

Guidance

Essential foundations for working successfully with Bilingual children experiencing SLCN and their families

**[Date Here]**

All practising members (as well as students with the support of their practice educators) can demonstrate that they are meeting the RCSLT Clinical Guidelines by integrating the following **essential steps** into their practice.

Please note that this document is not a comprehensive clinical guideline.

Please read the bilingualism evidence-based practice guidance, available here:   
[www.rcslt.org/members/clinical-guidance/bilingualism](https://www.rcslt.org/members/clinical-guidance/bilingualism)(NB please login to view the full guidance)

Once you have checked that you meet these essential steps, please:

1. Complete a reflection for your continuing professional development log (CPD log)
2. Show your commitment to equitable practice by adding: ‘RCSLT: I’m positive about Bilingualism and Cultural Diversity’ on your email signature, service information, appointment letters/cards, posters and websites to advertise your service, and other media.
3. Encourage your colleagues to do the same, and let others know on social media.

All the following essential steps apply to all bilingual clients regardless of age group, except where ‘child’ is specially stated (and even for these steps, the principle still applies).

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| **Pre-referral and referral** | | | **Progress/status** | | |
|  | **Essential step** | **Evidence and RCSLT Guidance** | **Achieved** | **Working towards** | **Not evidenced** |
|  | The **languages and dialects spoken** in the local area are **listed on the referral form**.  The list is based on published statistics. | Generic terms such as ‘Chinese’ instead of a specific language, such as 'Cantonese', or ‘Pakistani’ instead of 'Urdu', should alert the SLTs that the referring agent is either unfamiliar with the local community’s languages 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. |  |  |  |
|  | A **three-way telephone or video conference call is arranged** with the client/family, **interpreter** and speech and language therapist in order to check the client’s language(s) and to answer any questions about the appointment. | Correct identification of the child and 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. |  |  |  |
|  | **An interpreter is booked prior to the session** to review assessment/intervention materials, discuss cultural appropriateness and plan translation and adaptation of materials.  **Only professional interpreters over 18 are acceptable. Family members under 18 should never be asked to fulfil this role.** | The interpreter and SLTs should work together to identify any cultural or linguistic issues which may arise.  Collaborating with professional interpreters should not be viewed as optional and must not be restricted by budgetary constraints. |  |  |  |
|  | **The appointment format is accessible for the client/family**. This may include a letter in the majority language (such as English or Welsh) with a QR code to an audio version in home language.  Note that many clients/families cannot read their home language, check at the three-way appointment.  Translating letters and leaflets into home language scripts may be less useful than verbal translations for many communities.  Do not use computer text translation. | Websites including verbal as well as written translations of referral information and help and advice  The use of text-based translation, text-to-speech and speech-to-text translation, and other machine-based translation rely on non-human algorithms. Although such translation systems are improving at rapid rates and are readily accessible on personal computers and mobile devices, they cannot currently provide an acceptable alternative to human interpreters.  Other pitfalls include the possible transmission of Patient Identifiable Data across the internet in an unencrypted form, processing outside the UK or outside the European Union and other data transmission, as well as processing and storage – which may be hidden from the user.  The use of IT-based translation systems are, therefore, highly likely to compromise confidentiality and Information Governance legislation, including the Data Protection Act (1998) and the General Data Protection Regulation (GDPR, 2018). |  |  |  |
| **Assessment and intervention** | | |  |  |  |
|  | Each contact with a client should include the following, in partnership with an interpreter:   * **Planning time** * **The session** * **A debrief** to discuss the session outcomes and any cultural and translation queries arising * Double the time allocated for a typical monolingual client should be allowed for adaptations and the translation process (equitable service). | Services should allocate at least double the time at all stages, including assessment and intervention for bilingual clients and their families, in order to achieve the same positive outcomes as monolingual clients. |  |  |  |
|  | If the client only has difficulty working in the majority language/language of education (such as English, Welsh or Gaelic), then the client has an additional language need, and this is *not* the role of the speech and language therapist. Such clients should be referred to specialist teaching staff. | If there is a communication disorder, then it will be present in both/all the languages that the individual understands and uses. |  |  |  |
|  | The **care plan will be delivered in home language** and/or both languages.  Speech and language therapists should recommend a home language approach in the care plan and report recommendations. | A written care plan should be written in collaboration with the parent(s)/carer specifying the speech and/or language therapy aims. This should specify the language in which the therapy will be provided, and that the child must be successful in their home language prior to attempting the same targets in their additional language. Ideally the staff expected to provide support should be agreed and named and resources identified, along with the ‘dose’ (number of minutes per session and number of sessions per week). The agreed support is important as the amount of input is crucial to maintaining success. |  |  |  |
|  | The **parent/carer interview** (case history) must include a **language exposure and usage interview**. | 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 impacts on the child and the family.  The first interview with a bilingual adult or family member/carer 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. |  |  |  |
|  | **Assessment is carried out in home language** if a child has yet to develop the majority language or in both/all languages if they have started to acquire two or more languages.  This applies to speech development as well as language development since bilingual children may have different surface errors in each of their languages, and intervention for phonological errors does not generalise from one language to another. | 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. |  |  |  |
|  | For assessment of speech or language, **home language should be recorded if used by the client, not just the translation**.  A translation protocol should be used. | Translation grids are used in order to preserve the child’s original utterance and to make the stages of translation transparent. |  |  |  |
|  | **Published assessments should be adapted, *never* translated**.  If published assessments are used, standard scores must not be used for diagnosis, nor quoted on reports, nor used as criteria for access to specialist provision.  Informal, culturally appropriate assessment materials are superior to direct translations of published assessments in English. | With such huge differences between monolingual children and bilingual, bi-cultural children, in terms of language exposure and cultural experience, SLTs must not quote:   * age equivalents * standard scores * percentile ranks; or * other similar normative data derived from monolingual English-speaking populations. |  |  |  |
|  | **Intervention aims should be achieved in home language** and then in English. | There is 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.  SLTs should therefore offer home language intervention, prior to therapy in the language of education (English, Gaelic or Welsh), especially for sequential bilinguals. |  |  |  |
| **Cultural inquisitiveness: language, cultural practices and religion** | | |  |  |  |
|  | The speech and language therapist will have an attitude of **cultural inquisitiveness**, also known as cultural competence development. Remember that you will *not* achieve some mythical level of cultural competence; this is a journey and an on-going process.  SLTs will utilise their **reflective log** to monitor their journey of development in the areas of languages, culture and religion.  Language transmits culture and helps individuals  to access support from their family, extended  family and wider community. Home language and/or additional languages may be employed to access the client and family’s religion.  SLTs should **educate themselves** about the cultural practises, beliefs, religion and languages used by their clients, without expecting all families within a community to have the same expression of these aspects (stereotyping). This should be part of your ongoing continuing professional development (CPD).  **SLTs should include questions on language use, cultural practices, beliefs and religion. These questions should be asked in a respectful manner and not include superfluous information. Explain why you need information from clients** and how this will be used to **understand their needs and plan their care**.  **Clients should not be expected to educate professionals** on their language, culture, beliefs and religion. | It is the responsibility of the SLT to become culturally competent by having an ongoing awareness of how their own cultural biases 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. |  |  |  |
|  | **Culturally appropriate resources** should be used in discussion with the interpreter/adult informant. | The interpreter and SLTs should work together to identify any cultural or linguistic issues which may arise. |  |  |  |
| **Outcome** | | |  |  |  |
|  | Overall **outcome should be that the client maintains/develops home language** alongside the language of education/majority language. | The main aim of intervention with bilingual clients is to maintain, restore or achieve bilingualism. |  |  |  |
| **Further learning, allyship and supporting colleagues** | | |  |  |  |
|  | **SLTs should see learning about other languages, cultural practice, beliefs and religion as a life-long journey**. It is acceptable to have an attitude of respect for others’ way of life, but have limited knowledge, as long as you are committed to discovering more. | See Strategies to increase cultural competency:  [www.rcslt.org/-/media/Project/RCSLT/8-strat-increase-cult-comp.pdf](https://www.rcslt.org/-/media/Project/RCSLT/8-strat-increase-cult-comp.pdf) |  |  |  |
|  | The profession in the UK is composed of a majority of white monolingual English-speaking SLTs. It is important that this more privileged section of the SLT community supports those from bilingual and/or those from Black, Asian and minority ethnic backgrounds and those with diverse heritage.  This should involve:   * **actively challenging racism** in the workplace * **undertaking training and CPD** on bilingualism, cultures different to your own, and on religion * **becoming aware of your own culture, beliefs** and how they might influence your own practice * **encouraging colleagues to do the same** | See Cultural competence checklist:  <https://www.rcslt.org/-/media/Project/RCSLT/9-cult-competence-checklist.pdf> |  |  |  |

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| **Signature of supervisor/mentor:** | **Date:** |

# **Sign off**

# **Next steps**

This is not a comprehensive check list.

Please work as a team to improve the service in order to be equitable to all clients. This includes:

* carrying out continuing Professional development(CPD)
* reading and applying RCSLT clinical guidelines
* accessing training courses
* joining a Clinical Excellence Network (CEN)
* carrying out/contributing to audits to ensure best practice is applied throughout the service by all staff

Bilingual staff and those from diverse communities should not necessarily lead on service change and development. Students and speech and language therapists with *any* level of home language skill are encouraged to use these skills to make clients feel welcome, even if working alongside a required interpreter. It is the responsibility of all speech and language therapists to value bilingualism and cultural diversity and to actively challenge racism. This applies to both our clients and our colleagues.

###### Reference this checklist as:

###### Pert, S. & Shah, S. (2021). Essential foundations for working successfully with

###### bilingual children experiencing SLCN and their families. London: Royal College

###### of Speech and Language Therapists. Available at: https://www.rcslt.org/members/clinical-guidance/bilingualism/bilingualism-learning/#section-3

The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists in the UK. As well as providing leadership and setting professional standards, the RCSLT facilitates and promotes research into the field of speech and language therapy, promotes better education and training of speech and language therapists, and provides its members and the public with information about speech and language therapy.

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