specific areas, e.g. working with bilingual children/ adults with special needs, race awareness,
- d) the amount of resources required to treat effectively a bilingual client, e.g. SLT's time, co-worker's time,
- e) audit of time and resources involved with bilingual clients, e.g. for assessments, intervention, support.

4.0 **The Specialist Post**

4.1. Defining the Brief

This post should contribute to the mainstreaming of bilingualism and multiculturalism into SLT services within the Trust. It should support the Trust manager of the SLT service to mainstream the organisation of service delivery to the linguistic minority communities. It should support colleagues to meet the needs of those in the Trust who have a language difficulty and are bilingual. It should also deliver "hands-on" therapy where appropriate.

The specialist post should have responsibility for:

1. establishing and developing clinical expertise in assessment and management of bilingual clients who may be language impaired.
2. developing expertise in cultural awareness/diversity
3. establishing and developing basic in-service training modules for the SLTs in the department and bilingual co-workers in the department
4. developing a resources and information centre about bilingual language difficulty, client demography, cultural awareness info, languages and communities for SLTs within the department
5. feeding back information to the SLT managers concerning
 - a) relevant, recent research projects
 - b) treatment initiatives
 - c) links with related organizations
 - d) SIG Bilingualism (National and Local)
 - e) liaison with associated disciplines.
 - f) Language needs of population

4.2. The Post holder

It must not be assumed that SLTs from linguistic minority communities will chose to specialise in working with those who have bilingual language difficulty. The post holder must be committed, enthusiastic and pro-active about the post since it will necessarily involve dealing with many challenging issues. These include institutional racism, racism in colleagues, negative attitudes towards bilingualism, as well as presenting initiatives with little control over the decision to implement them, and training non-therapist staff. Some clinical and educational pre-requisites should be criteria for appointing a therapist to a specialist post in this field. For example, the candidate should have:

- a) a range of clinical work with clients from linguistic minorities, e.g. in clinic, in special schools, adults, across types of difficulty,
- b) attended study days organised by the SIG in Bilingualism and be a member of the SIG in Bilingualism
- c) shown a willingness to learn about the main community languages in the Trust
- d) shown a willingness to develop their research skills and to participate in relevant research projects
- e) a knowledge of the relevant literature on bilingualism.

5.0 The Bilingual Co-worker

5.1. Differentiating the roles of the bilingual co-worker and the monolingual assistant

1. Discussion about distinguishing the roles of bilingual co-workers and monolingual assistants has to be set in the context of *linguistic capital* (Bourdieu 1986). Linguistic capital is a metaphor for describing language as a currency which can buy certain things, for example, education or employment. In England, English has the most linguistic capital and minority languages have very little. They have almost no purchasing power in the education 'market' since we cannot be educated in minority languages (except Welsh) and they have little buying power in the employment market since we cannot get jobs using these languages. However, bilingual co-worker posts offer opportunities for recognising the linguistic capital of minority languages. SLT managers need to recognise the linguistic capital of bilingual co-workers and to remunerate their additional language skills.
2. The co-worker and the assistant make important contributions to the 'skill mix' model in their work with SLTs. Some aspects of work are included in initial in-service training, and are routine, for example: take care of equipment; work independently through simple therapy programmes; work alongside the therapist if necessary; administer regular assessments, under the supervision of or at the request of the SLT.
3. Neither the bilingual co-worker nor the assistant would be required to:
 - a. administer initial assessments independently; the SLT needs to be there to see the client's responses and performance,
 - b. analyse assessment data - needs to be done with the SLT,
 - c. make informed linguistic judgments - done with the SLT.
4. The SLT might rely more on the bilingual co-worker in these latter tasks because her/his role is to provide important linguistic information for the SLT by accessing the client's home language, i.e. the language not shared by the clinician. The co-worker would also be expected to:
 - a. advise the SLT on cultural issues
 - b. advise on family networks and child rearing practices
 - c. interpret, and translate where necessary
 - d. counsel the client/family (after appropriate training)
 - e. ensure that client/family are aware that information is confidential. This may be particularly important when the co-worker is a member of the same community as the client/family
5. Bilingual co-worker/assistant should facilitate SLT's access to important linguistic and case history information and be agents in the intervention process through the client's home language.
6. Departments working with co-workers/assistants need to consider the support mechanisms which need to be in place for the co-worker/assistant to feedback on all aspects of her/his work

5.2. Independence

Working independently of the SLT can be taken to mean that the SLT and the co-worker have discussed the case in question and the therapist has delegated the work appropriate to the skills and training of the co-worker. (See 5.1). Thus, the therapist and co-worker may work together or separately, but at all times the client's case is managed by the therapist.

The monolingual English assistant and the bilingual co-worker can be expected to work

independently of the SLT in prescribed situations, e.g. working through simple therapy programmes, preparing clinic equipment, bringing the client to an appointment. In addition, the bilingual co-worker will be expected to work independently in a wider range of prescribed situations than the monolingual English assistant, such as non-English language assessment and intervention, advising and counselling the client and/or relatives in the home language.

5.3. Recruitment and Training

The bilingual co-worker should demonstrate proficiency in speaking and, where possible, in literacy, in the required languages and English and have the ability and wish to be further trained. The process of selecting the co-worker needs to allow candidates the opportunity to discuss their personal views, particularly about disability and intervention, as well as about working with parents and professionals. Their views about their home language(s) are also important. Knowledge about other languages and cultures in the community as well as their own is desirable as it will allow flexibility when working within diverse communities.

The bilingual co-worker's unique role would necessitate some training in linguistic analysis of her/his non-English languages, language assessment and test administration, some training in therapy techniques with application to the discourse constraints of her/his languages, as well as some training in counselling.

5.4. A good working relationship

A good working relationship exists when the parties involved understand and appreciate the aims and skills each brings to their work. To achieve this it is essential that the therapist and the bilingual co-worker allow time in a formal and informal way to develop these concepts. The therapist may have to develop this quality of professional relationship with several co-workers, depending on the linguistic complexity of her/ his caseload. This can be made more efficient by organised in-service training in the SLT department between therapists, the bilingual co-workers and "casual" bilingual personnel. Opportunities for training sessions to include monolingual assistants should be welcomed.

5.5. The same language, culture, sex and age

The therapist should take steps to ensure as far as possible that the co-worker shares the language and dialect of the client, e.g. telephone contact prior to the appointment. It is also important to ensure as far as possible that the same culture is shared by the co-worker and the client population. Some difficulties may be anticipated between English-born speakers or speakers born overseas, in terms of language variations and cultural perspectives; for example the differences between English born Panjabi speakers, East African Asian language speakers, and those born in Pakistan/India. Disparities of this nature need to be discussed fully preferably before client contact. Similar considerations need to be given to gender differences, bilingual co-workers of the opposite sex to the client may not be recommended in certain circumstances where there may be sensitivity around sex differences, e.g. aspects of medical history, or counselling. Similarly, a younger or unmarried co-worker may find it impossible to ask an older client for some information or recommend certain advice. There may be differences of class, caste and educational background which may shape the relationship between co-worker and client and constrain the work to be done. Discussion before client contact can avoid unnecessary embarrassment and make the interview more successful. However, the needs of the client remain paramount. Co-workers should be given training and support to overcome any potential barriers.

5.6. Briefing and debriefing

The therapist should always allow time before seeing the client to brief the co-worker on the case and to discuss the session, e.g. aims, materials, seating. Time should be allowed afterwards for a debriefing session between the co-worker and therapist. This protocol should be followed at all stages of client management.

5.7. Linguistic analysis, assessment and therapy

It is recommended that the Trust manager of SLT services delegate the organisation of the training of the bilingual co-worker to the specialist post holder where there is one. The co-worker needs to know about administering formal tests and following informal assessment procedures and the basics of linguistic analysis of her/his own language. The therapist should also have a knowledge of the linguistic structures of the co-worker's home language so that together an analysis can be conducted and a decision about treatment made. The final decision about diagnosis and treatment choice is made by the therapist in the light of the bilingual information provided with the help of the co-worker. In therapy, the bilingual co-worker may be involved in drawing up the non-majority language treatment programme with the therapist and working through it independently, with frequent planned feedback sessions with the therapist.

5.8. Areas of work

The co-workers' role with the SLT could include the following

- a) interpreting and translating for SLT provision
- b) advising on appropriateness of materials and work with the therapist towards
- c) developing more appropriate assessment and therapy materials for the non-English language.
- d) assessments for speech and language in the home language
- e) transcribing and translating data and linguistic information
- f) assist with case history taking
- g) enabling and empowering clients, parents, spouse and family
- h) raising awareness for the SLT about cultural practices and perspectives, such as child rearing, disability
- i) raising awareness among SLTs about the value systems and perspectives of the community, the role of adults, family networks, beliefs and value systems, role of play
- j) raising awareness about speech/language therapy service in the linguistic minority community
- k) carrying out therapy programmes in the home language
- l) facilitating the SLT in identifying the nature and severity of the difficulty
- m) networking within the community

5.9 SLTs' role with co-workers should include the following:

- a) training co-workers and receiving training about working with co-workers/assistants and supporting them
- b) developing a good working relationship with co-workers recognising that the SLTs always have the "duty of care"
- c) integrating the co-workers into the SLT department
- d) establishing departmental ownership of the co-workers' service
- e) identifying the client groups for the co-worker to work with, which may only be one or two at the beginning and increase to include most types of speech and language difficulty and most bilingual clients as the co-worker's experience develops.

5.10 Role within the SLT department

The co-worker and the SLTs within a department need to develop strategies for ensuring these roles are achieved to meet the needs of the clients from linguistic minority communities. The SLT department can take an initiative in developing training for external bilingual personnel, such as link workers, advocates, interpreters, so that they are made aware of the SLT service, models of delivery and practice and the advantages of working through the client's home language. Bilingual co-workers should be encouraged to meet with their monolingual counterparts to integrate bilingualism and share good practice.

6. **The Assessment and therapy process**

6.1. The First Interview

Many services now offer telephone triage – this enables information to be gathered prior to initial interview and encourages attendance. It is important that this service can be offered in languages other than English.

The first interview should always aim to establish optimum co-operation and understanding between the client, family and therapist. Certain procedures should be developed for bilingual/bicultural clients to ensure this happens:

- a) ensure that a bilingual co-worker is present unless the therapist is satisfied that the interview can be conducted successfully for both parties in English;
- b) arrange for the first interview to be in a mutually convenient venue/time for therapist, co-worker and client;
- c) ensure that the client and family understand the role of SLT and are in a position to make an informed decision about co-operating,
- d) ensure that the client and family are aware that the information given to SLTs and co-workers is confidential

It is not recommended that the bilingual co-worker conducts the first interview with the client and family on her/his own. The co-worker may make an initial visit to confirm that the family will attend/be at home for the first interview. The SLT needs to complete the case history and consider appropriate assessment and further management of the client and family, and s/he may do this with the co-worker. Apart from clinical and professional issues, there are also issues concerning the insurance and safety of the co-worker.

6.2. Clinical Case History Taking

In addition to the primary case history information - medical, social and developmental - the therapist working with a linguistic minority client must obtain information on

- a) the patterns of language use and attitudes to the languages by the client and family members e.g. map the language use in the home and in the wider community, determine which languages the family can read
- b) the attitudes towards language disability held by the client and family.

This information may have to be gathered in various venues, over some time and mainly in therapy time, by the therapist who will rely on the teacher and client's family for accurate feedback. Suggestions about observation schedules are given in Mattes and Omark (1984) and diary data may be obtained from the family. In cases where little or no English is spoken and there is no bilingual support, it may not be possible to obtain a full case history. This would have implications for how further assessment, intervention and support would proceed. Reference to the "minimum standards" would be appropriate.

It is important that the therapist recognises that good, effective practice with clients from linguistic minority communities may take considerably more time and resources than that with monolingual English clients. More information based on precise audit data would be very helpful for building a case for the effectiveness of working with trained bilingual personnel.

6.3. Client Management

The decisions concerning SLT management of the client following assessment include choice of treatment procedures, counselling, possibly statementing for special education, or referral to another agency. In the case of the non-English monolingual, the bilingual or emerging bilingual client these decisions are strongly influenced by the bilingual and bicultural resources available to the therapist and client. Consequently, it is fundamentally important that these resources are organised at a Trust department level.

6.4. The Language of Therapy and Intervention

1. The decision about the language(s) of therapy must be influenced by the nature of the client's linguistic repertoire, which may be monolingual other than English, bilingual or have the sociolinguistic expectation of being bilingual. Therefore, it is strongly recommended that SLTs try to offer therapy and intervention in the languages used by the client in her/ his daily repertoire, particularly the client's home language. The emotional primacy of the home language and the long-term care role of the family who speak the home language, especially in the case of a client with special needs, argue forcefully for intervention to involve the child's home language.
2. The question of language choice in intervention must involve full discussion with the parents/spouse and family if it is to be an effective choice in terms of the client's co-operation and communication development (see Genesee, Crago and Paradis 2004). The bilingual resources for such an option must be in place. An option for English-only intervention because of lack of resources may very often be clinically unsuccessful and therefore not the preferred course of action, e.g. in cross-cultural counselling, or with non-English speaking clients. In the case of the school learner, English may need to be used in therapy in the context of communication needs within the school and curriculum. The communication needs for home would need to be conducted through the home language. These communication needs may occur at any level of the language system.
3. There are also implications for the use of alternative communication systems. These include developing an appropriate signing system for the home language, obtaining an appropriate synthetic voice, or obtaining an appropriate Braille script. Further to the case of the bilingual client who is hearing impaired, oral advocates will have to organise oral work in the home languages.
4. When an assessment has been conducted in both languages at whatever level, then a therapy programme can be drawn up in English and the home language. SLTs who are unsure of linguistic, phonological or dysfluency analysis skills across languages may find this aspect challenging. In-service training programmes should aim to build up these skills. In planning intervention, the SLT needs to bear in mind principles for determining where and how to intervene. Developmental order, functional and communicative load, together with the strengths and weaknesses of the assessment profile should guide selection of therapy aims and objectives. In community languages where there is no developmental information available, functional and communicative load and the client's profile may be the main guides in setting therapy objectives.
5. Intervention procedures may work through both languages in different ways depending on the nature of the difficulty. For example, there may be intervention in one language for one aim and in the other language for another aim. Alternatively, working in one language one day and the other on another day may meet the client's needs more appropriately. It has been shown that vocabulary learning improves when the items are learnt through the home language first (Perozzi 1985). Fluency programmes, such as Monterey, and techniques such as "slowed speech", could be successful across languages and cultures. The use of personal construct models and other psycho-dynamic or psycho-social approaches may need careful planning before being successful across cultures. Evidence base for children shows both the need for mother tongue therapy in cases of speech disorder (Zhu Hua and Dodd 2006, Holm and Dodd, 2001; Holm et al, 1999) and the efficacy of therapeutic intervention in the individual's mother tongue in language delay and disorder (Guttierrez – Clellen, 1999)
6. Where group work is recommended, the clients should share the same home language and regional variation with each other and the bilingual therapist or co-worker. Clients need to share a similar area of difficulty at a similar level of need.

7. Placing bilingual clients in majority-only language units should not preclude intervention in their home language. Where possible this should be stated in the statement of special educational needs, where available. If not available, the Education Department should be formally requested to fund a bilingual co-worker for the child. Parents should be counseled as to the outcome of placing a client in this setting. In addition, every effort should be made to support the speech and language difficulty in the child's home language as well as English. Where there is no difficulty in the child's home language the reasons for giving therapy need to be reappraised. Second language English problems should be managed by the specialist language services in education. In cases where the client is receiving speech and language intervention and support from the language services, it is important that the SLT and the teachers work together in the client's interests.

7.0 **The Way Forward**

The way forward for SLTs to achieve good clinical practice with bilingual clients is for investment to be made in the following recommendations:

- a) to include more study of bilingualism and comparative linguistics/phonetics in the training syllabus
- b) to recruit more bilingual SLTs from linguistic minority communities, possibly in a concerted recruitment drive which could be spearheaded by those Trusts with specialist posts
- c) to establish and develop the role of bilingual speech and language therapy co-workers, with nationally accredited training scheme
- d) to develop programmes of action research to monitor and increase the evidence base for our work with bilingual clients
- e) to further involve users in the development of services

Bibliography

- Baker C and Prys Jones (1998) *Encyclopedia of bilingualism and bilingual education*. Clevedon: Multilingual Matters
- Baker, C. (2000) *A parent's and teachers guide to bilingualism*, 2nd edition, Clevedon: Multilingual matters
- Baker, C. (1996) *Foundations of bilingual education* 2nd edition Clevedon: Multilingual matters
- Bourdieu, P. (1986) The Forms of Capital, from J.E Richardson (ed) *Handbook of Theory of Research for the Sociology of Education* Greenwood Press, pp241-58. Translated by R. Nice.
- Cline, T. (1997) Education for bilingualism in different contexts: teaching the deaf and teaching children with English as an additional language, *Educational Review* 49, 2,151-158
- Cline, T. and Frederickson, N. (eds) (1996) *Curriculum Related Assessment, Cummins and Bilingual Children*, Clevedon: Multilingual Matters
- Commission for Racial Equality (2007) [http://www.cre.gov.uk/legal/rra_discrimination.html]
- Cummins, J. (2000): *Language, Power and Pedagogy; Bilingual children in the crossfire*. Clevedon: Multilingual Matters Ltd.
- Duncan, D.M. (Ed) (1989) *Working with Bilingual Language Disability*. London: Chapman and Hall.
- Duncan, D.M. and Gibbs, D.. (1989), Mainstream bilingual schoolchildren: a model for remediation. In D. Duncan (ed.), *Working with Bilingual Language Disability*. London: Chapman & Hall, pp. 176–197.
- Frederickson, N. & Cline, T (2002). *Special Educational Needs, Inclusion and Diversity: A Textbook*. Buckingham: Open University Press.
- Genesee, F., Paradis, J., and Crago, M. B., (2004) *Dual language development and disorders: a handbook on bilingualism and second language learning*. London: Paul H. Brookes Publishing Company
- Gutierrez-Clellen, V.F. (1999) Language choice in intervention with bilingual children. *American Journal of Speech–Language Pathology*, 8, 291–302.

Hall, D. et al (2001) *Assessing the needs of bilingual pupils: Living in two languages*, 2nd edition. London: David Fulton

Holm, A. and Dodd, B. (1999) Differential diagnosis of phonological disorder in two bilingual children acquiring Italian and English. *Clinical Linguistics and Phonetics* 13:2 113-129

Holm, A. and Dodd, B., (2001), Comparison of cross-language generalisation following speech therapy. *Folia Phoniatrica et Logopaedica*, 53, 166–172.

Isaac, K. (2002) *Speech Pathology in Cultural and Linguistic Diversity*. London: Whurr

Juarez, M. A., (1983) Assessment and treatment of minority language-handicapped children: the role of the monolingual speech–language pathologist. *Topics in Language Disorders*, 3, 57–66.

Leung, C., (1996) Linguistic Diversity in the 1990s; Some Language Education Issues for Minority Ethnic Pupils. Occasional Paper 7 (Watford: National Association for Language Development in the Curriculum).

Linguistic Minorities Project (1985) *The Other Languages of England*. London: Routledge and Kegan Paul.

Madhani, N. 1989: First language Panjabi development. In Duncan, D., (ed) *Working with bilingual language disability*. London: Chapman and Hall, pp. 50–59.

Martin, D., Colesby, C. and Jhamat, K. (1997) Phonological awareness in Panjabi/English children with phonological difficulties, *Child Language Teaching and Therapy* 13,1, 59-72

Mattes, L. and Omark, D. (1984) *Speech and Language Assessment for the Bilingual Handicapped*. College-Hill Press.

Miller, N. (1978) The bilingual child in the, speech therapy clinic. *British Journal of Disorders of Communication* 13,1,17-30.

O'Hagan, K., 2001, *Cultural Competence in the Caring Professions*. London: Jessica Kingsley.

Perozzi, J. (1985) A pilot study of language facilitation for bilingual language handicapped children: theoretical and intervention implications, *Journal of Speech and Hearing Disorders* 50,403-6

Race Relations Act 1976 London: HMSO

Rodby, J., (1998) A polyphony of voices: the dialectics of linguistic diversity and unity in the twentieth century United States. In M. D. Linn (ed.), *Dialects and Language Variation*, London: Academic Press, pp. 447–474.

Sanders M (2000) *As good as your word: a guide to community interpreting and translation in public services*. London: The Maternity Alliance

Stokes, J. and Duncan, D. M., (1989) Linguistic assessment procedures for bilingual children. In D. M. Duncan (ed.), *Working with Bilingual Language Disability*, London: Chapman & Hall.

Stow, C., and Dodd, B., (2003) Providing an equitable service to bilingual children in the UK: a review. *International Journal of Language and Communication Disorders*, 38, 4, 351-377.

Stow, C. and Pert, S. (2006) Phonological Acquisition in Bilingual Pakistani Heritage Children in England. In Zhu Hua and B. Dodd (eds.) *Phonological Development and Disorders in Children: A Multilingual Perspective*, Clevedon: Multilingual Matters

Winter, K. (1999) Speech and language therapy provision for bilingual children: aspects of the current service, *International Journal of Language and Communication Disorders* 34, 1, 85-98

Zhu Hua, B. Dodd (Eds) (2006) *Phonological Development and Disorders in Children: a multilingual perspective*, Clevedon: Multilingual Matters

Eurotalk interactive CD rom -101 languages of the world

APPENDIX 1

ASSESSMENTS APPROPRIATE FOR USE WITH BILINGUAL CLIENTS

- Buxton, and Hooke, E. (1996) *Turkish Phonological Assessment*, (pilot form) obtainable from
E. Hooke, SLT Dept., Shrewsbury Centre, Shrewsbury Road, Forest Gate, London E7
8QP
- Chavda, P. and Jin, L. (2006) *Gujerati assessment of STASS* (South Tyneside Assessment of
Syntactic Structures), STASS Publications, UK
- Dewart, H. and Summers, S. (1995) *The Pragmatics Profile of Everyday Communication Skills*.
Windsor: NFER-Nelson (Note: Interview is conducted through the home language)
- Duncan, D., Gibbs, D., Noor, N., and Whittaker, H. 1988. *Sandwell Bilingual Screening,
Assessment Scales for Expressive Punjabi and English*. Windsor: NFER-Nelson (out of
print)
- Madhani, N. 1989. "First language Panjabi development" in D. Duncan, *Working with Bilingual
Language Disability* (see References)
- McChrystal, L. (1995) *Punjabi Phonological Assessment*, obtainable from:
L. McChrystal, SLT Dept., Shipley Health Centre, Alexandra Road, Shipley, Bradford
BD18 3EG
- Mumby, K. 1989. *The Punjabi Adaptation of the AST*, obtainable from:
Kathryn Mumby, 11 Cantley Crescent, Wokingham, Berks. RG11 1NU
- Stokes, J. 1989. "First language Bengali development" in Duncan, D. *Working with Bilingual
Language Disability*
- Stow, C., and Pert, S., (2006) *Bilingual Speech Sound Screen: Pakistani Heritage Languages*
(Winslow: Speechmark)
http://www.speechmark.net/speechmark/New_Titles/bilingualspeech.htm
- Stow, C. and Pert. S. (1998) *The Rochdale Assessment of Mirpuri Phonology with Punjabi, Urdu
and English* (Rochdale: Pert)
- Wheldall, K., Mittler, P., Hobsbaum, A., Duncan. D., Gibbs, D., and Saund, S. 1987. *The
Revised Sentence Comprehension Test with the Panjabi Version*. NFER-Nelson.

NOTE:

First language English assessment may be used on second language English data, since they are criteria-referenced. The Stage information will be useful although the Age information would be inappropriate. For example: LARSP (Crystal, Fletcher and Garman 1976) STASS. In some cases, secondary school learners have been assessed on the TROG since their English is developed and the difficulty seems to be at a higher processing level.

APPENDIX 2

COMMITTEE MEMBERS OF THE SIG BILINGUALISM
involved in developing this document

Sheila Anderson

Ann-Marie Caunce

Nasreen Chaudhry

Panna Chavda

Claire Ewen

Louise McChrystal

Merle Mahon

Deirdre Martin

Liz Parker

Yvonne Christie-Phillips

Tina Quinn

Allyson Strong

The Committee would like to thank, on behalf of the SIG members, the reviewers of this document for their comments.