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Speech-language pathologists’ assessment and intervention practices with multilingual children

Corinne J. Williams¹,² and Sharynne McLeod³

¹Curtin University of Technology, Perth, Australia
²Curtin Health Innovation Research Institute, Perth, Australia
³Charles Sturt University, Bathurst, Australia

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Correspondence:
Cori Williams, School of Psychology and Speech Pathology, Curtin University of Technology,
GPO Box U1987 Perth Western Australia 6845, Australia. Tel: +61-8-9266-7865. Email: c.j.williams@curtin.edu.au.

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ABSTRACT

Within predominantly English-speaking countries such as the US, UK, Canada, New Zealand and Australia, there are a significant number of people who speak languages other than English. This study aimed to examine Australian speech-language pathologists’ (SLPs) perspectives and experiences of multilingualism, including their assessment and intervention practices, and service delivery methods when working with children who speak languages other than English. A questionnaire was completed by 128 SLPs who attended an SLP seminar about cultural and linguistic diversity. Approximately one half of the SLPs (48.4%) reported that they had at least minimal competence in a language(s) other than English; but only 12 (9.4%) reported that they were proficient in another language. The SLPs spoke a total of 28 languages other than English, the most common being French, Italian, German, Spanish, Mandarin and Auslan (Australian sign language). Participants reported that they had, in the past 12 months, worked with a mean of 59.2 (range 1 – 100) children from multilingual backgrounds. These children were reported to speak between 2 and 5 languages each; the most common being: Vietnamese, Arabic, Cantonese, Mandarin, Australian Indigenous languages, Tagalog, Greek and other Chinese languages. There was limited overlap between the languages spoken by the SLPs and the children on the SLPs’ caseloads. Many of the SLPs assessed children’s speech (50.5%) and/or language (34.2%) without assistance from others (including interpreters). English was the primary language used during assessments and intervention. The majority of SLPs always used informal speech (76.7%) and language (78.2%) assessments and if standardised tests were used, typically they were in English. The SLPs sought additional information about the children’s languages and cultural backgrounds, but indicated that they had limited resources to discriminate between speech and language difference versus disorder.
As mobility between countries continues to grow, speech-language pathologists (SLPs) in many areas of the world are faced with the need to provide services to increasing numbers of multilingual1 people (Caesar & Kohler, 2007; De Lamo White & Jin, 2011; Girolametto & Cleave, 2010; Gupta & Chandler, 1993; Kohnert, Windsor, & Ebert, 2009; Kritikos, 2003; Stow & Dodd, 2005; Winter, 2001). The need to provide appropriate speech-language pathology services to multilingual clients is recognised by professional bodies in such countries as Australia (Speech Pathology Australia, 2009), the United States (American Speech-Language-Hearing Association, 2004), Canada (Crago & Westernoff, 1997) and Great Britain (Royal College of Speech and Language Therapists, 2005, 2006). However, the challenges of providing culturally sound speech-language pathology services to multilingual people have been documented for more than 30 years (Kohnert & Medina, 2009). One challenge lies in the recognised shortage of multilingual SLPs (Jordaan, 2008), with additional challenges including the provision of appropriate assessment, identification, and intervention for multilingual people.

Identifying speech and language disorder in children learning two (or more) languages is difficult (De Lamo White & Jin, 2011; Hambly, Wren, McLeod & Roulstone, 2011; Restrepo & Kruth, 2000), with the result that multilingual children may either be over- or under-represented in speech-language pathology caseloads (Bedore & Peña, 2008; Winter, 2001). The task is complicated by the fact that the characteristics of a child’s first language may transfer to the second language. In cases where the child’s second language is the dominant language of the community, and is also the language of the speech-language pathologist, such differences may be misinterpreted

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1 Throughout this paper, the term multilingualism includes the term bilingualism and is broadly defined as follows: “a person who is multilingual is able to comprehend or produce two or more languages in oral, manual, or written form regardless of the level of proficiency or use and the age at which the languages were learned” (Grech & McLeod, 2012, p. 121).
as disorder (Girolametto & Cleave, 2010). However, speech and language disorder will not present in one language only (Gutiérrez-Clellan & Simon-Cereijido, 2009). This being the case, assessment in both (or all) of the child’s languages is recommended (Kohnert, 2010). There are few resources for the assessment of languages other than English available to speech-language pathologists in English-speaking countries (Bedore & Peña, 2008). However, speech and language assessments do exist in many countries that speak languages other than English (e.g., Dollaghan & Horner, 2010) (see the appendix of McLeod, 2011b for a list of 59 monolingual and 5 multilingual speech assessments). Even if these assessments are sourced within English-speaking countries, typically they are normed on monolingual speakers in the countries of origin, and the stimuli and norms may not be suitable for multilingual children in the English-speaking country of the SLP.

It is recognised that multilingual speech and language acquisition is not the same as monolingual speech and language acquisition (Elin Thordardottir, Rothenberg, Rivard, & Naves, 2006). It has been suggested that intervention for multilingual children should address speech and language development in both languages (Elin Thordardottir, 2010; Gildersleeve-Neumann & Goldstein, 2011; Gutiérrez-Clellen, 2001; Kohnert, 2008). In an international survey of 99 SLPs Jordaan (2008) investigated aspects of the intervention provided to 157 bilingual children. She reported that the majority of SLPs surveyed provided intervention in one language only, the language in which they were fluent. Alternative methods of supporting development in both languages are recommended when the clinician is monolingual (Kohnert, 2008). This may include the use of collaborative strategies to address the minority language, strategies which promote language development in general, or strategies which lead to generalisation and transfer across languages.

The Need for Multilingual SLP Services in English-Dominant Countries

In many English-dominant countries, a significant proportion of people speak a language other than English. For example, in England, 16.0% of primary school pupils, 11.6% of secondary school pupils and 10.9% of special school pupils were known or believed to speak English as an
additional language (Department for Education, 2010). In the US, 19.7% of the population speak one or more of 318 languages other than English; however, the majority of these (62.3%) speak Spanish (Shin & Kominski, 2010). This has led SLPs in the US to primarily focus on Spanish-English children when designing research and resources for multilingual children (e.g., Bedore, Peña, Gillam, & Ho, 2010; Brice, Carson, & Dennis O’Brien, 2009; Goldstein, 2004; Yavaş & Someillan, 2005). In Australia, while 21.5% of the population speak at least one language other than English at home (Australian Bureau of Statistics; ABS, 2006, 2010), the number of speakers of each of the 400+ languages is relatively small. The most common languages other than English spoken by Australians are: Italian (7.4% of those who speak a language other than English at home), Greek (5.9%), Cantonese (5.7%), Arabic (5.7%), Mandarin (5.2%), Vietnamese (4.6%), Spanish (2.3%), German (1.8%), Hindi (1.6%), and Macedonian (1.6%) (ABS, 2006), reflecting the diverse cultures and countries of origin of the people of Australia. In addition, the most common languages other than English spoken by Australian children differs from those spoken by the general population. For example, McLeod (2011a) examined data from 4,983 4- to 5-year-old children in the Longitudinal Study of Australian Children. This sample was recruited via the national Medicare database, the most comprehensive database of Australia’s population in order to be representative of the Australian population for 4- to 5-year-old children. McLeod (2011a) reported that of the 12.2% who spoke a language other than English, the most common first languages were: Arabic, Cantonese, Vietnamese, Greek, and Mandarin. Italian was the most common second language after English, reflecting the fact that Italian was the most commonly spoken language other than English in the general population (ABS, 2006). In many cases, multilingual children in Australia may be sequential language learners, since they speak one or more languages in the home, and learn English when they begin their education (whether in prior-to-school or school settings). As such, these children have varying degrees of competence in each (or all) of their languages. Whilst some children learning more than one language will have a true
speech and/or language disorder, this is not caused or exacerbated by multilingualism (Kohnert, 2008; Elin Thordardottir, Ellis Weismer, & Smith, 1997).

The challenges of working with multilingual children for Australian speech-language pathologists are magnified by the demographic and geographical characteristics of the country. While English is the official language, spoken in government, business and education settings, Australia is a highly diverse society. Many of the 400+ languages spoken in Australia (including a number of Indigenous languages) are spoken by relatively small numbers of people (ABS, 2010, Table 1). For example, McLeod (2011a) reported that after English, the main languages spoken by children in New South Wales were Arabic and Cantonese, whereas Samoan and Vietnamese were the main languages spoken in the neighbouring state of Queensland. The majority of the population is concentrated in large urban centres, but the distance between these major centres is considerable. Immigrant resettlement schemes that aim to attract migrants to rural and regional areas (Hugo, 2004) mean that there are also multilingual children within many rural and regional centres. In addition, multilingual children are found in the far north and centre of the country, where Indigenous Australian communities continue to use their traditional languages alongside Australian English (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2005).

The 2001 Speech Pathology Australia (SPA) membership survey documented that 30.7% of SLPs spoke a language other than English; however, there was a “weak correlation between the languages spoken by speech pathologists who responded to the survey and those most commonly spoken within the Australian community” (Speech Pathology Australia, 2001, p. 10). For example, signed English was the most commonly reported language other than English, yet this is used by few members of the Australian population (ABS, 2006). After signing, the most common languages spoken by Australian SLPs were French, German, Italian, Afrikaans, Cantonese, Mandarin, Greek, Hebrew and Spanish. The majority (79.7%) of SLPs were born in Australia, with the next most common countries of origin being UK, then South Africa (Speech Pathology Australia, 2001).
This paper reports a survey of the knowledge and practices of SLPs working with multilingual children in Australia in 2010, a decade after the 2001 SPA membership survey. It provides Australian data to supplement the findings of an international survey of SLPs working with multilingual children conducted by the International Association of Logopedics and Phoniatrics (IALP) and reported by Jordaan (2008).

The current study aims to examine Australian speech-language pathologists’ (SLPs) perspectives and experiences of multilingualism, including their assessment and intervention practices, and service delivery methods when working with children who speak languages other than English. Specifically it aims to determine:

1. SLPs’ proficiency in and knowledge of languages other than English.
2. SLPs’ beliefs about multilingualism and SLP professional education and practice.
3. SLPs’ typical professional practice with all multilingual children on their caseloads, including: speech and language assessment and intervention, service delivery, and working with families from multilingual backgrounds.
4. SLPs’ actual practice when working with the last 3 multilingual children on their caseloads, including: assessment, intervention, use of interpreters, advice and attitudes about multilingualism.
5. Similarities and differences between SLPs’ ways of working with children from multilingual backgrounds in Australia compared with SLP practices in other countries as reported by Jordaan (2008).

METHOD

Participants

The participants were 128 speech-language pathologists from each state and territory in Australia. There were 125 (97.7\%\textsuperscript{2}) females. The largest proportion had been practising as an SLP

\textsuperscript{2} Throughout the manuscript the percentages relate to the valid percent for each question. In some questions, if respondents could indicate more than one answer, then only the number of respondents for each option is indicated.
for more than 10 years (n = 54, 42.5%). Of the remainder, seven (5.5%) had been practising for less
than one year, 24 (18.9%) between 1 and 3 years, 24 (18.9%) between 4 and 6 years, and 13
(10.2%) between 7 and 10 years (n = 13, 10.2%). Five (3.9%) were students. The majority had
undertaken their SLP professional preparation in Australia, while 11 (8.6%) were trained overseas
including USA, UK, New Zealand, and Belgium. One hundred and eighteen (92.2%) worked with
multilingual children.

The majority of the participants worked full time (n = 87, 73.7%). The participants worked
in the following settings (some worked in more than one setting): education (n = 43), community
health (n = 44), hospital (n = 9), private practice (n = 40), disability (n = 21), university (n = 4),
other (n = 7). Their main area/s of specialisation included: phonological delay/disorder (n = 63),
childhood apraxia of speech (n = 22) child language disorder (n = 75), fluency (n = 27), literacy (n
= 33), no specialty (n = 27), and other (n = 23) (including autism, feeding, disability, and AAC).

**Questionnaire**

Participants completed a four part questionnaire. The first part asked demographic
information about the SLPs. The second asked about SLPs’ beliefs regarding professional
preparation and practice for working with multilingual children and their families. In the third
section SLPs who worked with multilingual children (n = 118) described in general terms their
caseload characteristics and their assessment, intervention, and service delivery practices when
working with these children. The final section of the questionnaire asked the participants to describe
demographic information and actual practice for the last three multilingual children they had
worked with. The questionnaire was created by using and adapting questions from Jordaan (2008)
as well as a range of other sources: McLeod and Baker (2004), Watts Pappas, McLeod, McAllister
were provided with a range of possible responses (including *other*) from which to choose.
Qualitative responses were sought for certain questions (e.g., with regard to certain assessment and
intervention approaches) and following *other* responses.
Procedure

A total of 165 registrants attended a one-day Speech Pathology Australia National Tour workshop conducted by the first author and titled *Working with children from multilingual backgrounds*. These workshops were held in every state and territory in Australia during 2010. At the commencement of each workshop, participants were asked to complete the questionnaire. Distribution of the questionnaire was supported by Speech Pathology Australia, the national peak body for the profession, and ethical clearance was obtained from Curtin University. Participation was voluntary, and no identifying information was collected. Completed questionnaires were returned from 128 participants; thus, the response rate was 77.6% (128/165).

**RESULTS**

SLPs’ Proficiency in and Knowledge of Languages Other than English

Approximately one half of the participants (n = 62, 48.4% of 128) reported that they had at least minimal competence in a language other than English. Most of these (n = 38, 61.3% of 62) reported some competence in one additional language; however, some reported two (n = 17, 27.4%), three (n = 2, 3.2%), four (n = 2, 3.2%) and five (n = 3, 4.8%) additional languages. They spoke a total of 28 different languages, 17 of which were included in the most common languages spoken by the Australian population (see Table 1). The most common languages spoken were French (n = 19), Italian (n = 13), German (n = 9), Spanish (n = 9), Mandarin (n = 6) and Auslan (n = 6). Respondents were asked to rate their proficiency in each language other than English on a three point scale: minimal, functional, or proficient. Only twelve participants reported that they spoke a language other than English proficiently; five of these reported that they were proficient in more than one language other than English.

The majority of SLPs indicated that they would read a journal article/book chapter on working with children from culturally and linguistically diverse backgrounds every 6 months (n =...
56, 44.8%) or rarely (n = 41, 32.8%). Twenty (16%) reported that they read relevant content monthly, and eight (6.4%) weekly/fortnightly.

SLPs’ Beliefs about Multilingualism

The majority of respondents (60.3%) did not believe that SLPs should be fluent in more than one language (yes = 10 of 128, 7.8%, no = 76, 59.3%, unsure = 40, 31.3%, missing = 2, 1.6%). However, many commented that although being fluent in more than one language should not be compulsory, it would be beneficial. Fifty nine respondents (46.1%) believed that universities should actively recruit students who are fluent in more than one language (yes = 46.1%, no = 32, 25.0%, unsure = 37, 28.9%) and most (79.7%) indicated that students should be enabled to learn another language during their studies (yes =102, 79.7%, no = 6, 4.7%, unsure = 20, 15.6%). Asked whether their university training adequately prepared them for working with families from multilingual backgrounds, the majority (75.6%) replied in the negative (yes = 6, 4.9%, no = 93, 75.6%, unsure = 24, 19.5%).

The respondents were divided in their response to the questions of whether SLPs can provide assessment in a language in which they are not fluent (yes = 43, 33.9%, no = 55, 43.3%, unsure = 29, 22.8%), or intervention in a language in which they are not fluent (yes = 56, 44.1%, no = 42, 33.1%, unsure = 29, 22.8%). The participants were asked to explain their answer if they said “yes”. Their explanations included the ability to work through interpreters (e.g., professionally trained interpreters, parents, family members, English as a second language (ESL) teachers, Aboriginal education officers, or migrant resource workers), or through indirect models (e.g., carrying out intervention in English to provide a model for parents to implement in the child’s first language (L1)). The need for appropriate training of interpreters for supporting SLPs was mentioned by a number of respondents. Some indicated that SLPs can seek out knowledge of languages spoken by their clients, and use this together with their linguistic training in working with these clients.

Professional Practice with All Multilingual Children on SLPs’ Caseloads
The remainder of the results section of this paper is from SLPs who worked with children from multilingual backgrounds (n = 118). These SLPs indicated that they had worked with a mean of 59.2 (SD = 44.1, range = 1-100) multilingual children in the past year. There were a total of 65 different primary languages spoken by the children on their caseloads (see Table 1); 33 of these were included in the languages spoken by ≥0.1% of the Australian population. The most common primary languages spoken by the children on the respondents’ caseloads were: Vietnamese (n = 46), Arabic (n = 41), Cantonese (n = 24), Mandarin (n = 23), Australian Indigenous languages (n = 21), Tagalog (n = 15), Greek (n = 12), and other Chinese languages (n = 12) (see Table 1).

Insert Table 1 here

**Speech assessments with multilingual children**

Approximately half of the respondents indicated that they typically carry out the entire assessment of *speech* (articulation/phonology) skills of multilingual children by themselves (n = 55, 50.5%) and the other half did not (n = 54, 49.5%). Eleven had not assessed the speech skills of children from multilingual backgrounds. Those who did not conduct the entire assessment by themselves were typically assisted by: interpreters provided by their workplace (n = 36, 50.7%), children’s family members (n = 35, 49.3%), ESL teachers (n = 6, 8.5%), SLP colleagues (n = 2, 2.8%), and others (n = 10, 14.1%) (including school teachers, health workers, bilingual support workers, siblings, and classmates). Respondents reported that they sought information about the phonology of the children’s first language (n = 88, 86.3%), cultural knowledge (e.g., attitudes to disability, language socialisation) (n = 76, 74.5%) and other knowledge (n = 24, 23.8%) (including case history, child’s language experience, teacher and parents’ attitudes and knowledge, and information about phonological disorder in children’s first language).

The majority of respondents always (79, 76.7%) used informal procedures when assessing the *speech* of children from multilingual backgrounds (see Table 2) and typically used English-only standardised tests (always = 41, 41.4%, sometimes = 43, 43.4%). Most never (n = 62, 83.8%) used
standardised tests for children’s first languages, and few had used or developed local norms (infrequently = 17, 22.1%, never = 30, 39.0%).

Language assessments with multilingual children

The majority (n = 73, 65.8%) of respondents typically conducted the entire assessment of language skills of multilingual children with assistance from others. Three SLPs had not assessed the language skills of children from multilingual backgrounds. During language assessments, the SLPs were typically assisted by: interpreters provided by their workplace (n = 49, 56.3%), children’s family members (n = 44, 50.6%), ESL teachers (n = 18, 20.7%), SLP colleagues (n = 8, 9.2%), and others (n = 15, 17.2%) (including school teachers, psychologists, health workers, bilingual support workers, and members of the community). When assessing children’s language the SLPs indicated that they sought information about cultural knowledge (e.g., attitudes to disability, language socialisation) (n = 90, 88.2%), syntactic structure of the first language (n = 62, 60.8%), and other knowledge (n = 35, 34.7%) (including case history, child’s language experience, teacher and parents’ attitudes and knowledge, typical error patterns for the language).

The majority of SLPs always used (always = 86, 78.2%) informal procedures when assessing the language of children from multilingual backgrounds (see Table 2) and typically used (always = 35, 33.3%, usually = 51, 48.6%) English-only standardised tests. Most SLPs never used (never = 70, 88.6%) standardised tests for children’s first languages, and few had used or developed local norms (never = 44, 53.7%). Half of the SLPs used dynamic assessment (always = 18, 20.7%, usually = 31, 35.6%).

Service delivery practices for multilingual children

The typical methods of service delivery used with children from multilingual backgrounds are documented in Table 3. The most common intervention type was individual intervention (n = 103, 89.6%) followed by parent training (n = 87, 75.7%). Group therapy (n = 57, 49.6%) and provision of home programs (n = 55, 47.8%) were used by half of the participants. Intervention was typically
conducted in the clinic (n = 77, 67.0%) or at school/preschool (n = 72, 62.6%). The most common agents of intervention were the clinician (101, 87.8%) and parent/guardian (n = 94, 81.7%), followed by teachers (n = 64, 55.7%) and teachers’ aides (n = 51, 44.3%). Interestingly, interpreters (n = 34, 29.6%) and siblings (n = 29, 25.2%) were used as agents of intervention to a similar extent.

Insert Table 3 here

**Working with families from multilingual backgrounds**

A series of questions regarding working with families from multilingual backgrounds was asked. The respondents considered that the child (n = 22, 19.3%), the family (n = 63, 55.3%), or both (n = 29, 25.4%), were the client when conducting intervention with children from multilingual backgrounds. They indicated that their intervention goals focussed on the child (n = 41, 36.0%), the family (n = 42, 36.8%), or both (n = 31, 27.2%).

The majority of respondents (n = 76, 66.1%) felt that family involvement always affected the outcome of intervention. Less than half (n = 53, 46.1%) always had parents/ family members observing assessment sessions, and a quarter (n = 28, 24.3%) always had parents/ family members participating in assessment sessions. Similarly, less than half always had parents/ family members observing (n = 56, 49.1%) and participating (n = 49, 43.0%) in intervention sessions. A similar number (n = 49, 43.4%) always gave homework activities to parents/ other family members. Just over half indicated that they sometimes (n = 63, 55.3%) had difficulty involving multilingual families in intervention. Forty six (40.7%) reported that they were usually influenced by the family regarding how they were involved in intervention. The majority indicated that they usually (n = 41, 36.0%) or sometimes (n = 44, 38.6%) sought and used knowledge of relevant cultural attitudes to language learning. Forty (35.1%) reported that they sometimes sought and used knowledge of relevant cultural attitudes to child rearing (See Table 4).

Insert Table 4 here

SLPs were asked whether they agreed with the statement “a family-centred approach to early intervention asks SLPs to attend to families’ priorities for goals and services even if they do
not agree with them”. The majority (n = 91, 84.3%) agreed. Those who answered yes were asked to identify the challenges that this presented in working with children from multilingual backgrounds by providing an open response. The main theme of the responses was the challenges presented by cultural difference, and the impact this has on working with such families. For example, one respondent replied that a “different world view may result in beliefs and goals which are very different from mine. It can be difficult to reconcile these”. Respondents identified differences in cultural attitudes to disability and intervention, that extended to differences in expectations and understanding of the role of the SLP (e.g., the expectation that the SLP would make decisions regarding intervention rather than consult with parents “… some families want ‘you’ as the professional to fix the problem and give the answers”). Cultural differences in child rearing were also seen to present a challenge to accepted intervention practices. Challenges were identified in interacting with fathers of clients, due to differences in gender attitudes across cultures. Difficulty in reconciling these differences was identified. A second, less common, theme was that of priority. For some families, it was suggested that practical factors (e.g., food, shelter, and safety) were of greater importance than intervention. For others, time pressures (e.g., for those families running small businesses) presented a challenge. As shown in the following examples, respondents also identified challenges which related primarily to their own knowledge and understanding of cultural difference (“understanding what is important culturally to the family and why they have chosen the goals they have”) and of the specific cultures of their clients (“I don’t know about all the cultures of families I work with”).

**Resources for working with multilingual children**

Open-ended questions were used to determine the resources respondents used and needed to work with families of children from multilingual backgrounds. Respondents reported using a wide variety of materials for assessment of both speech and language. These included information acquired during or since their training (e.g., information on speech assessment from Speech Pathology Australia workshops (e.g., McLeod, 2008), information from families, and the internet), informal assessments (e.g., speech/language samples, probes created in collaboration with parents,
checklists), and formal tests including the *Diagnostic Evaluation of Articulation and Phonology* (DEAP) (Dodd, Hua, Crosbie, Holm & Ozanne, 2002), *Articulation Survey* (Aitkin & Fisher, 1996), *Clinical Evaluation of Language Fundamentals-4* (Semel, Wiig, & Secord, 2006), and the *Reynell Developmental Language Scales III* (Edwards, Fletcher, Gurman, Hughes, & Letts, 1997). Some respondents indicated that formal tests of language were interpreted qualitatively, others that English assessments were used, or that they used what was available in their clinics. Interpreters were also listed as a resource for use in the assessment of both speech and language. Few language specific (other than English) resources were reported to be used for either speech or language assessment. Two (of 63) respondents reported that they used dynamic assessment approaches when assessing children’s language skills.

A variety of materials was also reported to be used for speech and language intervention. Many respondents indicated that they made their own materials or pictures (e.g., using computer programs designed to create picture symbols), or that they used toys, books and materials from the clinic, or from the family home. Few reported the use of language specific resources, but some reported that efforts were made to ensure that the resources used were culturally appropriate. A small number of particular intervention approaches was mentioned (e.g., *The Hanen Program® for Parents*, Pepper & Weitzman, 2004; *PROMPT*, Hayden, 2008; maximal oppositions, Williams, 2005). Visual prompts and interpreters were also reported as resources for intervention.

**Professional Practice with Individual Multilingual Children on SLPs’ Caseloads**

Respondents completed the next section of the questionnaire if they had provided intervention to multilingual children with communication impairment in the past year. They were asked to describe in depth the last three bilingual children they had worked with. They were informed that for this section, children were considered to be bilingual if they were “regularly and consistently exposed to and expected to communicate in two languages” (Jordaan, 2008, p. 99). Seventy nine SLPs (61.7%) answered this final section of the questionnaire and information about 193 children was provided; that is, the respondents described an average of 2.4 children each. Of
the multilingual children described, 149 (77.2%) were male. They ranged in age: below school age (2 – 4 years\(^3\)) (n = 68, 35.4%), preschool age (4 – 6 years) (n = 70, 36.5%), primary school age (6 – 12 years) (n = 52, 27.1%), and above 12 years (n = 2, 1.0%). The majority of children spoke two languages (n = 176, 92.1%); however, a small percentage spoke three (n = 13, 6.8%), or four (n = 2, 1.0%). The majority (n = 129) spoke English as one of their languages; with the next most common languages being: Vietnamese (n = 35), Cantonese, (n = 21), Arabic (n = 17) and Mandarin (n = 13) (see Table 1). The respondents reported that typically both the children’s first language and English were used at home (n = 121, 65.1%); however, in some instances the first language only (n = 52, 28.0%) or majority language only (English) (n = 13, 7.0%) was used at home. English was identified by the SLP as the primary language within the community for most children (n = 148, 80.0%); however, for some children the primary community language was another language (n = 21, 11.4%) or both English and another language (n = 16, 8.6%).

Using the categories provided by Jordaan (2008), the reported areas of communication difficulty were (more than one area could be indicated for each child): delayed language development (n = 139, 73.2%), articulation/ phonological disorder (n = 63, 33.3%), intellectual impairment (n = 19, 10.1%), autism (n = 21, 11.1%), cleft palate (n = 1, 0.5%), stuttering (n = 10, 5.3%), pervasive developmental disorder (n = 7, 3.7%), selective mutism (n = 2, 1.1%), global delay (n = 12, 6.3%), and Attention Deficit Disorder (n = 6, 3.2%).

**Assessment**

For the majority of the children, assessment was conducted in English only (n = 90, 47.6%) or both languages (n = 81, 42.9%); while in a small percentage of cases the assessment was conducted only in the children’s first language (n = 18, 9.5%). The assessment was written-up/reported in English most of the time (n = 131, 70.4%); however, in some instances it was reported in both languages (n = 25, 13.4%), or the children’s first language only (n = 8, 4.3%). No assessment report was written for 22 (11.8%) of the children. The SLPs indicated that if the

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\(^{3}\) The age equivalent descriptors were replicated from Jordaan (2008) to enable comparisons
assessments were not conducted in the child’s first language (L1), this was because there were no assessments available (n = 59, 56.2%), no L1 resources available (n = 46, 45.1%), there was no access to an interpreter (n = 17, 16.7%) or other reasons (n = 31, 30.4%). The most common other reasons reported were that parents requested the assessment be carried out in English, or that English was the child’s dominant language.

**Intervention**

Intervention was conducted in English only in a little over half of the cases reported (n = 106, 57.9%). Other possibilities included intervention in both languages simultaneously (n = 52, 28.4%); starting in one language and switching to the other (n = 10; 5.5%); or intervention only in the child’s first language (n = 14, 7.7%). Intervention was conducted in English only if the SLP did not speak child’s L1 (n = 73, 68.9%), there were no L1 resources available (n = 36, 34.6%), there was no access to an interpreter (n = 30, 28.6%), or other reasons (n = 49, 46.7%). The most frequent other reason was parent request. Respondents were asked to choose from a list of possible reasons for the choice of the language of intervention. From most to least frequently reported, the reasons were: language spoken by child (n = 94, 52.8%), language of the SLP (n = 85, 47.8%), language of the school (n = 71, 39.9%), language of the community (n = 61, 34.3%), parental insistence (n = 60, 33.9%), language of difficulty for the child (n = 32, 18.0%), no alternative (n = 15, 8.4%), and other (n = 19, 10.7%).

**Use of interpreters**

Respondents were asked who they used as an interpreter during assessment and intervention, or both. Not all responded to these questions, so only the total number of responses is provided (percentages are not provided to avoid misinterpretation). The respondents indicated that for the last three children they worked with, they used:

- a professional interpreter during assessment (27), intervention (6), and both (25) (total = 58)
- parent as interpreter during assessment (11), intervention (19), and both (45) (total = 75)
- sibling as interpreter during assessment (2), intervention (1), and both (8) (total = 11)
• child as own interpreter during assessment (1), intervention (3), and both (4) (total = 8)
• colleague as interpreter during assessment (3), intervention (0), and both (2) (total = 5)

Advice and attitudes about multilingualism

The majority of SLP respondents advised parents of these children to speak both languages to their children (n = 106, 61.6%). A quarter gave the advice to speak L1 only (n = 44, 25.6%), few advised to speak English only (n = 12, 7.0%) or gave other advice (n = 10, 5.8%). They indicated that the attitude of mothers to maintaining the home language was typically positive (n = 134, 74.9%), with 11 (6.1%) mothers having a negative attitude and the SLPs were unsure about the attitude of 34 (19.0%) mothers. Respondents reported positive attitudes to maintaining the home language for 82 (50.2%) fathers, 51 (33.6%) teachers, and 46 (28.2%) children; however, they were unsure about the attitudes for a number of the fathers (unsure = 71, 43.8%), teachers (unsure = 76, 50.0%) and children (unsure = 108, 66.3%).

DISCUSSION

This study provides detailed information about the opinions and practices of SLPs working with multilingual children in Australia. Both similarities and differences can be seen on comparison with international studies. The majority of these Australian SLPs were monolingual, a finding which has also been made in studies in other countries (Caesar & Kohler, 2007; Gupta & Chandler, 1993; Jordaan, 2008). Jordaan’s data, which included information on 99 SLPs working in a total of 13 different countries, indicated that 74% of respondents were monolingual. In the current study, respondents were asked to indicate whether they spoke a language other than English, and their level of competence in that language. Although the percentage of respondents indicating that they spoke another language was relatively high (48.4%), many of these reported minimal or functional competence. If a definition of multilingualism was used that only included those who reported proficiency in a language other than English (cf. Cruz-Ferreira, 2010), then 83.5% of the respondents would be considered monolingual. This inevitably presents a challenge for SLPs working with multilingual children. The challenge is compounded by the fact that the languages
spoken by these SLPs rarely matched the primary languages spoken by the children on the SLPs’ caseloads (see Table 1), the languages spoken by Australian 4- to 5-year-olds (McLeod, 2011a), or the languages spoken in the Australian population (ABS, 2006). The two languages (Vietnamese and Arabic) most commonly spoken by children were not spoken by any SLP in the current study. Instead, the languages spoken by the SLPs more closely reflected the common languages taught in Australian schools (Liddicoat et al., 2007). It is clear, therefore, that the provision of SLP services to multilingual children will seldom involve SLPs who are able to use the child’s first language. Given the complexity of the linguistic situation in Australia, this seems likely to be the case even if there is an increase in the number of SLPs who speak a language other than English. The challenge is to develop a workforce which is able to support development in languages they do not speak (cf. De Lamo White & Jin, 2011).

The SLPs were asked about their practices in working with multilingual children. Inclusion of both (or all) the child’s languages in assessment and intervention has been described as an essential part of service provision for this population (Kohnert, 2008; Elin Thordardottir, 2010), and consideration of the cultural practices of the home is also recommended in SLP practice (Cheng, 2009; Wing et al., 2007). Previous research (Caesar & Kohler, 2005; Jordaan, 2008; Stow & Dodd, 2003) has demonstrated that the practice of SLPs with multilingual children does not always match what is known from the literature. For example, Jordaan (2008, p. 104) reported a “lack of provision of multilingual therapy” indicating that 87% of her respondents used only one language in intervention. In the current study, this tendency was less evident when SLPs described their practices with individual children, with approximately half using English as the only language of assessment (42.9%) and intervention (57.9%). Some of the SLPs who reported using both languages in intervention reported using both languages simultaneously, while others reported using the two languages sequentially. A small percentage reported using L1 only. These figures show an encouraging trend towards the inclusion of both languages in service provision for multilingual children in Australia. However, despite evidence that consideration of the first language is
important, English was still the only language reported for assessment and intervention in many cases. The reasons given for using English only centred on lack of access to L1 resources, either because the SLP did not have language competency in the child’s language, appropriate assessment and intervention resources were unavailable, or because assistance from appropriate interpreters was not available. Some respondents reported the use of untrained individuals (including the children themselves or their siblings) as interpreters during assessment and intervention, a practice which is not recommended (Isaac, 2002).

Practices relating to assessment and intervention for speech and language were described separately within the questionnaire. There were similarities and differences evident in the responses related to the two areas. Half (50.5%) of respondents reported that they conducted assessments of *speech* by themselves (i.e. without an interpreter); whereas during *language* assessments only one third (33.3%) conducted the assessment by themselves. For both speech and language, respondents indicated that they were most likely to use informal procedures in English, a finding which may be related to the lack of standardised tests for bilingual speakers of English, to the fact that most SLPs are monolingual, or to difficulties accessing the services of an interpreter. A large proportion of respondents also indicated that they used English-only standardised tests when assessing speech. This was also the case for respondents to a US survey of assessment of speech (Skahan, Watson & Lof, 2007). Half of the respondents in the current study reported that they used dynamic assessment approaches to assessment. This contrasts with the study by Caesar and Kohler (2007), where SLPs working in school settings reported a reliance on formal measures, and were not likely to use dynamic assessment approaches. It was noted that this may have been, in part, due to the testing requirements of the schools in which the SLPs in Caesar and Kohler’s sample work, since dynamic assessment has been recognised as an approach which is potentially very useful in assessment of multilingual children (Kohnert, 2010). De Lamo White and Jin (2011) recommended that an assessment of bilingual children’s speech and language should combine criterion referenced measures, dynamic assessment and a sociocultural approach.
The majority of SLPs in the present study reported that they always (66.1%) or usually (27.8%) believed that family involvement affected the outcome of intervention for multilingual children. While the current study related to children’s speech and language, these SLPs responses can be compared with responses on a similar survey conducted with Australian SLPs regarding family-centred practices for monolingual children with speech sound disorders (Watts Pappas et al., 2008). Overall, the responses on both surveys showed similar trends; however, typically there was greater involvement of families in the Watts Pappas et al. (2008) study. For example, while 84% of the SLPs in the Watts Pappas et al. (2008) study indicated that parents always/usually were present during assessments, 73.9% of SLPs in the present study always/usually were present during assessments (see Table 4). Similarly, while 95% of the SLPs in the Watts Pappas et al. (2008) study indicated that always/usually gave homework activities, 85% of SLPs in the present study always/usually gave homework activities (see Table 4). This trend for slightly less family involvement may be related to multilingual vs. monolingual children, speech vs. speech and language impairment, or differences between the two samples of SLPs.

In the current study, there was a discrepancy in the percentage of specific children reported to have speech (33.3%) and language (73.2%) difficulties. This percentage of children with speech difficulties appears low in relation to those with language difficulties (cf. Broomfield & Dodd, 2004; McLeod & Harrison, 2009; Mullen & Schooling, 2010; Stow & Dodd, 2003; 2005). For example, Stow and Dodd (2005) report a statistically significant under-diagnosis of speech disorders in their bilingual children (25.74%) relative to monolingual children (58.43%) with speech disorders and highlight that a disproportionate number of bilingual children (34.56%) are referred for language disorders in comparison to their monolingual peers (22.47%). The reason for this discrepancy in the present as well as previous studies is not clear, but may be related to the referral process (Stow & Dodd, 2003; 2005). The present study did not identify the source of referrals for these children; however, it seems possible that, should the referrals come primarily from monolingual speakers of English, then these referrals may be based on the characteristics of
the child’s English language use. Speech difficulties in the child’s first language may go unnoticed, and differences between the child’s first language and English phonology may be attributed to the influence of the first language. It may also be that the SLPs who work with these children do not have ready access to assessments that will allow them to identify speech impairment in multilingual children (McLeod, 2011b).

Speech-language pathology services to multilingual children requires SLPs to understand the typical course of multilingual development (Goldstein & McLeod, 2011), the likely impact of cultural differences (in such things as child rearing practices, and perceptions of language, learning and health systems) (cf. Johnson & Wong, 2002), and the difficulties inherent in assessment and intervention. The literature includes a number of calls for further inclusion of multilingual issues in training for SLPs (Hammer, Detwiler, Detwiler, & Blood, 2004; Stow & Dodd, 2003; Winter, 1999). The respondents in the current study clearly see this as a need in Australia, with approximately three quarters of participants reporting that they did not feel that they had sufficient training in working with multilingual children. It may be that the participants chose to attend the workshop in order to develop their skill in an area important to their clinical practice, but one in which they saw a need to further develop their knowledge. When asked to indicate their areas of specialisation, none listed services to multilingual children. The implications, and challenges, for university courses are clear – to increase knowledge of approaches to working with multilingual children in their graduates. There is also a challenge for employers and the profession in Australia, to ensure that SLPs working with multilingual children are supported by others with specialist skills in this area. This need for SLPs to receive specialist support has been identified by Speech Pathology Australia in the recently revised Competency-Based Occupational Standards (Speech Pathology Australia, 2011).

Limitations and Future Research

The data presented in this survey provide useful information, but leave some questions unanswered. The respondents were SLPs who elected to attend a workshop devoted to working with
children from multilingual backgrounds. Ninety two percent had worked with multilingual children. This indicates that all respondents were interested in learning more about working with culturally and linguistically diverse children. There are two possible reasons for this interest: they may have limited knowledge in the area, and wanted to learn more, or they may have extensive knowledge and/or experience and wanted to ensure that they had the most recent knowledge. The results cannot, therefore, be taken as indicative of the beliefs and knowledge of all SLPs working in Australia. The current survey identified that a large proportion of the participants felt that their training had not equipped them to work with this population, but did not identify what this training had included, nor what they felt needed to be included. It is possible that the respondents worked in areas that included high proportions of multilingual children, suggesting that the proportion of multilingual children reported on caseloads in this study may not represent the Australian context as a whole. Additionally, the current research has not been able to provide an insight into the referral of multilingual children to speech-language pathology services, nor has it considered the challenges in working with children with other communication or developmental difficulties. These are clearly areas that warrant further research.

**Conclusion**

This paper has provided detailed information regarding the assessment and intervention practices of speech-language pathologists working with children from culturally and linguistically diverse backgrounds in Australia. The findings represent the views of a sample of SLPs with an interest in working with this population. Extension of the research to investigate the knowledge and practices of Australian SLPs more generally would provide a more representative picture of the Australian situation. Approximately one half of the SLPs had at least minimal competence in a one or more of 28 languages, but only 9.4% reported proficiency speaking the languages. The most common languages spoken by the SLPs (French, Italian, German, Spanish, Mandarin and Auslan) did not correspond with the most common languages spoken by the children they worked with (Vietnamese, Arabic, Cantonese, Mandarin, Australian Indigenous languages, Tagalog, Greek and
other Chinese languages). Many of the SLPs assessed children’s speech and language in English, without assistance from others (including interpreters), although they sought information about the children’s languages and culture. The SLPs indicated they had limited resources to discriminate between speech and language difference versus disorder, or to assess and provide intervention to these children. This provides a clear indication of resourcing needs in multilingual Australia. The most valuable resource, however, may be proactive and confident SLPs who apply their existing skills, knowledge, and ability to consider the evidence to working with multilingual clients.

ACKNOWLEDGMENTS

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REFERENCES


Table 1
Languages other than English spoken by SLPs, children on their caseloads, Australian preschool children (McLeod, 2011a), listed according to the most common languages spoken by the Australian population (adapted from Australian Bureau of Statistics, ABS, 2006)

<table>
<thead>
<tr>
<th>Language</th>
<th>Number of SLPs who speak the language</th>
<th>Level of proficiency of SLPs</th>
<th>Primary languages used by children on SLPs’ caseloads</th>
<th>Languages spoken by SLPs’ last 3 clients</th>
<th>Proportion of Australian 4- to 5- year-olds’ primary language (McLeod, 2011a)</th>
<th>Proportion of Australian 4- to 5- year-olds’ additional language (McLeod, 2011a)</th>
<th>Proportion of the Australian population who speak the language at home (ABS, 2006)</th>
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</tbody>
</table>

- Dashes mean that there was no information about this language for this participant group.
a These numbers add to more than 62 since 51.6% of the SLPs spoke more than one language; and some spoke up to 5 languages. The remaining respondents to the questionnaire were monolingual in English.

b These numbers add to more than 110 since most SLPs worked with children from different language backgrounds.

c These numbers add to more than 193 since 15 children spoke three or more languages.

d Some participants indicated that they spoke Chinese, but did not specify whether they spoke Cantonese, Mandarin, Putonghua, etc.

e Rates of Auslan use were not listed in summary data table but were extracted from the full classification list of languages spoken at home (Australian Bureau of Statistics, 2006). Therefore, individuals using Auslan are contained within the figures for Auslan and Other languages in this table. Auslan usage was added as it is relevant to this study.

f The SLPs spoke 12 additional languages: Bislama (1), Catalan (1), Fiji Sign Language (1), Fijian (1), Fijian Hindi (1), Hakka (1), Kriol (1), Swahili (1), Tok Pisin (1), and Ukrainian (1).

g The SLPs’ caseloads included children who spoke the following additional languages: Acholi (1), Afghani (1), African languages (4), Armenian (1), Asian languages (4), Assyrian (3), Bangladeshi (1), Bangli (1), Burmese (3), Dinka (8), Hakka (1), Hebrew (1), Hmong (1), Indian languages (8), Kirundi (2), Kriol (3), Maori (1), Middle Eastern languages (1), Nigerian (1), Nubia (1), Nuer (1), Pacific languages (1), Punjabi (3), Sindhi (1), Somali (5), Sri Lankan (2), Sudanese (10), Swedish (1), Tibetan (1), Tigrinyan (1).

h The last 3 clients seen by the SLPs spoke the following additional languages: Albanian (1), Assyrian (1), Bangladeshi (1), Czech (1), Dinka (1), Hakka (2), Hebrew (2), Kissi (1), Kiswahili (1), Kriol (3), Nauruan (1), Nepalese (2), Non-verbal (1), Punjabi (1), Somali (3), Sri Lankan (1), Tibetan (1), Ukranian (1).
Table 2.

Methods used to assess the speech and language of children from multilingual backgrounds.

<table>
<thead>
<tr>
<th>Method</th>
<th>Always</th>
<th>Sometimes</th>
<th>Infrequently</th>
<th>Never</th>
<th>Valid cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) English-only standardised test</td>
<td>41 (41.4%)</td>
<td>43 (43.4%)</td>
<td>10 (10.1%)</td>
<td>5 (5.1%)</td>
<td>99</td>
</tr>
<tr>
<td>b) Standardised test for child’s first language</td>
<td>1 (1.4%)</td>
<td>5 (6.8%)</td>
<td>6 (8.1%)</td>
<td>62 (83.8%)</td>
<td>74</td>
</tr>
<tr>
<td>c) Informal procedures</td>
<td>79 (76.7%)</td>
<td>24 (23.3%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>103</td>
</tr>
<tr>
<td>d) Developed local norms</td>
<td>10 (13.0%)</td>
<td>20 (26.0%)</td>
<td>17 (22.1%)</td>
<td>30 (39.0%)</td>
<td>77</td>
</tr>
<tr>
<td>e) Dynamic assessment</td>
<td>23 (28.0%)</td>
<td>36 (43.9%)</td>
<td>8 (9.8%)</td>
<td>15 (18.3%)</td>
<td>82</td>
</tr>
<tr>
<td>f) Processing approaches (e.g., non-word repetition)</td>
<td>5 (6.3%)</td>
<td>18 (22.5%)</td>
<td>20 (25.0%)</td>
<td>37 (46.3%)</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method</th>
<th>Always</th>
<th>Sometimes</th>
<th>Infrequently</th>
<th>Never</th>
<th>Valid cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) English-only standardised test</td>
<td>35 (33.3%)</td>
<td>51 (48.6%)</td>
<td>12 (11.4%)</td>
<td>7 (6.7%)</td>
<td>105</td>
</tr>
<tr>
<td>b) Standardised test for child’s first language</td>
<td>0 (0.0%)</td>
<td>6 (7.6%)</td>
<td>3 (3.8%)</td>
<td>70 (88.6%)</td>
<td>79</td>
</tr>
<tr>
<td>c) Informal procedures</td>
<td>86 (78.2%)</td>
<td>22 (20.0%)</td>
<td>0 (0.0%)</td>
<td>2 (1.8%)</td>
<td>110</td>
</tr>
<tr>
<td>d) Developed local norms</td>
<td>5 (6.1%)</td>
<td>24 (29.3%)</td>
<td>9 (11.0%)</td>
<td>44 (53.7%)</td>
<td>82</td>
</tr>
<tr>
<td>Section Description</td>
<td>Count 1</td>
<td>Count 2</td>
<td>Count 3</td>
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</tr>
<tr>
<td>e) Dynamic assessment</td>
<td>18 (20.7%)</td>
<td>31 (35.6%)</td>
<td>14 (16.1%)</td>
<td>24 (27.6%)</td>
<td>87</td>
</tr>
<tr>
<td>f) Processing approaches (e.g., non-word repetition)</td>
<td>3 (3.9%)</td>
<td>11 (14.5%)</td>
<td>19 (25.0%)</td>
<td>43 (56.6%)</td>
<td>76</td>
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Table 3.

Typical methods of service delivery used with children from multilingual backgrounds (n = 115)

<table>
<thead>
<tr>
<th>Service delivery</th>
<th>n (%)</th>
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<tbody>
<tr>
<td><strong>Intervention type</strong></td>
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<tr>
<td>Individual</td>
<td>103 (89.6%)</td>
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<tr>
<td>Group therapy</td>
<td>57 (49.6%)</td>
</tr>
<tr>
<td>Parent training</td>
<td>87 (75.7%)</td>
</tr>
<tr>
<td>Sibling training</td>
<td>15 (13.0%)</td>
</tr>
<tr>
<td>Home program</td>
<td>55 (47.8%)</td>
</tr>
<tr>
<td><strong>Place of assessment and intervention</strong></td>
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</tr>
<tr>
<td>Clinic</td>
<td>77 (67.0%)</td>
</tr>
<tr>
<td>Preschool /school</td>
<td>72 (62.6%)</td>
</tr>
<tr>
<td>Client’s home</td>
<td>32 (27.8%)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (7.8%)</td>
</tr>
<tr>
<td><strong>People involved in assessment and intervention</strong></td>
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</tr>
<tr>
<td>Clinician</td>
<td>101 (87.8%)</td>
</tr>
<tr>
<td>Parent/guardian</td>
<td>94 (81.7%)</td>
</tr>
<tr>
<td>Sibling</td>
<td>29 (25.2%)</td>
</tr>
<tr>
<td>Teacher</td>
<td>64 (55.7%)</td>
</tr>
<tr>
<td>Teacher’s aide</td>
<td>51 (44.3%)</td>
</tr>
<tr>
<td>Interpreter</td>
<td>34 (29.6%)</td>
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</table>
Table 4.

**Working with families from multilingual backgrounds**

<table>
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<tr>
<th>Question</th>
<th>Always n (%)</th>
<th>Usually n (%)</th>
<th>Sometimes n (%)</th>
<th>Rarely n (%)</th>
<th>Never n (%)</th>
<th>Valid Cases</th>
</tr>
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<tbody>
<tr>
<td>1. Do you feel that family involvement affects the outcomes of your intervention?</td>
<td>76 (66.1%)</td>
<td>32 (27.8%)</td>
<td>7 (6.1%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>115</td>
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<tr>
<td>2. Do parents/other family members observe your assessment sessions for their child?</td>
<td>53 (46.1%)</td>
<td>32 (27.8%)</td>
<td>22 (19.1%)</td>
<td>6 (5.2%)</td>
<td>2 (1.7%)</td>
<td>115</td>
</tr>
<tr>
<td>3. Do you ask parents/other family members to participate in your assessment sessions?</td>
<td>28 (24.3%)</td>
<td>31 (27.0%)</td>
<td>38 (33.0%)</td>
<td>11 (9.6%)</td>
<td>7 (6.1%)</td>
<td>115</td>
</tr>
<tr>
<td>4. Do parents/other family members observe your intervention sessions for their child?</td>
<td>56 (49.1%)</td>
<td>30 (26.3%)</td>
<td>18 (15.8%)</td>
<td>8 (7.0%)</td>
<td>2 (1.8%)</td>
<td>115</td>
</tr>
<tr>
<td>5. Do you ask parents/other family members to participate in your intervention sessions?</td>
<td>49 (43.0%)</td>
<td>43 (37.7%)</td>
<td>15 (13.2%)</td>
<td>5 (4.4%)</td>
<td>2 (1.8%)</td>
<td>115</td>
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<tr>
<td>6. Do you give homework activities to parents/other family members in your intervention?</td>
<td>49 (43.4%)</td>
<td>47 (41.6%)</td>
<td>16 (14.2%)</td>
<td>1 (0.9%)</td>
<td>0 (0.0%)</td>
<td>113</td>
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<tr>
<td>7. Do you have difficulty involving families as much as you would like in intervention?</td>
<td>12 (10.5%)</td>
<td>29 (25.4%)</td>
<td>63 (55.3%)</td>
<td>9 (7.9%)</td>
<td>1 (0.9%)</td>
<td>114</td>
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<tr>
<td>8. Are you influenced by the family regarding how you involve them in intervention?</td>
<td>35 (31.0%)</td>
<td>46 (40.7%)</td>
<td>30 (26.5%)</td>
<td>1 (0.9%)</td>
<td>1 (0.9%)</td>
<td>113</td>
</tr>
<tr>
<td>9. Do you seek out and use knowledge of relevant cultural attitudes to language learning?</td>
<td>14 (12.3%)</td>
<td>41 (36.0%)</td>
<td>44 (38.6%)</td>
<td>14 (12.3%)</td>
<td>1 (0.9%)</td>
<td>114</td>
</tr>
<tr>
<td>10. Do you seek out and use knowledge of relevant cultural attitudes to child rearing?</td>
<td>14 (12.3%)</td>
<td>31 (27.2%)</td>
<td>40 (35.1%)</td>
<td>26 (22.8%)</td>
<td>3 (2.6%)</td>
<td>114</td>
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