IASLT | *The* Irish Association *of* Speech + Language Therapists

Culturally Responsive Practice in Speech & Language Therapy in Ireland: Best Practice Principles

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1.0 Summary

- Culturally responsive practice is a commitment to the lifelong process of "becoming more effective in providing services across cultures" (Hyter & Salas-Provance, 2019:25).
- Speech and language therapists (SLTs) must advocate for equitable services for all.
- At a global level, multilingualism is the most common linguistic state.
- Speaking two or more languages does not cause speech, language, and communication difficulties.
- Speech, language, and communication difficulties are not exacerbated by being multilingual.
- SLTs should not advise multilingual people to discontinue using one of their languages.
- All of a multilingual person's languages need to be assessed.
- Standardised tests should not be used to assess language in multilingual people due to issues of content and linguistic bias (Scharf- Rethfeld et al. 2020; O'Malley-Keighran & Carroll, 2024).
- In certain circumstances, standardised tests may be useful as part of informal assessment of language with item analysis to indicate areas of relative strength and difficulty in the language of the test.
- SLTs should have timely access to trained interpreters to facilitate best practice with culturally and linguistically diverse (CaLD) people.
- There is an urgent need to professionalise and monitor the quality of health interpreting services in Ireland.
- Best practice is that family members or friends must not be deployed as interpreters in any circumstances (National Council on Interpreting in Health Care, 2011). However, there are numerous factors which can make it difficult for SLTs to adhere to best practices in relation to working with interpreters.
- SLTs must support all of a person's languages in speech and language therapy (SLT) intervention, taking into consideration present and future language needs.

2.0 Foreword

The document was prepared by a working group of the IASLT Affiliated Linguistic and Cultural Diversity Special Interest Group (LCD-SIG) chaired by Dr Mary-Pat O'Malley in conjunction with the Irish Association of Speech and Language Therapists (IASLT). The process comprised a review of available literature including research and relevant international clinical and best practice guidelines, a cross-sectional survey of SLTs in Ireland, and consultation with IASLT. While every effort was made to ensure rigour throughout, this document was prepared by a small group of SLTs without public involvement or consultation and should be appraised accordingly.

The content is informed by a growing body of literature that is of varying methodological quality (e.g., Siering et al., 2013) which will be addressed in future iterations as new evidence becomes available. This document should be read critically in conjunction with existing and emerging research literature, and clinical guidelines and position statements from (international) SLT professional or statutory bodies, including, but not limited to: American Speech-Language-Hearing Association (ASHA), International Association of Logopedics and Phoniatrics (IALP), New Zealand Speech-language Therapists' Association(NZSTA), Royal College of Speech and Language Therapists (RCSLT), Speech-Language and Audiology Canada (SAC) and Speech Pathology Australia (SPA).

Further readings, available on-line at the respective websites, include:

- IASLT Strategic Plan 2023-25
- CORU Standards of Proficiency for speech and language therapists
- Second National Intercultural Health Strategy 2018-2023, (HSE Social Inclusion Office, 2018)

The purpose of this document is to provide overarching principles, terminology, and practical examples to support and underpin culturally and linguistically inclusive SLT practice in Ireland. It supersedes the IASLT Guidelines for Speech and Language Therapists Working with Linguistically Diverse Service Users (2016).

3.0 Foundational concepts and definitions

While acknowledging variable definitions of relevant terminology, the following terms, used consistently throughout this document, are presented below. These concepts underpin the document and the recommendations for culturally responsive practices in SLT in the Republic of Ireland.

3.1 Culture

According to Causadias (2020:310) 'culture is a fuzzy concept without fixed boundaries, meaning different things according to situations'. The fuzziness renders it difficult to define culture, leading to a long tradition of reviewing definitions of culture. The following definition of culture underpins these best practice principles:

Culture is the shared, accumulated and integrated set of learned beliefs, habits, attitudes, and behaviors of a group of people or community

(Kohnert, Ebert, & Pham, 2021: 24).

Culture is at once the context in which languages are developed and used across the lifespan and a significant means by which culture is transmitted (Kohnert et al., 2021). Furthermore, culture also needs to be considered when working with people with eating, drinking, and swallowing challenges as it can also influence food choices and eating patterns, both in everyday life and in specific rituals (Arbit et al., 2017; Ratcliffe et al., 2019).

3.2 Diversity

Diversity is a dynamic, relational reality that exists between people (Barrera & Kramer, 2017). Diversity is defined by context. It is only when 'comparing values and beliefs reflected in specific behaviours across cultures that differences become apparent' (Kohnert et al., 2021:24). No single person can be said to be diverse, culturally or otherwise, except in reference to other people or contexts (Barrera & Kramer, 2017). Diversity, unlike other characteristics such as hair colour, cannot exist independently of its context. Diversity is a relational construct, never a problem

in and of itself. 'It lives in the relational space *between* persons (e.g. that person is diverse *from me*). Diversity is thus, never about who *they* are; it is about who *we* are ' (Barrera & Kramer, 2017:8). In societies that have a dominant cultural and language variant, health and social inequities can be exacerbated, particularly for members of minority cultures (Federici, 2022) .

3.3 Health and health equity

Health is a fundamental human right (WHO, 1946). Health equity is when people can achieve full potential for health and wellbeing. Health inequity is underpinned by social inequities in the distribution of resources, money, and power, (i.e. the social determinants of health). These include language, culture and societal values, social inclusion, social class, gender and gender identity, ethnicity, education, employment, income security and social protection, non-discrimination, and justice. These social determinants of health impact on equitable access to quality healthcare and well-being (Donkin et al., 2018). As SLTs working in the context of cultural and linguistic diversity, we must critically examine the origins and positionality of our field which is predominantly based in the Global North and underpinned by tools and techniques developed for monolingual populations. It is essential that SLT practice continues to evolve to respond to the needs of underserved communities. In order to do this, SLTs need to understand principles of equity in accessing wider health, social, and community support services, disparities in social determinants of health, and inherent limitations in the reliability and validity of clinical tools designed without a lens of diversity (Abrahams et al., 2023).

3.4 Cultural Competence and Cultural Humility

A wide range of definitions and debate feature in the literature. For example, according to Kohnert et al., (2021:32), cultural competence is '*a congruent set of behaviours, attitudes, and policies that come together in a system, organisation or individual that enables professionals to work effectively in cross-cultural situations'*. It includes knowledge about 1) diversity of needs, 2) attitudes that recognise and value difference, and 3) flexible skills to provide culturally appropriate and culturally

sensitive care (Nguyen, Naleppa, & Lopez, 2021). The term *cultural competence* is problematic in that it suggests an end-point where practitioners are competent but it is not possible to be competent in another person's culture and the concept does not address structural inequalities.

Cultural humility has been proposed as an alternative or complementary concept or term. According to Danso (2018), cultural humility involves a life-long commitment to self-reflection and analysis and to redressing power imbalances. It emphasises self-critique and respect. Practitioners using it as a model are expected to challenge institutional forces and processes that shape the relationship between practitioners and clients (Danso, 2018). However, the concept lacks conceptual clarity and it is not clear how it can be put into practice (Danso, 2018).

Our preferred terminology in this document is ***culturally responsive practice*** defined below.

3.5 Cultural Responsiveness

According to Hopf et al. (2021), culturally responsive SLTs are those who value diversity, actively work to further their knowledge of varying cultural perspectives, and also act to create spaces that communicate clear respect and value for cultural diversity. Cultural responsiveness arises in all aspects of SLT practice, including the area of feeding, eating, drinking, and swallowing (FEDS). This includes issues such as food culture, shared decision-making around preferences for modified diets, and other ethical issues (Kenny, 2015; Riqueleme, 2007). A culturally responsive perspective requires introspection and reflection on the part of SLTs. It requires SLTs to seek out knowledge of the cultures of the people attending the service. Culturally responsive SLT practice promotes health equity, social inclusion, and access to services. It is necessarily intersectoral and responsive to the increasing diversity in Irish society (HSE Social Inclusion Office, 2018; IASLT, 2023).

3.6 Multilingualism

In this document, we use the term *multilingual* to encompass both cultural and linguistic diversity as suggested by McLeod, Harrison, Whiteford, and Walker (2015). Language cannot be separated from culture (Paradis, Genesee, & Crago, 2021). Traditionally, definitions of multilingualism have focused on proficiency and/or age of acquisition of the languages. However, the working definition of *multilingualism* adopted in these best practice principles is from an inclusive, functional, needs-based perspective as described by Kohnert et al. (2021). In this approach, proficiency and age of acquisition are considered different characteristics of multilingual people but not as determining factors for defining who is or is not multilingual. Furthermore, according to the International Expert Panel on Multilingual Children's Speech (2012: 1):

'*People who are multilingual, including children acquiring more than one language, are able to comprehend and/or produce two or more languages in oral, manual, or written form with at least a basic level of functional proficiency or use, regardless of the age at which the languages were learned*'

(adapted from Grech & McLeod, 2012:121).

It is also important to remember that multilingualism is a dynamic process not a static state (De Bot, 2019). There is currently a monolingual bias in our understanding of language and communication in multilingual people with regular benchmarking of multilinguals against a monolingual 'ideal' (Genesee, 2022). De Houwer (2022) reminds us how this pervasive monolingual bias threatens the well-being of multilingual children and their families. It is important for SLTs to support the use of all of a multilingual person's languages in their contexts of use in the present and in the future.

4.0 The International and National Contexts

At a global level, multilingualism is the most common linguistic state (De Bot, 2019). However, for a large part of the western population, there is a persisting perception that 'monolingualism is the 'normal' and desirable state' (De Bot, 2019: 1).

4.1 The Irish context:

Ireland is a multilingual and multicultural society which must be reflected in service provision (HSE Social Inclusion Office, 2018). Furthermore, the Republic of Ireland has three official languages: Irish, English, and Irish Sign Language (ISL). SLT services must respond to the needs of CaLD service users and ensure that there is an equitable and accessible evidence-based service for all (Pert, 2023). In order to achieve an equitable service, assessment of CaLD individuals will take more time, at least double when compared with assessment of monolingual people- and will require more resources, especially when the SLT does not share the languages of the individual and their family (Pert, 2023). SLTs should be active in advocating for changes to organisational rules and pathways of care to ensure that best practice guidelines are being employed and implemented (Verdon, McLeod, & Wong, 2015). From a societal viewpoint, SLTs should aim to raise awareness in settings such as schools, hospitals, and community-based services on best practice for supporting CaLD individuals to functionally engage within their communities and beyond. However, we also wish to acknowledge the institutional barriers faced by SLTs when it comes to implementing best practices in the context of cultural and linguistic diversity.

Key points in relation to linguistic diversity from Census 2022 include:

- 751,507 people spoke a language other than Irish or English at home and 182 separate languages were coded.
- Amongst European nationals living in Ireland in 2022, Polish was the most common language spoken, with 123,968 speakers, followed by Romanian, French, Spanish, Portuguese, and Lithuanian (Central Statistics Office, 2022).

- The fastest growing languages spoken were Ukrainian (up 165%), followed by Hindi (154%), and Croatian (137%) (Central Statistics Office, 2022).
- In 2022, 751,507 people usually resident in Ireland spoke a language other than English or Irish at home which represents an increase of 23% from 2016.
- Polish remained the most commonly spoken foreign language, being spoken by 123,968 people, while the number of people who spoke Polish declined by 9% from 2016.
- Similarly, the number of people speaking French and Russian at home both declined by 6%.
- The number of people speaking Portuguese at home more than doubled to almost 44,000 people in 2022 reflecting the growing Brazilian population.
- Among those born in Ireland, the most commonly spoken languages were French (32,244 people) and Polish (32,060 people).
- A further 18,966 Irish-born people spoke Spanish at home.
- Of the new ethnic groups added in Census 2022, 94,434 people identified as Indian/Pakistani/Bangladeshi while a further 20,115 identified as Arab and 16,059 as Roma. The number of usually resident Irish Travellers increased by 6% to 32,949.
- Compared with 2016, people in the Other Asian ethnic group almost halved to 44,944, which may be due to the introduction of the Indian/Pakistani/Bangladeshi category. The number of people identifying as Chinese increased to 26,828 (CSO, 2023).

4.2 Official Languages of Ireland

4.2.1 The Irish language

- The number of people who indicated that they could speak Irish increased by 6% from 2016 to 1,873,997, representing 40% of the population aged 3 years and over who completed the question on Irish language.

- Of the people who said they could speak Irish, 623,961 spoke Irish daily within and outside the education system accounting for 33% of the Irish- speaking population, down 3% from 2016.
- 71,968 of the daily speakers used Irish outside the education system, a fall of 1,835 on the 2016 figure.
- Irish speakers have statutory linguistic rights to access public services, including state-provided SLT through Irish. (Government of Ireland, 2003, 2021)

4.2.2 Irish Sign Language (ISL)

In 2017, the Irish Sign Language Act was passed recognising ISL as the third official language of the state. According to the Irish Deaf Society (2023), ISL is the first and/or preferred language of 5000 deaf people in Ireland and approximately 40,000 people in general communicate in ISL (family, friends, co-workers, etc). ISL is also supported by legislation in Ireland through the Irish Sign Language Act (2017) which recognises the right of the ISL community to use, preserve, and develop the language. For public bodies, including those providing SLT services, the Act requires them to do all that is reasonable to provide ISL interpretation when people are seeking to avail of these services (Irish Statute Book, 2023). The 2022 Census reports 233, 400 people with deafness or hearing impairment which is approximately 5% of the population. However, only 4206 people are mentioned as using ISL at home. The census does not inquire about the use of ISL outside the home (Conama, 2023).

5.0 Context of Multilingualism: a Life Span Perspective

The literature varies in relation to multilingual beginnings in childhood. De Houwer (2021) structures her exploration of bi/multilingual language development around three life stages: (i) babies and infants up to approximately aged two years, (ii) early childhood (toddlers and pre-schoolers) up to approximately aged six, and (iii), middle childhood up to approximately eleven years. She distinguishes between three language learning contexts in childhood:

- Bilingual First Language Acquisition (BFLA) where the family is the primary setting in which children develop their (two or more) first languages.
- Early Second Language Acquisition (ESLA) where children develop their additional languages through early years care and education (preschool).
- Second Language Acquisition (SLA) where children acquire additional languages via education/ school entry. A key distinction in SLA contexts is that children are learning to read and write in the additional languages as well as developing oral comprehension and expression.

It is important to bear in mind that children may of course be acquiring more than two languages in any of these language learning contexts.

Multilingual people are rarely if ever 'balanced' in all of their languages, and will have different levels of proficiency in understanding, speaking, reading and writing in these languages across the lifespan. There are many factors that influence the acquisition of additional languages including motivation, personality, language learning aptitude, age, structures of the languages, and the frequency and quality of exposure (De Houwer, 2021; Paradis, et.al., 2021). Other factors include which languages are spoken, where the languages are spoken, who speaks to the person in each language, how similar the languages are, whether the languages are used in education, and the relative status that each language holds in society and in each cultural group.

5.1 Dominance

The concept of language dominance is complex and encompasses a wide range of aspects (Silva-Corvalan & Treffers-Daller, 2016). Consideration of language dominance is important as an individual's proficiency in each of their languages and their relative strengths in each language can impact on their performance on language tasks (Treffers-Daller, 2019). A clear division exists between:

1) **Direct measures of language dominance** which assess an aspect of the individual's language proficiency, such as, grammar, vocabulary and/or syntax, use of a language sample (Schmid & Yilmaz, 2018) and
2) **Indirect measures of language dominance** such as language background/history questionnaires which measure variations in the person's exposure to different languages, situations where they use their languages, how much they use their languages, as well as personal background factors such as age, level of education, contexts in which languages are acquired, language habits, and language experiences (Schmid & Yilmaz, 2018; Treffers-Daller, 2019).

Clinically, how a person performs on the direct measures needs to be interpreted with reference to information gathered via indirect measures. It is important to remember that due to the inherent heterogeneity of multilingual people, there is no established consensus on how to measure language dominance (Unsworth, 2016). Focusing solely on direct measures to establish language dominance is difficult because languages differ in terms of morphology, syntax, and typology in addition to the lack of comparable tests in different languages (Treffers-Daller, 2019). Focusing on indirect measures that consider exposure levels and patterns of input and use can potentially be more useful clinically. However, they do not always have a strong correlation with the aforementioned direct measures. A converging evidence approach is now recommended as best practice (Castilla-Earls et al., 2020). This means that multiple pieces of assessment data are considered together to identify trends in a particular direction in order to arrive at a diagnostic decision (Castilla-Earls et al., 2020).

In clinical settings, it is not always useful to label an individual's languages in terms of their 'first' and 'second' language (e.g. L1 and L2 etc.) as language dominance (proficiency and frequency of use) can change over time and so the stronger language now may not always be the strongest language for that individual (Grosjean, 2012). It should also be noted that individuals use languages for different aspects of their lives and in different modalities. An individual may be more competent in the modalities of reading and writing but may use a different language for speaking. It is therefore best to look at all languages known to the person and collect an in-depth language history regarding their language use. (Please see Section 8 below for further details on assessment).

Kohnert et al. (2021:232) report on the 'tremendous variability among bilingual adults in their social circumstances, language histories, educational and vocational opportunities, and communication needs'. Depending on multiple factors, adults' proficiency in their languages may be 'very high, very low or anywhere between these endpoints along the language-ability continuum' (Kohnert et al., 2021: 232). Language proficiency is 'a fluid process, not necessarily an end state' (Kohnert et al.,2021: 233). Continued language use across the life span is needed to maintain optimum language skills over time. Language attrition, where previously attained language ability declines over time, can be affected by external resources such as lack of available opportunities and experiences across social, educational, and vocational environments. Internal resources which may influence language attrition include 'the integrity of the cognitive, sensory, motor, and neurobiological systems (Kohnert et al., 2021: 233).

5.2 Code-switching and mixing

Code-mixing/switching is a common feature of multilingualism and serves important linguistic, communicative, social, and cultural purposes (Kohnert et al., 2021). Code-mixing involves the use of elements from two (or more) languages within or across utterances and is grammatically, socially, and culturally constrained (Paradis et.al. 2021). Various authors have found that code mixing reflects competence at a sociolinguistic level rather than psycholinguistic incompetence (Kohnert et al., 2021). Similarly, research shows that bilingual parents code-switch in ways that support their infants' successful bilingual language acquisition (Kremin, Alves, Orena, Polka, & Byers-Heinlein, 2022).

5.3 Levels of cross-cultural adaptation

It is important that SLTs appreciate individual levels of cultural adaptation where people have by choice or through circumstances beyond their control, moved to Ireland. According to Kim (2017), the term *cross-cultural adaptation* refers to the dynamic process by which people who have relocated to unfamiliar or changed cultural environments establish or re-establish and 'maintain relatively stable, reciprocal, and functional relationships with those environments' (Kim 2017: 4). Furthermore, Kim (2017: 8) reminds us that ' cross-cultural adaptation takes place through the communicative interface of an individual and a new and unfamiliar cultural environment in which the individual needs to carry out his or her daily functions'. This process takes time and involves learning new cultural patterns and practices while possibly losing some of their previous cultural habits. Therefore, the SLT, as a healthcare professional, when working with CaLD clients has a role in supporting clients to navigate the healthcare system.

Examples of CaLD clinical scenarios from a needs-based perspective

Irina: *Irina is a 77-year-old Polish grandmother who came to Ireland to live with her daughter, son-in-law, and 2 grandchildren. She does not speak English and recently had a stroke.*
Olena: *Olena is a 10-year-old child who came from Ukraine 6 months ago and attends a Gaelscoil. This is her first time being exposed to English and Irish and the school has an Irish language immersion policy.*
Maya: *Maya is a 5-year-old girl who is being raised speaking Irish, Spanish, and English. Maya recently started stammering and her parents reported concerns that she is exposed to too many languages and they should reduce the amount of language exposure for Maya to help her 'catch up' with her peers.*
Ria: *Ria is a 68-year-old right-handed woman who had a left-sided frontoparietal stroke 1 month ago. Prior to stroke she used English and (Venezuelan) Spanish. She generally used both languages at home and English at work as a cafeteria manager. She wrote, read, and watched TV mostly in Spanish. Ria demonstrated features of Broca's aphasia in both languages characterised by agrammatism and naming problems while comprehension was a relative strength.*
Muhammad: *Muhammad is a 55-year-old Muslim man with Parkinson's disease, who has been referred by his GP due to difficulty swallowing. He speaks English proficiently.*

6.0 Working with Interpreters

In theory, key to maximising health equity is timely access to health services via trained health interpreters and accessible, translated health information materials in line with language and literacy needs (HSE Social Inclusion Office, 2018; MacFarlane, 2018; MacFarlane et al., 2012). However, clinical reality is complicated by the fact that to date, there are no regulations or legislation for the interpreting industry. In addition, there are no accreditations, standards or qualifications meaning that the quality and range of services can vary greatly (HSE Social Inclusion Unit, 2009). Interpreters may be employed to work with many languages, and finding competent interpreters for less commonly spoken languages can be very difficult. According to O'Connor et al. (2017), there are clear shortcomings in the current interpreter services, in particular, a lack of quality control, poor access, and rigor in practice. Therefore, there is an urgent need to professionalise and monitor the quality of health interpreting services in Ireland. This is pressing given the use of untrained interpreters or proxies where there is a lack of service availability (Immigrant Council of Ireland, 2017).

Interpreters may not share the same dialect as the client, and an interpreter who is not as proficient in the language of interest will not be as accurate at spotting where the client's language is differing from the expected norm. Furthermore, sharing a language does not mean sharing a common culture and SLTs need to be sensitive to the possibility that depending on the situation, the client and the interpreter may come from opposite sides of an ethnic or cultural divide or conflict (Wright, 2024). Roger and Code (2011) observed misinterpretations both when the interpreters interpreted the test items to the adults with acquired communication impairments and when the interpreter interpreted the adults' responses back to the SLTs. Huang, Siyambalapitiya, and Cornwell, (2019) report the following challenges in their systematic review of the literature on SLTs and interpreters working together with adults with acquired communication impairments:

- Uncertainty regarding the accuracy of interpretation
- Unclear role expectations
- Poor access to interpreters
- Lack of time
- Participants talking over one another

A lack of access to trained interpreters was echoed in a recent (unpublished) survey of 80 SLTs working in a range of health and education settings across Ireland. While 88% worked with professional / trained interpreters, 86% additionally worked with proxies and/or people who are not professional interpreters. This included parents and other family members but also children under 18 years (20%). In addition to service availability challenges, respondents also perceived barriers to working effectively with interpreters given the additional training requirement necessary when language is the therapeutic target and not merely the modality of care. These barriers included insufficient time to deliver SLT-specific training, a lack of continuity of interpreters from session to session, a lack of access to interpreters in all languages, and family reluctance to avail of interpreters.

Family members, friends, carers, or untrained volunteers must not be deployed as interpreters under any circumstances (Scharff-Rethfeld et al., 2020; National Council on Interpreting in Health Care, 2011; HSE, 2009). SLTs should ensure that professional interpreters are involved in all aspects of assessment: providing advice, assessment, intervention, and multi-disciplinary meetings and any decision-making in partnership with the client and family (RCSLT, 2024). Suggestions for dealing with the challenges outlined above include administering the test with the interpreter to ascertain if they understand the instructions, have same gender interpreters, and sourcing community volunteers as collaborators in developing culturally responsive ways of assessing and working with people who have feeding, eating, drinking, and swallowing impairments (Wright, 2024).

It is necessary for the SLT and the interpreter to allow time in a formal and informal way to plan before and debrief after clinical sessions. Key issues that should be agreed upon could include the goals of the SLT session and the need for confidentiality and impartiality. A written contract including a confidentiality agreement is recommended. The interpreter's role is to function as a voice to explain, to repeat the questions and responses of the SLT and the client without giving additional information or paraphrasing (Kohnert et al., 2021). There is some debate regarding the neutrality of the interpreter and the role of the interpreter as advocate (Bankcroft, 2005; Ozolins, 2014; Aguilar-Solano, 2015).

Langdon's (2015) Briefing-Interaction-Debrief (BID) model is recommended to structure sessions with professional interpreters:

6.1 Briefing-Interaction-Debrief (Langdon, 2015)

- *Briefing:*

The SLT and the professional interpreter review the client's background information and outline the purpose of the conference, interview, or assessment.

The SLT arranges seating so that the client can see everyone's face (e.g. sitting in a triangle with the interpreter to one side of the clinician). Furthermore, Huang, Siyambalapitiya, and Cornwell (2019:699) identified additional content covered in the Briefing phase:

- How to facilitate good communication with people with communication disorders
- What errors the interpreter should look for
- The need to avoid asking the patient clarifying questions in the course of the assessment, and to alert the SLT when responses are unclear rather than repairing them in the process of interpreting

- *Interaction:*

The SLT and the professional interpreter should work as a team. All members should address the client and family directly. The SLT should always be present even if an interpreter has been trained in using specific assessment instruments. Monitoring the professional interpreter's administration of a given task and the client's reactions

is the responsibility of the SLT. In all cases, the interpreter should remain neutral and act as a bridge between the SLT and the client.

- *Debriefing:*

At the end of a session, the interpreter and the SLT should review the process, discussing both what went well, and any challenges or areas for improvement.

The RCSLT website also contains useful documents for SLTs working with professional interpreters in-person and on-line. According to the RCSLT (2021), in order to achieve equitable clinical outcomes, SLTs working with multilingual families should have at least double the time compared to when working with a family where they share the language. According to Pert (2023), to fail to provide this is an instance of institutional racism.

According to Pert (2023:112), "if the SLT has a near native level of proficiency, then they need not work alongside an interpreter for that particular language community. It is the professional responsibility of each SLT or professional to judge her ability to work effectively in that language". Pert (2023) suggests that if the bilingual SLT is confident working in the language in question, they should proceed to work with the client and/or family in that language. A bilingual SLT whose languages are not those of the client will still need to work alongside an interpreter when working with families from other language communities (Stanford et al., 2024).

7.0 From Referral to Intervention

It is imperative for SLTs to remember that using multiple languages does not cause or exacerbate speech, language, or communication difficulties. In relation to speech language and communication interventions, SLTs have an obligation to support all of a person's language needs (both present and future) in all of their languages and should never advise people to discontinue using one of their languages. CaLD people need all of their languages to participate fully in all areas of their lives. Uninformed advice to stop using a language can be considered a form of language-related discrimination (De Houwer, 2022). This does not mean that services are to be provided in all of a client's languages. It is more an issue of including the languages

in goal setting for speech and language, and communication interventions in particular.

7.1 Referral

SLTs have a key role in the education of others about responsible and appropriate referral. CaLD individuals are at risk of under- and over-referral to services (McLeod et al., 2017). SLTs have a role to play in creating awareness of when to refer to SLT for assessment and while there is a lack of guidance on how specifically to do this, Winter (1999) makes a case for erring on the side of over-representation at referral stage to reduce the risk of clients missing out on necessary services.

At the point of referral to SLT services, the following information should be considered:

- What language/s are spoken at home and in the community? What domains are each language used in?
- Does the person have identifiable stronger/preferred language(s)?
- Is a professional interpreter required?
- What is the history of language exposure, input, and use?
- What are current and future language needs?
- What is the nature of the communication difficulty? Are all languages affected?
- What is the individual's cultural background?
- What is the person's previous and current engagement in health services and education as appropriate to the scenario

According to Scharff-Rethfeld et al. (2020:3), interviews with the family and/or the individual themselves should determine 'the individual's experience in each language, such as the age of acquisition and the level of proficiency that has been achieved in each language'. The use of comprehensive language background questionnaires is recommended in order to establish a full picture of a person's language exposure, experience, and ability. These questionnaires will also allow

collection of information pertaining to the individual's exposure to languages as well as the context and communicative partners for which the individual needs their languages. It is also important to identify the frequency with which each language is spoken and the age of initial exposure to each language. Certain language questionnaires are available to use with multilingual people including but not limited to:

- **Quantifying Bilingual Experience Questionnaire** (Q-BEx) (DeCat et al., 2022). Child-focused and available on-line.
- **Questionnaire for Parents of Bilingual Children** (PaBiQ) (Tuller, 2015). Infant and toddler version available from Dr Ciara O Toole.
- **Alberta Language Development Questionnaire** (ALDeQ) (Paradis, Emmerzael, & Duncan, 2010). Appropriate for use with children acquiring English as an additional language who are aged 4.5 to 7.5 years, with between 4 months to 40 months of exposure to English as a second language.
- **Alberta Language Environment Questionnaire** (ALEQ-4) (Paradis, Soto-Corominas, Chen, & Gottardo, 2020). Available for children acquiring English as an additional language. There are different versions for children of different ages available at the CHESL website.
- **Language Experience and Proficiency Questionnaire** (LEAP-Q) (Marian, Blumenfeld, & Kaushanskaya, 2007). Suitable for people aged 14-80 and available in over 20 languages and can be administered in a digital, paper-and-pencil, and oral interview format (Kaushanskaya, Blumenfeld, & Marian, 2019).

Prior to beginning a speech and language assessment, the SLT should accurately identify the language(s) of the home and book a professional interpreter accordingly (i.e. one for each language).

7.2 Assessment: Giving Meaning to Measures

The process of speech and language assessment is a complex one comprised of four general inter-related purposes:

1) Identification of speech, language, communication, or FEDS issues
2) Description of the person's communicative systems which can include the nature and severity of the issues in addition to influencing factors
3) Planning of a course of action and prediction of the outcomes of this course of action
4) Evaluation of the effects of the course of action over time (Kohnert et al., 2021)

There is no one-size-fits-all approach and each scenario needs to be approached on a case-by-case basis as heterogeneity is a key feature of being multilingual. Assessment should be carried out in all of the languages that the individual uses in their everyday life and that they need for full participation in their communities. Clinical decisions should only be made once all languages have been assessed. This is due to the fact that difficulties will occur in all the languages an individual speaks (Nayeb et al., 2021). Gathering information related to the person's demographics, their language exposure and opportunities for use of their languages as part of pre-assessment information-gathering is paramount to provide evidence-based diagnosis and case management decisions. Direct assessment of each of the languages an individual speaks is not often possible for a variety of reasons (Thordardottir & Topbas, 2019). Therefore, SLTs are required to implement a combination of direct and indirect assessment approaches.

SLTs can use one or more frameworks to structure their assessment process. Adopting a **socio-cultural approach**, based on the assumption that a person's language use is 'inseparable from the influence of their social and cultural environments' (De Lamo White & Jin, 2011: 621) has long been recommended and a converging evidence approach using multiple measures is considered best practice (Buac & Jarzynski, 2022). Such measures include ethnographic interviewing, dynamic assessment, language processing measures such as non-word and sentence repetition, and narrative approaches such as the *Multilingual Assessment Instrument for Narratives, MAIN* (Gagarina et al., 2019).

Bronfenbrenner's Ecological Model which 'explains how human development and behavior are influenced by a set of interactions between system structures, such as family, cultural, socioeconomic, political, and psychological domains, which ultimately shape our behaviour, life decisions, and wellness over a lifetime is also useful' (Backonja, Hall, & Thielke, 2014: 46).

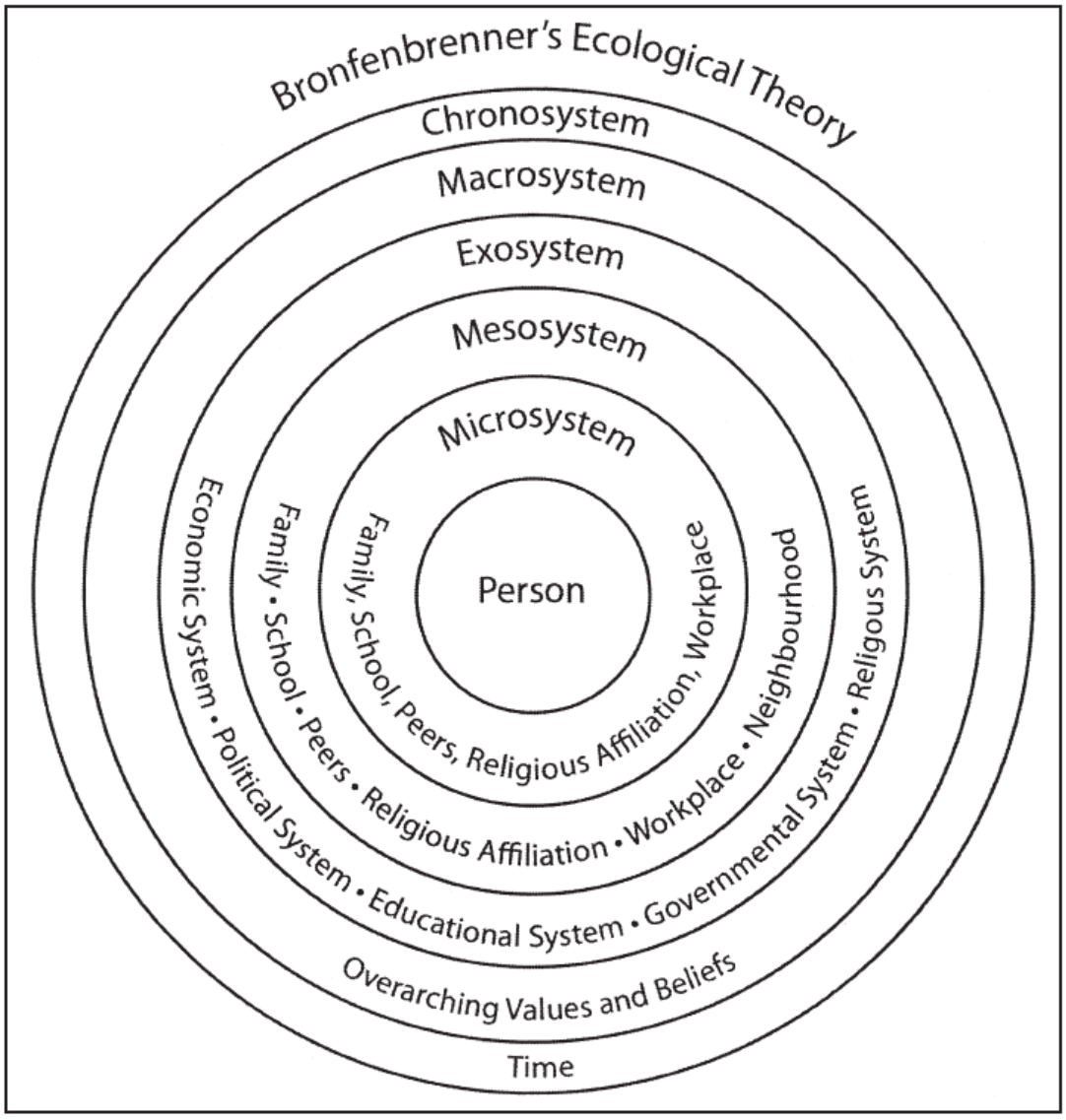

Figure 1: An adapted illustrated model of a Bronfenbrenner's Ecological Theory (Adapted from Berger, 2007)

According to De Lamo White and Jin (2011:622), 'the rationale for using a sociocultural approach is that by collecting data and viewing it through the perspective of the target culture, the clinician is able to make a less biased and more

valid interpretation of findings: thus the clinician is less likely to draw conclusions which lead to misdiagnosis.'

The World Health (2001) International Classification of Functioning, Disability, and Health (ICF) (2001) and International Classification of Functioning, DIsability and Health-Children and Youth version (WHO, 2007) were developed in order to describe how people live with their health conditions (Kohnert et al, 2021). SLTs can use the five components of Body Functions, Body Structures, Activities & Participation, Environmental Factors, and Personal Factors to structure a holistic approach to assessment (Kohnert et al., 2021).

7.3 Standardised Testing

Standardised tests are developed with data that has been collected from monolingual typically-developing English speaking individuals in the majority of cases. Using this data to compare a CaLD individual's language performance to that of their monolingual peers is unfair, biased and unethical. We recommend that standardised tests are not used with multilingual people for assessment. The use of standardized tests and thus the use of material developed with a monolingual mindset and/or applying normative data that has been developed with monolingual individuals is questionable as it will increase construct, method, and item bias and subsequently the risk of misdiagnoses (Scharf Rethfeldt et al., 2020). Centeno et al. (2017) recommend adapted versions of available tests in conjunction with a professional, trained interpreter. As bilingual/multilingual people are a tremendously heterogeneous population, the development of multilingual norms may not be possible. Furthermore, Scharf-Rethfeld et al, (2020: 7), remind us that SLTs '*must be aware of syntactic, morphological, phonetic, phonological, socio-pragmatic, and semantic differences across languages when assessing bilingual or multilingual speakers*'. Informing ourselves about these differences is a key component of culturally responsive practices in SLT. Recommended resources are available here.

Due to the lack of applicable norms, informal assessment is often the only available option. One approach is to use standardised test material in an informal way (Scharf-Rethfeld et al., 2020). In this approach, the examiner administers the stimulus items from a test without using the scores required to determine an overall score that is required by the test. When this mode of testing is used, it is important to employ item analysis to determine which items on the test present difficulty. Furthermore, SLTs need to appreciate that there are cultural differences in test-taking experiences as not everyone will have such experience. SLTs will need to take this into account, for example, 'explanations may need to be provided, practice items and stimuli may need to be repeated, and test items reworded' (Scharf-Rethfeld et al., 2020: 10).

7.4 Translating Test

It is not recommended to translate tests as the differences in the normative populations used in the original standardisation sample, differences in the levels of linguistic difficulty and order of acquisition across languages, and differences in syntax, morphology, phonology, semantics, and pragmatics across languages mean that translating tests is not a viable option (Centeno et al., (2017); Pert and Letts, (2001)).

7.5 Guidelines for Assessment

Assessment should aim to establish an individual's strengths and weaknesses across their languages whilst considering all language domains. SLTs should be cognisant that individuals can have varying levels of performance in a particular language, depending on the domain in which they use this language. For example, a Polish-English bilingual child may have better skills in reading and writing in English than Polish where English is the language of education and the context and language through which the child is learning these skills. It is extremely rare to have balanced bilingual individuals with equally strong language competence, in two or more languages, across domains (Grosjean, 2013).

Examples of CaLD clinical scenarios from a needs-based perspective: focus on assessment

***Irina**: Irina's daughter speaks fluent English. The SLT explains that it is best practice to employ an interpreter rather than a family member and books an interpreter from the interpreting company contracted by their hospital. The SLT informs the interpreter about aphasia post-stroke and together they look over subtests of the Polish version of the Bilingual Aphasia Test (BAT) (Paradis, 1987) in preparation for its administration.*
***Olena**: The SLT asks Olena's parents about her language development in Ukrainian prior to arriving in Ireland. Through a trained interpreter, the SLT elicits a language sample from Olena based on a narrative production from a wordless picture book. The interpreter also helps her to assess Olena's single word comprehension in Ukranian from a picture-point task and some basic instructions from an act-out task. The SLT also tries similar comprehension and expression tasks in English and checks Olena's comprehension of school-related vocabulary and basic instructions in Irish. The SLT then completes a comprehensive language background and exposure questionnaire to establish past and present language exposure with support from an interpreter. With parental permission, she contacts Olena's teachers to determine how she is functioning at school. The SLT also explores Olena's perspective via the SPAA-C (McLeod, 2004) and/or the Sound Effects study protocol (McCormack et al., 2021) which involves drawing, with the assistance of the interpreter.*
***Maya**: The SLT asks Maya's parents about her language development and proficiency in all the languages she is exposed to and that she speaks. The SLT also uses a detailed background history interview to elicit information about the age when Maya started stuttering (stuttering onset) and the frequency and characteristics of her stutter in each language. The SLT explores information on risk factors (including a family history of stammering, temperament, environment, and speech/language skills). The questionnaire*

asks about Maya's awareness of stammering and the situations where she and her parents notice her stutter. The SLT also asks about how much the stuttering appears to be impacting on Maya's day-to-day activities. As the SLT speaks both English and Irish, and is skilled in working through both of these languages, they obtain a narrative language sample from Maya by showing her ***wordless picture books*** *in Irish and English. The SLT also requests the skills of a trained interpreter to support the SLT's assessment of Maya's language skills for Spanish, again using a series of information carrying words in both English, Irish, and Spanish. The SLT advises Maya's family to keep a diary of her communication for two weeks to determine any environmental factors that may also be relevant to Maya's stammer. The SLT can also* ***use the questionnaires to evaluate the family's cultural beliefs*** *towards stuttering and how this may also influence treatment approaches and outcomes (Shenker, 2013). The SLT may emphasise that it is typical for children aged between 2 and 5 years of age to stutter occasionally and allowances should be made for this.*
Ria: *The SLT obtained an informal conversation sample (in Spanish and English), asking Ria about her work prior to the stroke. The Boston Diagnostic Evaluation of Aphasia (BDAE) Spanish and English versions were administered (Goodglass, Kaplan & Barresi, 2001) . Because the BDAE norms for Venezuelan Spanish speakers were not available in the literature, the scores were reported in percentages. This allowed the therapist to build a profile of language abilities across different communication modalities and languages. Comprehension test scores were higher than expressive ones. Spanish scores were somewhat better than English. Overall, Ria showed a parallel recovery pattern with naming problems and agrammatic utterances in both languages as well as typical bilingual discourse features such as code-switching and mixing.*
Muhammad: *The SLT takes time to research the cultural norms in relation to Ramadan and fasting in order to arrange an appointment at a suitable time. Where questions remained in relation to guidelines regarding fasting and*

illness the SLT then consulted with the local mosque where the imam advised that illness is a valid exemption from fasting. The SLT phones Muhammad to explain that an assessment of his swallow will entail trialling food and drink, and to ask if he is happy to proceed with the appointment, or would prefer to defer it until after Eid al-Fitr. The SLT also checks with Muhammad to ensure that the items included in the assessment are in accordance with Islamic dietary laws. They also consult the RCSLT's recent guidance for SLTs on navigating Ramadan which is available via the RCSLT website.

8.0 Intervention

According to Kohnert et al., (2021: 293), ' Assessment and intervention are not discrete processes and are not necessarily taken in a unidirectional or sequential manner. Often the transition from assessment to intervention is seamless, occurring in the same session with no clear boundaries between the activities'. Furthermore, Kohnert et al. (2021:189) define intervention as 'planned action intended to produce positive effects or favourably alter the course of disorder or condition'. It is this broad strokes perspective on intervention that we have adopted in this document. We recommend a holistic approach emphasizing socio-cultural contexts of language use, quality of life, activities and participation. Kohnert el al. (2021) present suggested clinical action plans combining multiple strategies as outlined in Table 1 below:

Table 1 Suggested Clinical Action Plans (Kohnert et al., 2021)

Professional Actions (A)	Partners in Therapy (B)	Target Areas (C)
Advocate	Teachers	Home language(s)
Teach, instruct, train	Client	Language(s) of education
Consult	Parents, extended family	Intersection of two/more languages
Inform	Educators	Environment

When working with multilingual individuals, the SLT's goal is to promote enhanced language abilities in all languages spoken. Future language needs must also be taken into consideration and addressed in intervention (Kohnert et al., 2021). In the case of children who are monolingual speakers of a language other than English, or whose English language proficiency is very limited, the SLT needs to not only assess the child's development in his or her first language, but also consider parental attitudes towards the home language(s) and explain the need for its maintenance. Parents need to be made aware that working in the child's home language is to the child's benefit, both in terms of their linguistic and socio-emotional development, even if it is not the language of education. Parents should be encouraged and supported to continue using the home language with their child and initial intervention should focus exclusively on developing skills in the home language(s) (Kohnert, et al., 2021).

When working with adults, the goal is to facilitate functional language skills within the linguistic environments in which they participate. Treatment must respond to

premorbid cultural and linguistic experiences and support routine and personally-meaningful language practices and life participation (Centeno et al 2017). Providing intervention in all languages is recommended. Encouraging language switching may encourage recovery that is in line with premorbid language usage whilst providing a compensatory strategy when experiencing difficulty (Centeno et al 2017).

Examples of CaLD clinical scenarios from a needs-based perspective : focus on intervention

Irina: *Having established that Irina can understand single written words in Polish, the SLT prints the Emergency Multilingual Aid (HSE.) for her. Irina is presenting with apraxia. The SLT and Irina's daughter choose a number of family names and short functional words in Polish as stimuli for apraxia drills.*
Olena: *The SLT determines that Olena has a speech sound disorder but that her language skills seem to be age appropriate . As the errors are articulatory in nature, they know that it is likely that any intervention in English or Irish could transfer to Ukrainian. Nonetheless, the SLT ensures that the speech targets feature in target words across all three languages with assistance from the interpreter, parents, and teachers.*
Maya: *The SLT provides multilingual advice sheets on stammering for Maya's parents, class teacher, and peers to support Maya's communication at school and in the home. The SLT adopts a watchful waiting or watch and see approach and will take additional clinical actions as appropriate.*
Ria: *One-month post-stroke, Ria saw a Spanish-English bilingual SLT twice weekly, in her home, for three months. The SLT discussed diagnostic profile, therapy plan, and developed goals collaboratively with Ria and her family. The intervention targeted both Spanish and English naming and simple utterance construction. Language targets were functionally relevant to Ria's interests, home, work, and family life. Throughout all activities, Ria was encouraged to switch between languages as needed. This maximised ecological validity of the therapy in that it supported Ria's*

premorbid pattern of typical bilingual discourse and code-switching. It additionally provided Ria with a compensatory strategy to maximise communication success. Finally, by incorporating this dual-language strategy, the potential for cross-linguistic facilitation (or reinforcement across the bilingual language system) and gains in cognitive-linguistic strategies like attention and control, is maximised. The SLT additionally worked on supported communication techniques with Ria's family, and included family members as interlocutors in the therapy sessions. At the end of this three month period, Ria demonstrated clear improvement in both languages. She continued to rely more on Spanish, consistent with her premorbid language patterns. Longer-term gains were not examined.
Muhammad: *The SLT asks Muhammad and his wife about his typical dietary intake. The SLT is unfamiliar with some of the foods mentioned and asks Mohammed and his wife to bring these in at his follow-up appointment to ascertain their consistency. The SLT then uses photos of these items mapped to the IDDSI levels to formulate a personalised swallow care plan for Muhammad.*

9.0 Conclusion and Recommendations

This document aimed to present overarching principles for SLTs working with culturally and linguistically diverse people. Foundational concepts were defined and an overview of culturally responsive practices from referral to intervention presented. For future iterations, we recommend consultation with a wider range of stakeholders including CaLD people who attend SLT services in a range of settings. We wish to emphasise that Verdon, McLeod, and Wong (2015) advocate for sufficient time to be made available to SLTs so that they can adopt the recommended strategies for following best practice when working with culturally and linguistically diverse individuals and their families. They also found a contradiction between the rules and policies that controlled practice and best practice principles in some contexts. SLTs and managers need to be activists for initiating and implementing changes to organizational rules to be allowed more time and resources for working with CaLD individuals and their families (Verdon et al., 2015). SLTs will need to continually refresh their knowledge and skills and engage in

consistent, continued professional development in relation to culturally responsive practice. This need for continued professional development will require support from management of organisations providing SLT in order to ensure that services are accessible and equitable for CaLD individuals and that SLTs are fully resourced in order to deliver culturally responsive practice consistently for all.

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