

# ESTABLISHING LANGUAGE AND CULTURAL PROFICIENCY IN WORKING WITH CLD POPULATIONS

## CSHA DIVERSITY COMMITTEE 2003-2004

### INTRODUCTION

These guidelines are applied when at least one professional level (a through c) or conversational level (a or b) clinician is on staff.

The SLPs who claims that he/she can provide services in a language other than English, must understand multicultural issues and bilingual language development.

**The definition of bilingual-SLP (ASHA)** which has been adapted by CSHA states that:

“ To be listed as a bilingual speech-language pathologist or audiologist you must be able to speak English as your primary language and speak (or sign) at least one non-English language with native or near native proficiency in lexicon (vocabulary), semantics (meaning), phonology (pronunciation), morphology/syntax (grammar), and pragmatics (uses) during clinical management. Additionally, the following abilities are necessary in order to provide appropriate bilingual assessment and remediation services in the client’s language:

1)- ability to describe the process of normal speech and language acquisition to both bilingual and monolingual individuals and how those processes are manifested in oral( or manually coded) and written language;

2)-ability to administer and interpret formal and informal assessment procedures to distinguish between communication differences and communication disorders in oral or manually coded) and written language;

3)-ability to apply intervention strategies for treatment of communication disorders in the client’s language, and

4)-ability to recognize cultural factors which affect the delivery of speech-language pathology and audiology services to the client’s language community.

The Foreign Language Service Institute (FSI) defines level 3 as the minimum requirement of proficiency to adequately conduct professional responsibilities in a certain career. We could decide to go for level 4 depending on how we write it. The following definitions are directly applied to the recommended linguistic and cultural competencies of interpreters and translators who collaborate with speech-language pathologists and audiologists.

### OVERVIEW

#### LEVEL 1-MONOLINGUAL

- Minimal to no verbal skills in L2.
- Can understand reading in L2.

#### LEVEL 2- MONOLINGUAL+

- Rudimentary knowledge of basic terms/phrases which are generally situationally specific in L2.
- Can read and write in L2 at a very minimal level.

### LEVEL 3-BASIC SKILLS

- More advanced second language proficiency.
- Can gather basic information from parent or client, but at times needs interpreter for assessments, translations and conferences with parents and families.
- Variable literacy skills.

### LEVEL 4-NEAR FLUENT

- Ability to communicate in L2 although may make some grammatical errors.
- Able to write but may need editing.
- Can hold conferences and provide assessments although may need interpreter for more complex cases where more disordered language is involved.
- Knowledge of multicultural issues and second language acquisition.

### LEVEL 5 - FLUENT

- Fluent in the oral and written language in L2.
- Can conduct interviews, assessment with no need for assistance from an interpreter.
- Does not need to be native in L2, but have near-native language proficiency.

<b>Level 1: Monolingual</b>
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<b>Level 2: Monolingual Plus</b>
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The emphasis is on:

- Intensive second language classes
- Language education through coursework and immersion experiences.
- Ongoing education regarding multicultural/multilingual issues is required.

***When language proficiency reaches a BASIC LEVEL,  
the clinician in training advances to level 3.***

<b>Level 3: Basic Skills</b>
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- Initially, observe evaluation, treatment and family counseling sessions of a clinician with mastery level bilingual skills.
- Emphasis is on intensive Spanish, Cantonese, etc., language education throughout coursework and immersion experiences.
- For the initial six to nine months, schedule regular meetings as needed with a mastery level clinician.
- When mutually agreed upon, the clinician in training can start providing some treatment (not evaluating or family counseling) with assistance of a mastery level clinician.
- The mastery level clinician is to observe/assist with the initial sessions.

*After six to nine months, or when mutually agreed upon, the clinician in training moves to the next level.*

- The clinician in training may not be the primary case manager.
- Emphasis is ongoing education regarding multicultural/multilingual issues.

*After a mutually agreed upon time, the clinician in training moves to the next level.*

- For the initial three to six months, schedule regular meetings as needed, with the mastery level clinician.

#### **Level 4: Near Fluent**

- Initially, provide some cognitive-communication services (treatment only in both languages) with assistance of a clinician with mastery level bilingual.
- Observe evaluation, treatment, and family counseling sessions of the clinician with mastery level bilingual skills until mutually determined that the clinician in training is ready to initiate some treatment.
- For the initial six to nine months, schedule meetings as needed, (e.g., two to three times monthly), with the mastery level clinician.
- The mastery level clinician will observe the initial treatment sessions, and provide feedback regarding vocabulary, ideas for therapy tasks, etc.
- The emphasis for ongoing education regarding multicultural/ multilingual issues.

*After this period, or when mutually agreed upon, the clinician in training moves up to the next level.*

- Provide a range of cognitive-communication services, including evaluation and treatment in both languages, with assistance of a clinician with mastery level bilingual skills.
- Emphasis for ongoing education to increase professional vocabulary and verbal skills in L2.
- For the initial three to six months, schedule meetings as needed, (e.g., two to three times monthly) with a mastery level clinician.
- Advocate for and provide education regarding multicultural/multilingual issues.

*After a mutually agreed upon time, the clinician in training moves to the next level.*

- Provide a range of cognitive-communication services, including evaluation and treatment in both languages, combined with ongoing meetings as needed (e.g. one to two times monthly), to discuss vocabulary, therapy tasks, etc, with a mastery level clinician.

#### **Level 5: Fluent**

- Initially, observe and receive education and feedback from a mastery level clinician.

- When mutually agreed upon, the clinician in training can start providing evaluation, treatment, family counseling and education.
- For the initial three to six months, schedule meetings as needed, (e.g., two to three times/month) with a mastery level clinician.

*After this period, or when mutually agreed upon, the clinician in training moves up to the next level.*

- Provide a complete range of cognitive-communication services, including evaluation, treatment, family counseling and education in both languages, combined with ongoing meetings as needed, (e.g., one to two times monthly) to discuss vocabulary, therapy tasks, etc, with mastery level clinician.

*After a mutually agreed upon time, the clinician in training moves to the next level.*

- Provide a complete range of cognitive-communication services, including evaluation, treatment, family counseling and education in both languages (given the clinician's individual areas of expertise). Advocate for and provide education regarding multilingual/multicultural issues.

*After a mutually agreed upon time, the clinician in training moves to the next level.*

- Provide a complete range of cognitive-communication services, including evaluation, treatment, family counseling and education in both languages (given the clinician's individual areas of clinical expertise). Advocate for and provide education regarding multicultural/multilingual issues. Includes active participation in professional activities and presentations in both languages.

## References:

Carr, S. (1997). A three- tiered health care interpreter system. In S. Carr, R. Roberts, A.Dufour and D. Steyn (Eds), *The critical link: Interpreters in the community*. (pp.271-288). Philadelphia: Johns Benjamin Publs. (Proposes various responsibilities of interpreters who have varying proficiencies in a given language in the health care arena). This information could be applied to practicing self-proclaimed bilingual SLPs.

Wilks, K.(2003) . *How bilingual are bilingual speech-language pathologists working in the public schools*. (A pilot study survey of language proficiency of a small group of SLPs claiming to be bilingual in Spanish and English ). (Found that, in reality, most of the respondents had a reported average ability in oral language proficiency in Spanish but many lacked adequate written language skills in the language). Unpublished Master's project. San José State University (Langdon, Chair; Weddington and Meyerson, Advisors).