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Association

Ad Hoc Committee on Bilingual Service Delivery

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Final Report

Competencies, Expectations, and Recommendations for Multilingual Service Delivery

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Background

In 2019, the Ad Hoc Committee on Language Proficiency defined *language proficiency,* offered proposed changes to English language proficiency requirements for certification to the Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC), and recommended that the ASHA Board of Directors (BOD) establish an ad hoc committee to define language proficiency, knowledge, and skill requirements for bilingual service providers.

By 2021, ASHA had established the Ad Hoc Committee on Bilingual Language Competence and Service Delivery to address this charge. Following significant member feedback opposing proposed changes to ASHA certification standards related to English language proficiency, the work of the Ad Hoc Committee on Bilingual Language Competence and Service Delivery was paused.

Outcomes of this Ad Hoc Committee's discussions included acknowledgment of (a) federal law and state mandates requiring all service providers, both monolingual and multilingual, to be able to provide services for multilingual populations; (b) unjust and disproportionate responsibility placed upon multilingual service providers to provide multilingual services; and (c) the need for additional support for all practitioners related to supporting the communication needs of multilingual clients/patients/students. The Ad Hoc Committee recommended that the BOD consider a shift in focus from (a) defining what characteristics and roles constitute *bilingual and multilingual service providers* to (b) outlining the skills and knowledge that all clinicians need in order to work with individuals who use a language different from their own and who use multiple languages.

With Resolution 17-2021, the ASHA BOD established the Ad Hoc Committee on Bilingual Service Delivery (hereafter, "the Committee"), which was charged with (a) describing competencies needed when the clinician and the client/patient/student use different languages; (b) outlining expectations for clinical practice when more than one language is needed for effective service delivery; and (c) making recommendations to ensure that clinicians have the support, tools, and resources to appropriately serve their clients/patients/students.

The Committee comprised invited members having one or more of the following qualifications:

- is a practicing bilingual ASHA-certified clinician (Spanish and/or additional languages)
- is a bilingual ASHA-certified audiologist (Spanish and/or additional languages)
- is a bilingual ASHA-certified speech-language pathologist (Spanish and/or additional languages)
- is a native user of an additional language who has practiced in their native language in another country
- is a bilingual audiology or speech-language pathology assistant with professional interpretation and/or translation experience
- is an academician from a communication sciences and disorders (CSD) program with a bilingual emphasis track

- is an expert in bilingual language development
- is a staff ex officio (appointed by ASHA's Chief Executive Officer)
- is ASHA's Vice President for Planning (who serves as BOD liaison)

To address the charge, the Committee defined *multilingual service delivery,* specified the commitment to clients/patients/students via a *Bill of Language Rights,* surveyed ASHA members about the current state of multilingual service delivery, and studied relevant ASHA resources related to multilingual service delivery. These actions were fundamental to the development of competencies for multilingual service delivery and recommendations to the ASHA BOD for supporting member competence in this area.

Defining Multilingual Service Delivery

Going forward, the term *multilingual* will be used in place of *bilingual,* as it characterizes contexts in which two or more languages are used, making *multilingual* the more inclusive term. There are two common scenarios of multilingual service delivery that require overlapping—but, in some ways, distinct—knowledge and skills. *Cross-linguistic* refers to contexts in which a service provider's and a client/patient/student's language(s) are not the same. *Multilingual* refers to contexts in which the client/patient/student engages, with varying degrees of skill, with two or more languages. If the clinician is multilingual, then multilingual service delivery may or may not be cross-linguistic.

> **Definition: *Multilingual service delivery* refers to clinical practice with a client/patient/student who uses a language different from that of the clinician and/or who uses multiple languages.**

Additionally, the Committee would like to note that any clinician can engage in *multilingual service delivery.* For clarity, the term *multilingual service provider* will be used to refer to clinicians who are themselves multilingual. It should be assumed that the term *language,* which is used throughout this report, is specific to the dialect variations of the language(s) of interest to the clinician and client/patient/student.

Bill of Language Rights

The Committee agreed that a first step in creating competencies for multilingual service delivery, was to clearly define expectations for service delivery with multilingual persons and those who use languages outside of spoken English. The Committee contends that acceptance and attention to language rights will lead to more equitable and accessible speech, language, and hearing services for persons who use languages outside of spoken English.

Subsequently, a subcommittee was established to describe members' professional and ethical responsibility in service delivery and clients/patients/students' rights to communicate in their languages. The subcommittee was inspired by the *National Joint Committee's Communication*

Bill Of Rights, which affirms the rights of minimally speaking persons, as well as the National Aphasia Association's *Aphasia Bill of Rights*, which asserts the rights of persons with aphasia. What emerged from that subcommittee was the *Bill of Language Rights*.

The *Bill of Language Rights* underwent multiple revisions before the subcommittee put forth an initial draft. In addition, the subcommittee took the following steps to conduct select peer review of the *Bill of Language Rights* draft:

- Established a timeline for the select peer review process.
- Generated a list of select peer reviewers, including subject matter experts (SMEs) and stakeholders affected by the content of the document.
- Created a review form that reviewers could use to comment on the overall document and individual sections within the document.
- Compiled and de-identified results to prepare a quantitative and qualitative analysis and summary.
- Discussed peer-review results and reached consensus on revisions through subcommittee conference calls, full Committee discussions, and asynchronous independent Committee member reviews.
- Revised the *Bill of Language Rights* based on feedback and discussions to prepare the final version for ASHA BOD consideration.

The subcommittee conducted two calls for select peer review, sending the draft version to a total of 32 SMEs. The first call for select peer review was conducted from November 1–14, 2022. The call was sent to 19 SMEs recommended by Committee members to obtain feedback across professions, work settings, states, primary roles, and language status (monolingual and multilingual). Because the Committee wanted to collect more input from audiologists, males, service providers working with deaf and hard of hearing (DHH) populations, augmentative and alternative communication (AAC) specialists, and consumers, a second call for select peer review was conducted from February 28 to March 14, 2023. It was sent to 13 SMEs recommended by Committee members.

Feedback Summary

- Overall, 20 out of 32 SMEs responded to the call for select peer review—three audiologists, 16 SLPs, and one related stakeholder.
- Of these, five were clinical service providers, two were researchers, 12 were university professors, and one was an administrator.
- Respondents worked in a variety of settings, with one working in a nonresidential health care facility, four in schools, 14 in colleges/universities, and one in hospitals.
- Respondents varied in their years of practice and locations. Years of practice ranged from 6–10 years (five respondents), 11–19 years (seven respondents), 20–29 years (three respondents), and 30–39 years (five respondents). Six respondents were from California, four were from Texas; two were from Florida, New Mexico, and New York; and one each was from Colorado, Massachusetts, Michigan, and North Carolina.

- When asked if they believe that communication professionals should have such a Bill of Rights, 19 respondents stated “yes,” and one respondent was “unsure.”
- When asked if this document, as drafted, would be useful in framing clinical service delivery to multilingual persons, 19 respondents stated “yes,” and one respondent was “unsure.”
- Open comments from the select peer review rounds were aggregated, totaling more than 195 lines of text. The Committee considered and addressed many suggested edits—including additions, deletions, and terminology changes. However, not all suggestions were incorporated into the current version.

Overall, the feedback from SMEs was constructive, generally positive, and carefully considered in developing the current version of the *Bill of Language Rights*.

The Committee offers the *Bill of Language Rights* (see Appendix A) as a declaration recognizing that all individuals, regardless of their communication ability, have an essential right to communicate in their preferred and heritage language(s), including signed language(s) and via AAC.

Survey of Audiologists and SLPs

The Committee determined that there was a need to understand the current perspectives of audiologists and SLPs on multilingual service delivery to inform competencies and recommendations. A subcommittee defined the purpose of the survey and generated questions to populate the survey. To support the Committee’s charge, ASHA fielded a web-based survey to a sample of 9,000 ASHA-certified audiologists and SLPs—4,000 CCC-A and 5,000 CCC-SLP professionals employed as clinical service providers (including multilingual service providers) in the United States and U.S. Territories.

The purpose of this 2023 survey was to collect input from monolingual and multilingual ASHA constituents in various settings to better understand the realities of service delivery across languages. The three broad areas of interest included (1) current practices, (2) supports and challenges, and (3) training and professional development needs. The 2023 survey was fielded on February 28, 2023. Follow-up email reminders were sent to non-responders on March 7 and March 14. The survey ended on March 17. A total of 458 (156 CCC-A and 302 CCC-SLP) individuals completed the survey for an overall response rate of 5.1% (3.9% for CCC-A and 6.0% for CCC-SLP). Respondents had an opportunity to enter a drawing for a $100 Amazon gift card.

The survey questions and a detailed report prepared by ASHA’s Surveys and Analysis Team can be found in Appendix B. Results are presented separately by language status and profession for monolingual audiologists and SLPs, for multilingual audiologists and SLPs, and for all respondents combined. Language status (monolingual and multilingual) was based on Q16, which asked if the participant was comfortable communicating in a language other than English. This question was the most direct reference to language ability in the survey.

Percentages are rounded and may not add to exactly 100%. A brief summary of the findings is provided below.

Across all respondents, 40% are employed in an educational setting, 29% in a hospital, 17% in a nonresidential health care facility such as a private practice or clinic, and the remainder in a residential health care or other facility. About a third (33%) of the respondents are ASHA-certified audiologists who are employed mostly in hospitals or nonresidential health care facilities. Most respondents have been practicing for 1–10 years (36%), whereas a much smaller portion (3%) has been practicing for more than 40 years. More multilingual audiologists and SLPs began practicing in the last 10 years. Of all respondents, more participated from California (11%), New York (8%), Texas (7%), Pennsylvania (5%), and Florida (5%) (these five areas are also states with high multilingual population counts), whereas there were no respondents from Rhode Island, South Dakota, or West Virginia.

More than a third of the respondents (39%) report comfort using another language outside of spoken English for academic, professional, and/or personal purposes, although only 29% self-identify as multilingual service providers according to ASHA's current description. Of those comfortable using an additional language or languages, 13% of respondents "often or always" do, whereas 19% of respondents "sometimes" do. The survey even captures additional languages (Galician, Papiamento) not represented among ASHA's current multilingual service providers. For the purposes of data analysis and interpretation, respondents who indicate that they are comfortable using an additional language outside of spoken English are classified as multilingual. Conversely, those who are not comfortable using an additional language are considered monolingual.

Highlights

- Of all respondents, most (92%) have a current caseload with one or more multilingual persons.[1] Of these, 61% have a caseload ranging from 1% to 30% multilingual persons, and 31% report that more than one third of their clients are multilingual. Compared with monolingual service providers (29%), multilingual service providers (77%) report that 40% or more of their clients are multilingual.
- More than half of the multilingual providers (75% audiologists and 51% SLPs) report a requirement to deliver services in additional languages besides English, whereas 73% of monolingual SLPs do not have this requirement.
- Although 40% of all respondents are required to report standardized test scores (or results) for eligibility determination or reimbursement, monolingual (50%) and multilingual (53%) SLPs are more likely to report this requirement. Equally alarming, 55% of respondents are not required to translate clinical documents and written communications into additional languages.

[1] The Committee defines a *multilingual person* as someone who expresses themselves in more than one language, has been exposed to more than one language, or may be learning English while using an additional language or languages.

- Almost 50% of respondents say they secured on-site interpreting services for practice using multiple languages in the last year. A less popular—but widely used—method includes in-person and remote support (hybrid interactions) and telephonic interpreting services (both used by 39% of respondents). Video interpreting services and machine-based (or artificial intelligence [AI]–based) interpreting services are common methods as well, used by 35% and 24%, respectively, of all respondents in the last year.
- Language support is most often provided by a client's family member, friend, or cultural brokers/informants (59%) or certified and/or licensed interpreters, translators, and/or transliterators (42%). Less common sources of language support include collaborating with multilingual non-CSD professional staff (32%), working with multilingual CSD assistants (9%), or providing interpretation services themselves as multilingual providers.
- In general, 53% of all respondents say that they face challenges to addressing multiple languages in service delivery; of the respondents who are SLPs, the percentage is slightly higher (55%). The two most common challenges are (1) diagnosing, treating, and managing communication disorders using the client's languages and (2) accessing less biased assessment tools and/or language-specific materials. Additional challenges include supporting communication outside of English, securing language assistance services or language-matched service providers, and locating cultural and linguistic features and normative data for named languages and dialects. More SLPs rank these as their top challenges, despite language status. Multilingual SLPs consider the role of advocating for resources to support service delivery to be more challenging.
- When asked about supports needed to improve the quality of care for clients whose languages that the member does not use, the top three needed supports among all respondents are (1) access to interpreters and translators; (2) language-specific assessment tools, research, resources, and materials; and (3) content- and/or language-specific training to improve skills for service delivery.
- Only 34% of all respondents are required to engage in professional development related to multilingual service delivery. The three most popular and interesting topics in multilingualism are (1) assessment and intervention approaches, materials, and tools; (2) differential diagnosis of speech, language, and hearing disorders; and (3) cultural and linguistic features of named languages and dialect varieties. In addition to these areas, monolingual audiologists want more information on collaboration with interpreters and on language access laws and rights. Monolingual SLPs want more information on second language acquisition and on multilingual communication development, whereas multilingual SLPs want to learn more about successful strategies for working with multilingual persons.
- Respondents report that the following items are the most popular sources for guidance, professional development opportunities, evidence-based resources, and technical assistance to support multilingual service delivery: free ASHA resources (78%); related professional associations and non-profit organizations (44%); and ASHA written content, like Practice Portal documents, live chats, or journal articles (39%). Overall, more SLPs use free, paid, and written ASHA tools than do audiologists.

- Members prioritize actions that they believe ASHA can take to support CSD professionals in service delivery with multilingual clients, including (1) design accessible and easy-to-use resources for clinical analysis and decision making; (2) advocate for funding, compensation, and/or reimbursement when additional languages are needed; and (3) create professional development focused on multilingual service delivery and language-specific assessment tools, research, resources, and materials.

Review of Existing ASHA Resources

The Committee determined that there was a need to examine the available ASHA resources related to multilingual service delivery. A subcommittee was established to identify and critique ASHA resources (including rescinded documents) to inform competencies and recommendations. Particular consideration was given to ASHA resources that are free and accessible to practitioners via the Internet. Although the focus was on multilingual service delivery, relevant documents that are broadly related to cultural and linguistic diversity were also considered. For a complete list of resource titles, types, and links, see Appendix C.

ASHA offers several resources that support multilingual service delivery. Of particular importance is the Bilingual Service Delivery Practice Portal page (ASHA, n.d.-a). The Committee appreciates that ASHA staff members are currently in the process of completing a much-needed update to this portal. ASHA also provides other resources that contain information about multilingualism, the benefits of multilingualism, and some information about languages outside of spoken English—all of which members will find helpful.

The resource review raised some general concerns, which include the following:

- Many resources are outdated. Some of the ways in which multilingualism is conceptualized and discussed have evolved. Concepts such as translanguaging and sociolinguistic frameworks have changed how we think about communication. Newer research can inform members' understanding of multilingualism and clinical practice.
- Many resources are difficult to find online unless one knows where to look for them.
- The utility of the resources is limited by lack of context. Details about different languages and multilingualism are scattered throughout the ASHA website and microsites. Without training or support, it can be difficult to understand how to put the pieces together to make clinical decisions.

To consider how providers might use ASHA resources, the subcommittee conducted a sampling of clinical questions related to multilingualism posted by audiologists and SLPs to various social media platforms. More than 30 posts were identified that covered various aspects of speech, language, hearing, cognition, and swallowing across the lifespan. We found that, for many questions, ASHA resources provided little to minimal guidance. Questions related to general issues, such as working with interpreters or assessing dual language learners in the schools, could be directed to ASHA's online resources. However, many questions were for specific languages or clinical goals not clearly addressed in any ASHA resources.

The Committee recognizes that ASHA cannot provide resources to answer every potential clinical question related to multilingual service delivery. However, the Committee spent significant time discussing the importance of modeling for practitioners how to think through clinical decisions related to multilingual service delivery. Resources designed to guide practitioners through models and frameworks for multilingual assessment and intervention can help those practitioners develop skills that they can then carry across different clinical contexts. The intent is not to be prescriptive but rather to offer practitioners options and examples for how to think through clinical questions.

Developing the Competencies

The development of competencies for multilingual service delivery began with an understanding of the historical context. Competencies and recommendations were pulled from ASHA documents and resources (both current and rescinded) related to multilingual service delivery. The Committee worked to revise, update, and delete competencies while also identifying knowledge and skill areas that were lacking. Consideration was given to current research, critical approaches to communication, and the importance of social and linguistic justice. The competencies went through a series of reviews and revisions within the Committee and a review by members of the Multicultural Issues Board.

Generating Recommendations

The cumulative activities of the Committee led to the development of recommendations for supporting effective, ethical, and culturally sustaining multilingual service delivery. The recommendations went through a series of reviews and revisions within the Committee and a review by members of the Multicultural Issues Board.

Conclusion

The following pages offer a list of competencies for engaging in clinically relevant and culturally sustaining multilingual service delivery, recommendations to the ASHA BOD for supporting clinicians in multilingual service delivery, and appendixes containing supporting materials. The Committee believes that the impact of defining and supporting multilingual service delivery is far reaching and that the competencies and recommendations can inform priorities for advancing ASHA's Strategic Objectives, including the following:

- Objective #4: Enhance service delivery across the continuum of care to increase value and access to services
- Objective #5: Increase influence and demonstrated value of audiology and speech-language pathology services
- Objective #6: Increase Diversity/Equity/Inclusion (DEI) within the Association and the discipline

- Objective #7: Enhance international engagement
- Objective #8: Increase members' cultural competence
- Objective #9: Transform learning across the discipline

The relevance of this work to objectives related to DEI is clear. However, it is important for the professions to move away from seeing multilingual service delivery as confined to an isolated context and population. Instead, we must view multilingual service delivery as a critical component that is infused into, and underlying across, all aspects of the professions—regardless of context, population, demographics, or specific areas of focus. In a multilingual world, developing competency in multilingual service delivery enhances the value of, and access to, the services that ASHA members offer. Developing multilingual service delivery competencies requires a fundamental transformation of knowledge and learning throughout the professions to de-center monolingualism and English. These implications are addressed in more detail in the recommendations.

List of Appendixes

- Appendix A: Bill of Language Rights
- Appendix B: 2023 Bilingual Service Delivery Survey Results
- Appendix C: Review of Existing ASHA Resources Related to Multilingual Service Delivery

ASHA Member Competencies for Multilingual Service Delivery

This section lists competencies for culturally and linguistically sustaining multilingual service delivery, broken down into two major areas:

- Competencies for Engaging in Cross-Linguistic and Multilingual Practice (Competencies 1–7)
- Competencies for Clinical Practice When the Client/Patient/Student Uses More Than One Language (Competencies 8–18)

Competencies for Engaging in Cross-Linguistic and Multilingual Practice

1. Engage in culturally responsive and critically reflective practice.
    1.1. Acknowledge systemic inequities and how they impact educational and health disparities.
    1.2. Acknowledge the impact of social and political power and prestige—and established policies on language choice and use.
    1.3. Practice self-reflection to develop awareness of one's own privilege, positionality, beliefs, and biases—and their impact on clinical decision making.
    1.4. Articulate the importance of personal and environmental factors on clinical decision making, such as age; citizenship; disability; education; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; socioeconomic status; or veteran status.
2. Advocate for consumers, families, and communities in the areas of communication, cognition, hearing, swallowing, and balance.
    2.1. Increase familiarity with community resources available for the dissemination of educational, health, and medical information in the languages common to local communities.
    2.2. Support local communities in preventing and reducing the risk for communication, swallowing, cognitive, hearing, and balance-related health conditions.
    2.3. Support the advocacy efforts of clients, patients, families, and communities in the areas of communication, swallowing, cognition, hearing, and balance.
    2.4. Provide information in written and/or spoken forms in the preferred language(s) and language modalities of the client/patient/student and their family members and care partners.

3. Consider the effect of the intersection of language and culture on the communication of the client/patient/student.

    3.1. Obtain information on the linguistic community of the client/patient/student in order to identify significant cultural and linguistic influences.

    3.2. Identify socialization patterns that affect speech and language development and use in the communities of the client/patient/student.

    3.3. Consider the impact of the client/patient/student's social representation (including attitudes, values, and beliefs) on fostering multiple communicative modalities using AAC (including signed languages) and assistive technology.

    3.4. Acknowledge how the standards of communicative competence in the communication environment of the client/patient/student impact speech and language use.

4. Develop effective collaborative relationships with interpreters, translators, and cultural brokers.

    4.1. Uphold federal guidelines for ensuring language access in health care and educational settings.

    4.2. Advocate for sustainable funding for interpreter, translator, and cultural broker services.

    4.3. Employ effective processes and procedures for working collaboratively with interpreters, translators, and cultural brokers.

        4.3.1. Describe the roles and responsibilities of interpreters, translators, and cultural brokers and the skills required of an effective interpreter, translator, or cultural broker.

        4.3.2. Clarify the roles and responsibilities of audiologists, SLPs, and assistants when working with interpreters, translators, and cultural brokers.

        4.3.3. Distinguish between, and adhere to, the differing roles of the CSD provider and the interpreter, translator, and/or cultural broker.

        4.3.4. Develop processes and procedures for effectively working with the range of individuals (including trained professionals, community members, family, and paraprofessionals) who can act as interpreters, translators, or cultural brokers.

        4.3.5. Implement the briefing (pre-session), interaction, and debriefing (post-session) format for effectively working with an interpreter.

        4.3.6. Provide the information required by interpreters, translators, and cultural brokers to maximize engagement in cross-linguistic interactions.

5. Establish foundational knowledge of speech and language features and processes of various languages to inform clinical practice.

    5.1. Obtain information on the features and developmental characteristics of the language(s) and dialect(s) spoken or signed by the client/patient/student.

    5.2. Identify, obtain, and integrate available resources, and/or consult with relevant persons, to observe typical speech and language development in the speech community and communication environment of the client/patient/student.

    5.3. When applicable, explain the limitations of available resources and gaps in existing resources, particularly in the many languages of a diverse society.

    5.4. Identify and implement least-biased assessment processes as needed for informative and accurate assessment, including holistic assessment procedures.

    5.5. Determine when and how the assessment process must be modified to account for the language(s) of assessment.

    5.6. Explore the research and preferred practice patterns in the assessment of communication, swallowing, cognition, hearing, and balance for the language(s) of assessment.

    5.7. Utilize an assessment process that integrates multiple sources of information about the communication, swallowing, cognitive, hearing, and balance skills of the client/patient/student.

    5.8. Incorporate common speech, language, cognition, hearing, and swallowing development and use patterns for the language(s) of assessment when formulating a diagnosis.

    5.9. Implement effective communicative interaction strategies and interviewing techniques, such as ethnographic and motivational, so care partner/parent and/or client/patient feels comfortable providing accurate and complete information.

        5.9.1. Conduct family/care partner/teacher interviews to gather qualitative data.

        5.9.2. Implement communication strategies to engage effectively with care partners/family and/or client/patient/student.

    5.10. Critique and mitigate sources of cultural and linguistic bias in the assessment process.

    5.11. Identify state and federal guidelines for qualifying for speech, language, and hearing services in schools and their implications for cultural and linguistic diversity.

    5.12. Appraise the intended use of standardized tests and interpretation of standard scores.

        5.12.1. Articulate the limitations of, and harm caused by, standardized assessment.

5.12.2. Advocate for the validity of assessment methods other than standardized tests.

5.12.3. Explain the inherent problems in using formal and informal translations of tests.

5.12.4. Articulate how any deviation from the standardized procedures and mismatch between the client/patient/student and the standardization sample of a test invalidates standardized scores.

6. Provide evidence-based intervention that supports the language(s) and communication modalities of the client/patient/student.

   6.1. Evaluate the cultural and linguistic context of evidence-based practice and the limitations of applying evidence across languages and cultures.

   6.2. Integrate evidence-based practice, practice-based evidence, and community-engaged learning to facilitate best outcomes.

   6.3. Prioritize client and family perspectives to guide treatment planning.

   6.4. Develop strategies for facilitating outcomes relevant to the language(s) of the client/patient/student.

7. Consider the use and limitations of technologies that are designed to assist communication across languages.

   7.1. Appraise emerging and existing web and app-based language assistance technologies.

   7.2. Integrate multiple technologies to promote language access and note their strengths and weaknesses in aiding cross-linguistic communications.

   7.3. Observe and obtain client/patient/family/care partner feedback on available technological options.

Competencies for Clinical Practice When the Client/Patient/Student Uses More Than One Language

8. Develop foundational knowledge in multilingualism.

   8.1. Identify the cognitive and linguistic benefits of multilingualism.

   8.2. Approach multilingual competence as a continuum of communication skills that vary across languages, topics, modality, and contexts.

   8.3. Identify factors—such as education and community value—that influence multilingual language competence across the lifespan.

8.4. Explain why the distinction between *social language* and *academic language* is important in understanding second (or additional) language acquisition.

8.5. Consider how one's heritage language may continually influence how a client/patient/student speaks or signs in additional language(s).

9. Discuss *code-switching* and *code-mixing* as rule-governed language.

9.1. Explain the social influences on code-switching and code-mixing.

9.2. Describe the grammatical constraints on code-switching and code-mixing.

10. Communicate the benefits of multilingualism to families who may have been told or made to feel that they should avoid using languages outside of spoken English with their children and family members.

11. Explain patterns of language development and multilingualism, including the following:

11.1. The difference between an *accent* and a *dialect.*

11.2. Typical language development in varying multilingual acquisition contexts (e.g., simultaneous, sequential, etc.).

11.3. The processes that are characteristic of second-language acquisition, including language transfer, language attrition, interlanguage, and affective variables.

11.4. Typical development in the client/patient's language(s) and dialect(s).

12. Describe models of multilingual education and English language development (ELD).

12.1. Explain the impact of different models on first language (L1) and second/additional (L2) language development.

12.2. Establish familiarity with the multilingual and ELD learning models offered in the local school district.

13. Examine how specific speech, language, and hearing health conditions manifest in multilingual speakers; including but not limited to the following:

13.1. Explain how patterns of language use may change for multilingual persons experiencing neurological recovery or decline.

13.2. Stuttering can vary across the language(s) of a client/patient/student.

13.3. Multilingual speakers may experience increased difficulty processing sound in noise.

14. Implement assessment processes that (a) reduce bias and (b) support an informative and accurate multilingual assessment.

14.1. Conduct assessments of communication, swallowing, cognition, and hearing that account for skills in all languages the client/patient/student uses.

14.2. Develop skills in acquiring information on language history and use as well as the implications for speech and language development and competence.

14.3. Consider speech and language patterns in light of how languages that are in contact with one another influence one another.

14.4. Observe how specific patterns of skills in speech, language, hearing, and cognition can manifest in similar ways and different ways between a communicator's languages.

15. Recognize factors to consider in selecting language(s) of intervention.

    15.1. Include the client/patient/student and their family/care partners in determining the preferred language(s) for intervention.

    15.2. Match goals to language(s) based on individual needs.

16. Implement strategies to facilitate generalization of treatment effects between languages and contexts.

    16.1. Include the family to support heritage and/or preferred language(s).

    16.2. Plan carryover activities in heritage and/or preferred language(s).

    16.3. Support and create space for an individual's repertoire of language skills, encouraging a range of communicative efforts.

    16.4. Recognize the need for scaffolding accessibility for social and/or academic skills needed in their linguistic environment.

17. Support the maintenance of heritage language comprehension and use for individuals who communicate by using AAC or assistive technology.

18. Consult and collaborate with the multilingual and ELD instructors during assessment and intervention in schools. This collaboration can occur in many ways, ranging from meaningful conversations to formal, planned activities. By collaborating, the professionals should do all of the following tasks:

    18.1. Share ideas, resources, and plans.

    18.2. Compare results and interpretations of assessments with the ELD instructor.

    18.3. Coordinate goals and objectives, and develop intervention plans.

    18.4. Evaluate progress toward speech and/or language intervention goals and ELD goals.

18.5. Prepare for, and participate in, individualized education program (IEP) or individualized family service plan (IFSP) reviews.

Recommendations

The Ad Hoc Committee on Bilingual Service Delivery makes the following recommendations:

1. **Recommendation: That the ASHA BOD request that the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) and Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) consider ways to integrate the *ASHA Member Competencies for Multilingual Service Delivery* drafted by this Committee into accreditation and certification standards.**

Current and future ASHA members must be prepared to address the unique linguistic needs of a multilingual population. The Committee is aware that the Association is exploring, through Strategic Objective #9, a competency-based educational model that could guide educational preparation and determination of competency for clinical practice. The Ad Hoc Committee on Graduate Education for Speech-Language Pathologists (2020) concluded that "competencies should be considered for areas such as critical thinking, problem-solving skills, professional responsibilities, ethics, cultural competence, interprofessional collaborative practice, evidence-based practice, and both oral and written communication skills (p. 49)." This Committee has attended to these overarching areas in the *ASHA Member Competencies for Multilingual Service Delivery*, as a starting point for integration. The Committee encourages the BOD to share the proposed *ASHA Member Competencies for Multilingual Service Delivery* with the SO #9 Team, as well as with CAA and CFCC as competencies are considered and explored further.

2. **Recommendation: That the ASHA BOD request that the ASHA Scientific and Professional Education Board (SPEB) increase the number of professional development course offerings for certification maintenance related to multilingual service delivery, including content on underserved languages/communities.**

The Committee is aware that the most recent version of the CAA Standards for Accreditation of graduate education programs in audiology and speech-language pathology, includes greater specificity related to diversity, equity, and inclusion (DEI), including addressing the communication needs of multilingual persons. This should increase the likelihood that audiology and speech-language pathology graduate students will demonstrate emerging competence for multilingual service delivery. Similarly, the CFCC's certification maintenance requirement for DEI-focused professional development could increase the likelihood that all members, both monolingual and multilingual service providers, will take courses related to multilingual service delivery.

It would benefit clinicians and those they serve to expand professional development/continuing education offerings on multilingual service delivery, including content on various named languages, given the increased focus on DEI in CSD, the scope of the *ASHA Member*

Competencies for Multilingual Service Delivery, and the high likelihood that clinicians will encounter multilingual clients/patients/students in clinical practice. Language-specific content could focus on the top languages beyond spoken English, that are used in the US, such as but not limited to Spanish, Arabic, Mandarin/Cantonese, Tagalog, French and Vietnamese. Course offerings could also be based on the subject matter expertise and language experience ASHA members have to develop such courses.

3. **Recommendation: That ASHA create specific messaging to widely publicize the option to include time spent learning another language as professional development hours for certification maintenance to meet the new diversity, equity, and inclusion (DEI) requirement.**

Although language learning is currently one option to meet certification maintenance standards, ASHA members could benefit from more explicit and prominent messaging about acceptable opportunities and procedures for earning professional development hours/continuing education units in this way. Promotion of language learning options as a way to meet the diversity, equity, and inclusion (DEI) requirement for certification maintenance could demonstrate a clearer urgency for monolingual practitioners to build familiarity with the various languages they may encounter clinically, while multilingual practitioners could increase their confidence and competence using their target languages (and/or additional languages). This would be a way to expand the knowledge of and skills in languages and dialects outside of spoken General American English, support competence in multilingual service delivery, and over time, may increase the number of ASHA members who can provide services in multiple languages as multilingual service providers.

4. **Recommendation: That the ASHA BOD accept the *Bill of Language Rights* as essential professional expectations for multilingual service delivery.**

The *Bill of Language Rights* promotes language equity and justice by prioritizing clients' and families' human right to communication and service delivery in their language(s). If accepted, the *Bill of Language Rights* would be widely available to ASHA members and the public as a formal declaration that clarifies and affirms ASHA's long-held position that members acknowledge and respect the linguistic practices of multilingual persons and will respond appropriately to their needs in service delivery. The *Bill of Language Rights* was inspired by the National Joint Committee's *NJC Communication Bill of Language Rights* (ASHA, n.d.-a), and aligns with the requirements of existing legislation and *National Culturally and Linguistically Appropriate Services (CLAS) Standards* that require service delivery in the client/patients/student's languages.

As a resource, this document outlines expectations that are aligned with the *ASHA Member Competencies for Multilingual Service Delivery* for culturally and linguistically sustaining service delivery. ASHA members can (a) reference the *Bill of Language Rights* to ensure these rights are honored in their daily interactions and interventions involving multilingual persons, and (b) share the *Bill of Language Rights* with supervisors, administrators, payers, policymakers, and

clients/patients/students and families/care partners to influence decisions related to multilingual service delivery and caseload management.

The *Bill of Language Rights* is fundamentally based on the provider's perspective and was drafted and reviewed by practitioners and scholars, most of whom are multilingual. To ensure that this document fully captures the needs of multilingual clients/patients/students—as well as the professional and ethical expectations of clinical interactions with ASHA members—this document should include feedback from consumers prior to disseminating it to ASHA members. This will demonstrate ASHA's commitment to (a) listening to and partnering with multilingual consumers, (b) promoting linguistic justice, and (c) changing member practices to reduce harm.

5. **Recommendation: That ASHA prioritize the creation and expansion of additional resources that are clear, accessible, and comprehensible, to support clinical decision making in multilingual service delivery.**

The Committee appreciates that existing ASHA resources provide clinicians with needed facts and guidance related to multilingual service delivery. However, the committee's work uncovered unmet needs that can be addressed with new and/or expanded resources, in the areas of:

- Advocacy (e.g., salary supplements for multilingual service providers, funding and reimbursement for language assistance services, workload management, state guidelines for multilingual service delivery)
- Interprofessional practice and interprofessional education (e.g., collaborating with interpreters, translators, cultural brokers, English Language Development (ELD) teachers, DHH teachers, etc.)
- Tools, clinical approaches, and materials for use with multilingual populations (e.g., language-specific stimuli, contrastive analysis, translated consumer content, etc.)
- Multilingual service delivery in audiology practice
- Multilingual service delivery with adults, seniors, and AAC users
- Training materials for audiologists, speech-language pathologists, assistants, non-CSD professional staff, and family/community members who may provide language assistance services and support

Members are also in urgent need of cohesive, digestible, and interactive multimedia content that links information to form a clear direction for clinical practice. They need to know how to think through clinical cases and how to use the available resources most effectively and efficiently. To meet this need, the Committee recommends that ASHA take the following actions:

- Create video-based case studies that present frameworks that guide clinicians on taking the next best step in multilingual service delivery. The cases can demonstrate how to use ASHA resources at the relevant stages of clinical decision making.
- Increase the quantity of practical clinical resources and tools, such as video-based tutorials and modeling, scripts for service delivery in additional languages, and more user-friendly, bite-sized content featured on the That's Unheard Of microsite.

- Integrate updated research, terminology, and frameworks into resources on multilingual service delivery, and infuse information pertaining to multilingual persons with communication needs across the "Big Nine."
- Offer webchats and/or promote ASHA Online Community posts that demonstrate how to work through a case while allowing participants to ask questions, discuss their ideas, and share experiences. A summation of the processes and resources could be offered to make the procedures clear and actionable.
- Update editorial guidelines to minimize the use of the term "issues" to describe resources that cover topics related to multilingualism and multiculturalism and avoid "othering" (e.g., languages other than English) as much as possible. These editorial changes would avoid framing these topics as "problematic" and may minimize negative assumptions about multilingual service delivery and multilingual individuals.

The Committee acknowledges that resources are currently being updated, created, and disseminated to support multilingual service delivery. The suggestions and strategies herein are based on a review of the resources available at the time. As is customary for ASHA's new, updated, and existing offerings, priority should be given to making resources related to multilingual service delivery easily accessible for and widely disseminated to members.

6. **Recommendation: That ASHA build into new and/or existing communities an electronic platform for the free exchange of resources in languages commonly used by ASHA members and consumers to support multilingual service delivery.**

Clinicians often request and share materials on social media and in the ASHA Online Community groups. Unfortunately, this content is isolated and difficult to find. Survey results showed that most clinicians are not required to translate clinical documents and written communications into additional languages, although some do. Multilingual service delivery would be enhanced if clinicians had a central location for finding and sharing information and resources in additional languages.

The Committee is aware that ASHA has launched a project to develop an equity and accountability action site where users can report efforts and share ideas for systemic changes that promote DEI in their organizations/facilities. This companion microsite to That's Unheard Of, will be a welcome and timely addition to ASHA's suite of websites that could host the exchange of information in additional languages developed by organizations. Resources could include but should not be limited to patient education materials, clinical tools/materials, scripts to guide and support common clinical interactions, research summaries, and CSD glossaries. Resources could be generated and shared by ASHA members based on the languages they use and need (see language suggestions from recommendation #2) for multilingual service delivery, thus placing minimal demands on ASHA staff or volunteers.

7. **Recommendation: That ASHA use the Committee's definitions of *multilingual service delivery and multilingual service provider* to revise the Bilingual Service Delivery**

Practice Portal page, and that the page be expanded to focus on Multilingual Service Delivery.

The Bilingual Service Delivery Practice Portal page is ASHA's foremost clinical decision-making tool related to multilingual service delivery. However, the Committee recommends *multilingual* in place of *bilingual,* as a more inclusive term that characterizes contexts in which two or more languages are used. Thus, the definition and competencies for multilingual service delivery should be integrated into a Multilingual Service Delivery Practice Portal page, replacing the Bilingual Service Delivery Practice Portal page.

Likewise, the current definition/description of "bilingual service providers," should be revised to refer to "multilingual service providers," and acknowledge the dynamic and multidimensional nature of multilingualism. The definition/description of *multilingual service providers* would be enhanced by:

- Acknowledging and affirming providers whose first language is not English, as they bring valuable linguistic and cultural assets to CSD and society
- Ensuring that *ASHA member competencies for multilingual service delivery* are embedded into roles and responsibilities
- Outlining the expectations of multilingual assistants, who also provide services using multiple languages, but are not included in the current description
- Updating descriptors, such as "native or near-native," and static conceptualization of "proficiency," which fail to reflect the dynamic nature of language skills that can vary across context and modalities—and across a lifespan

Enhancing the definition of *multilingual service provider* could significantly improve *multilingual service delivery* by helping practitioners understand how their range of skills across languages can (and cannot) be used in clinical contexts.

8. **Recommendation: That ASHA implement strategies and create new resources to retain and support multilingual service providers, as they seek equitable workloads and adequate compensation for their professional duties.**

Multilingual service providers are experiencing overwhelming demands on their time and resources by delivering services in multiple languages and many are providing language assistance services (interpretation and translation) themselves. Though not solely responsible for multilingual service delivery, multilingual service providers bring immense value to workplaces and communities by expanding access to language-matched speech-language and hearing services with cost-saving efficiency. Focused efforts are needed to promote the retention of multilingual service providers, who often report challenges and stressors related to their professional duties. Multilingual service providers need resources to advocate for manageable workloads and compensation for their unique clinical skills and roles. Specific resources should include:

- Advocacy tools for educating organizational leadership about the demands, responsibilities, and resource needs of multilingual service providers

- Demonstrations/examples of the costs of securing language assistance services and the consequences of misidentification of multilingual persons to convey the value of language-matched service providers in CSD
- Tips for salary negotiations to increase compensation for multilingual skills
- Workload management tools and strategies that consider the time multilingual service providers need to (a) develop tools for service delivery and (b) effectively communicate with families and care partners.

The Committee acknowledges that ASHA focuses on the recruitment of multilingual service providers, which could also minimize the additional burdens placed upon multilingual service providers. In addition to supporting monolingual service providers to develop competencies in multilingual service delivery, a focus on retention (and recruitment) of multilingual service providers would add more language-matched providers in CSD and support to keep them in the professions.

9. **Recommendation: That the ASHA BOD request that the Journals Board, Research and Scientific Affairs Committee, and the Committee on Clinical Research, Implementation Science, and Evidence-Based Practice implement strategies to increase the inclusion of multilingual participants in research, and to curate and disseminate scholarship in the discipline related to multilingual service delivery.**

Clinical decision making relies heavily on evidence-based practice—particularly, scientific research that demonstrates efficacy and effectiveness. However, there are obstacles that limit the publication of research that can inform multilingual service delivery. Research may limit non-English-speaking and/or multilingual participants to maintain participant homogeneity. As an example, approximately 150 articles are published *per year* on White monolingual, non-Latino, English-speaking children with speech and language diagnoses as study participants. Yet approximately 25 articles have been published *in the past 30 years* that include multilingual children with speech sound disorders in their study samples (updated from Kohnert & Medina, 2009). Researchers may fail to specify the race or even the language of the participants (Beveridge & Bak, 2011; Ellis, 2009). Additionally, racism and entrenched definitions of (and criteria around) what scholarship is worthy of publication creates obstacles for researchers who study the topics of (a) multilingualism and (b) languages besides English (Horton et al., 2023).

Multilingual service delivery is hampered by the lack of diverse and generalizable assessment and treatment research. Many of the journal articles and standards have been written (and norms derived) for monolingual General American English speakers across their lifespan. It is imperative that researchers (a) prioritize language and cultural diversity in the selection of research questions and participants and (b) directly address obstacles in the review and dissemination of scholarship.

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Appendix A

Bill of Language Rights
(Under Consideration by the Board of Directors of the American Speech Language Hearing Association)

Communication is a fundamental human right. All persons, regardless of their communication ability, have an essential right to communicate in their preferred and heritage language(s), including signed language(s) and via augmentative and alternative communication. Given that language is deeply rooted in and inseparable from culture, and is a defining element of a person's identity, language rights are a powerful extension of human rights. This *Bill of Language Rights* is to explicitly emphasize clients and families as well as their distinctive narratives, and to prioritize their communication in any chosen language(s). This document is a critical step toward changing current practices to ensure language justice.

Historically, a monolingual, English-only ideology has prevailed in the United States and has overly influenced clinicians, researchers, aides, technicians, assistants, and students in audiology and speech-language pathology. This ideology has done great disservice to speakers of world languages and multilingual persons with and without communication disorders and has resulted in the abject failure to create an environment that nurtures linguistic diversity and preserves heritage languages. Honoring clients' language rights is integral to socially just, culturally responsive, culturally sustaining, and ethical practice in audiology and speech-language pathology. Without a holistic consideration of clients' relevant and meaningful languages, audiologists, speech-language pathologists, and aides, technicians, assistants, and students cannot accurately understand or support clients' language expression and comprehension abilities or their functional communication repertoire.

With this *Bill of Language Rights*[2], we uphold that each person has the following fundamental language rights:

1. The right to be provided equitable care and unconditional respect as a multilingual communicator, regardless of language background.
2. The right to service delivery without the influence of linguistic racism, discrimination, or exclusion in any context.
3. The right to access care and services in their heritage language(s).
4. The right to communicate in their heritage language(s).
5. The right to have translanguaging[3] recognized as a valid index of communicative competence.
6. The right to communicate with a clinician who understands the client's language(s) and related cultural or linguistic frameworks pertaining to communication and health.
7. The right to access trained interpreters who can support the client's language understanding and expression.
8. The right to receive multimodal resources in heritage language(s).
9. The right to make informed decisions about language interventions that prioritize, preserve, and nurture their heritage language(s).
10. The right to have access to service providers with training in culturally, linguistically and historically responsive practices.

[2] In discussing multilingualism, it is necessary to include visual forms of language for Deaf and Hard of Hearing (DHH) populations. Authors of this document acknowledge there are circumstances wherein children with hearing loss may have been deprived access to a formal language and therefore, may have not established a solid language foundation. This population requires special consideration when conducting evaluations or planning intervention. This discussion is beyond the scope of this proposed *Bill of Language Rights.* For more information, view ASHA's Practice Portal page on *Language and Communication of DHH Children* and the National Association of the Deaf's (NAD) *Bill of Rights for DHH Children*.

[3] *Translanguaging:* This term refers to the natural and fluid language practices of bi/multilingual persons and presents a way of conceptualizing and honoring how a multilingual person dynamically uses their full linguistic repertoire.

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2023 Bilingual Service Delivery Survey Results

Survey Methodology and Response Rate

On February 28, 2023, a web-based survey was fielded to 4,000 CCC-A and 5,000 CCC-SLP professionals. Follow-up email reminders were sent to non-respondents on March 7th and 14th. The survey closed on March 17th. A total of 458 (156 CCC-A and 302 CCC-SLP) individuals completed the survey for an overall response rate of 5.1% (3.9% for CCC-A and 6.0% for CCC-SLP). This report was prepared by ASHA's Surveys and Analysis Team.

Notes

Data with an *n* size of < 25 should be considered with caution. Percentages are rounded and may not add to exactly 100%. Comments have been edited for spelling.

Survey Results

1. Approximately what percentage of your current caseload includes multilingual persons?

Percentiles	All Respondents (*n* = 452)		Monolingual CCC-As (*n* = 72)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n* = 117)		Bi/Multilingual CCC-SLPs (*n*= 95)	
	%	#	%	#	%	#	%	#	%	#
0%	7.7	35	--	--	--	--	--	--	--	--
1-10%	35.2	159	40.3	29	25.0	10	47.9	56	26.3	25
11-20%	14.4	65	25.0	18	20.0	8	12.8	15	10.5	10
21-30%	11.3	51	15.3	11	20.0	8	14.5	17	5.3	5
31-40%	8.0	36	7.0	5	7.5	3	8.5	10	8.4	8
41-50%	6.6	30	4.2	3	15.0	6	4.3	5	7.4	7
51-60%	2.2	10	2.8	2	2.5	1	2.6	3	3.2	3
61-70%	2.4	11	0.0	0	2.5	1	3.4	4	5.3	5
71-80%	5.1	23	4.2	3	5.0	2	1.7	2	11.6	11
81-90%	5.3	24	1.4	1	0.0	0	3.4	4	15.8	15
91-100%	1.8	8	0.0	0	2.5	1	0.9	1	6.3	6

Note: Dash (—) = 0.0% or 0.

2. When working with multilingual clients in your current work setting, are you required to:

Response	All Respondents		Monolingual CCC-As		Bi/Multilingual CCC-As		Monolingual CCC-SLPs		Bi/Multilingual CCC-SLPs	
	%	#	%	#	%	#	%	#	%	#
Deliver services in English only?										
Yes	18.3	72	4.2	3	10.0	4	34.2	40	12.6	12
No	74.8	294	91.6	65	87.5	35	54.7	64	83.2	79
I don't know	6.9	27	4.2	3	2.5	1	11.1	13	4.2	4
Deliver services in additional languages besides English?										
Yes	48.4	190	76.1	54	75.0	30	18.8	22	50.5	48
No	45.0	177	21.1	15	25.0	10	72.7	85	43.2	41
I don't know	6.6	26	2.8	2	0.0	0	8.6	10	6.3	6
Engage in professional development related to multilingual service delivery?										
Yes	34.4	135	25.4	18	27.5	11	39.3	46	31.6	30
No	61.7	242	73.2	52	62.5	25	56.4	66	67.4	64
I don't know	3.8	15	1.4	1	10.0	4	4.3	5	1.1	1
Report standardized test scores for eligibility determination or reimbursement?										
Yes	40.0	156	15.5	11	17.5	7	50.4	59	53.2	50
No	46.7	182	64.8	46	47.5	19	44.4	52	42.6	40
I don't know	13.3	52	19.7	14	35.0	14	5.1	6	4.3	4
Translate clinical documents and written communications into additional languages?										
Yes	39.1	153	22.5	16	37.5	15	48.7	57	42.1	40
No	55.2	216	73.2	52	60.0	24	46.2	54	51.6	49
I don't know	5.6	22	4.2	3	2.5	1	5.1	6	6.3	6

3. In the last 12 months, how have you collaborated with interpreters in service delivery? (Select all that apply.)

Answer Choices	All Respondents (*n* = 366)		Monolingual CCC-As (*n* = 69)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n*= 111)		Bi/Multilingual CCC-SLPs (*n*= 91)	
	%	#	%	#	%	#	%	#	%	#
Machine- (or AI-based) interpreting services, usually app- or web-based	23.8	87	33.3	23	17.5	7	23.4	26	25.3	23
Mixed interactions; combinations of in-person and virtual	39.3	144	46.4	32	42.5	17	33.3	37	41.8	38
On-site interpreting services, with all participants in-person	49.5	181	65.2	45	62.5	25	45.1	50	42.9	39
Telephonic interpreting services	38.5	141	58.0	40	37.5	15	40.5	45	24.2	22
Video interpreting services	35.0	128	56.5	39	50.0	20	23.4	26	30.8	28
With a multilingual audiology assistant or SLP assistant	9.3	34	11.6	8	10.0	4	10.8	12	7.7	7

Question 3 Table Continued										
With multilingual professional staff (not practicing in the communication sciences and disorders [CSD] professions)	31.7	116	20.3	14	30.0	12	37.8	42	38.5	35
With certified and/or licensed interpreters, translators, and/or transliterators	41.8	153	58.0	40	50.0	20	38.7	43	31.9	29
With client's family member, friend, or cultural brokers/informants	58.7	215	65.2	45	82.5	33	48.7	54	55.0	50
Other (See below.)	7.7	28	4.4	3	10.0	4	4.5	5	9.9	9

Other responses

Monolingual CCC-As

- All staff have passed interpretation exams, family members only used at patient request.
- I physically type out my message (Deaf pop).
- Multilingual audiologist

Bi/Multilingual CCC-As

- I speak English and Spanish.
- Self I am bilingual.
- Speaks another language myself.
- We always provide certified, licensed interpreters when an interpreter is needed either by phone, video, in-person -whatever the patient needs

Monolingual CCC-SLPs

- Bilingual SLP coworker
- I have not collaborated with interpreters.
- None (2)
- Translation during IEP/Tri meetings

Bi/Multilingual CCC-SLPs

- I am a bilingual SLP.
- I am bilingual.
- I help as interpreter is the language is Spanish.
- I speak Spanish and English and serve as my own interpreter.
- I speak Spanish fluently and don't require an interpreter.
- If the language is Spanish I translate my own meetings, conferences with parents.
- no collaboration
- None, I am multi-lingual and do not need these services to provide services in my patient's native languages.
- Spanish is the native language of my bilingual students, and I speak Spanish.

4. Over the last 12 months, when working with clients whose languages you do not use, how often did you:

Response	All Respondents		Monolingual CCC-As		Bi/Multilingual CCC-As		Monolingual CCC-SLPs		Bi/Multilingual CCC-SLPs	
	%	#	%	#	%	#	%	#	%	#
Ask about preferred languages for service delivery and communications?										
Never	11.5	41	7.1	5	7.5	3	16.2	19	11.1	10
Rarely	8.7	31	4.3	3	7.5	3	9.4	11	10.0	9
Sometimes	8.2	29	10.0	7	5.0	2	10.3	12	6.7	6
Often	23.9	85	25.7	18	35.0	14	21.4	25	18.9	17
Always	47.8	170	52.9	37	45.0	18	42.7	50	53.3	48
Encounter obstacles to providing services in multiple languages?										
Never	11.8	42	4.4	3	15.0	6	16.2	19	11.1	10
Rarely	19.4	69	29.0	20	32.5	13	10.3	12	16.7	15
Sometimes	36.3	129	50.7	35	25.0	10	30.8	36	35.6	32
Often	24.2	86	14.5	10	17.5	7	32.5	38	25.6	23
Always	8.2	29	1.5	1	10.0	4	10.3	12	11.1	10
Need language assistance for service delivery?										
Never	15.5	55	2.9	2	7.5	3	22.2	26	15.6	14
Rarely	12.9	46	7.1	5	5.0	2	14.5	17	18.9	17
Sometimes	31.2	111	24.3	17	22.5	9	38.5	45	34.4	31
Often	21.1	75	30.0	21	37.5	15	15.4	18	15.6	14
Always	19.4	69	35.7	25	27.5	11	9.4	11	15.6	14
Obtain language assistance for service delivery?										
Never	19.5	69	4.3	3	5.0	2	31.9	37	20.2	18
Rarely	14.7	52	8.6	6	10.0	4	19.8	23	18.0	16
Sometimes	17.0	60	12.9	9	10.0	4	17.2	20	23.6	21
Often	20.3	72	21.4	15	37.5	15	14.7	17	20.2	18
Always	28.5	101	52.9	37	37.5	15	16.4	19	18.0	16
Provide written content in preferred languages?										
Never	20.6	73	23.2	16	12.5	5	21.4	25	15.7	14
Rarely	20.3	72	26.1	18	35.0	14	18.8	22	12.4	11
Sometimes	26.3	93	29.0	20	35.0	14	18.0	21	29.2	26
Often	16.4	58	13.0	9	7.5	3	18.8	22	23.6	21
Always	16.4	58	8.7	6	10.0	4	23.1	27	19.1	17
Seek additional information, technical assistance, or other support for service delivery?										
Never	16.6	58	15.9	11	15.0	6	18.0	21	13.6	12
Rarely	19.2	67	23.2	16	17.5	7	18.0	21	15.9	14
Sometimes	30.1	105	36.2	25	35.0	14	29.1	34	26.1	23
Often	22.6	79	18.8	13	20.0	8	24.8	29	27.3	24
Always	11.5	40	5.8	4	12.5	5	10.3	12	17.1	15
Use a client's preferred languages in service delivery?										
Never	15.8	56	14.3	10	2.5	1	24.8	29	7.9	7
Rarely	11.9	42	1.4	1	5.0	2	24.8	29	9.0	8
Sometimes	15.0	53	5.7	4	22.5	9	14.5	17	20.2	18
Often	24.9	88	25.7	18	32.5	13	18.0	21	29.2	26
Always	32.5	115	52.9	37	37.5	15	18.0	21	33.7	30

5. Select the top 3 supports that you need to improve the quality of care for clients whose languages you do NOT use.

Response – Weighted sums presented*	All Respondents	Monolingual CCC-As	Bi/Multilingual CCC-As	Monolingual CCC-SLPs	Bi/Multilingual CCC-SLPs
	#				
Access to interpreters and translators	614	150	78	189	148
Language-specific assessment tools, research, resources, and materials	575	118	64	160	182
Content and/or language-specific training to improve skills for service delivery	385	49	32	168	97
Ways to communicate with clients outside of clinical encounters and meetings	218	48	18	79	52
Funding for language assistance services	204	40	35	80	42
Other (See below.)	33	9	6	7	9

*The weighted sum was calculated by assigning a "3" to the respondent's top reason, a "2" to their second reason, and a "1" to their third reason and adding the total sum across all respondents. The possible range for all respondents was 0-1,041 (*n* = 347), 0-210 for Monolingual CCC-As (*n* = 70), 0-120 for Bi/ Multilingual CCC-As (*n* = 40), 0-348 (*n* = 116) for Monolingual CCC-SLPs, and 0-270 (*n* = 90) for Bi/Multilingual CCC-SLPs.

Other responses

Monolingual CCC-As

- Information for small business to gain access to how to get - and pay for- Interpreters.
- Multilingual support groups
- Support groups for patients/families in their native language
- Time intensive
- Translation services for reports
- Written translation

Bi/Multilingual CCC-As

- Ask for family to accompany the client.
- Directory of translated printed resources that patients or clinicians can print at short notice.
- Google translate.
- My top selection is the biggest thing I need.
- Need for testing materials in multiple languages.

Monolingual CCC-SLPs

- Access to printed materials online such as swallow exercises and instructions for thickening liquids.
- Additional training and guidance on using authentic assessment vs. standardized scores to qualify in the public-school setting.
- Bilingual SLPs and SLP-As

- Guidance on how to provide the highest quality and ethical services to multilingual children in early intervention.
- Translation of written Pt Education and home program materials

Bi/Multilingual CCC-SLPs

- Access to more pre-made handouts and materials in other languages.
- Communication with parents who speak other languages (non-English)
- Consistent and efficient way to have written information translated.
- Professional support to help determine best practices.
- Qualified interpreters in Navajo

6. Are you facing any challenges in addressing multiple languages in service delivery?

Answer Choices	All Respondents (*n* = 353)		Monolingual CCC-As (*n* = 72)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n*=117)		Bi/Multilingual CCC-SLPs (*n*=94)	
	%	#	%	#	%	#	%	#	%	#
Yes	53.3	188	45.8	33	57.5	23	58.1	68	52.1	49
No	46.7	165	54.2	39	42.5	17	41.9	49	47.9	45

7. Please select your top 3 challenges to addressing multiple languages in service delivery.

Response – Weighted sums presented*	All Respondents	Monolingual CCC-As	Bi/Multilingual CCC-As	Monolingual CCC-SLPs	Bi/Multilingual CCC-SLPs
	#				
Diagnosing, treating, and managing communication disorders using client's languages	319	55	38	125	89
Accessing less-biased assessment tools and/or language-specific materials	218	36	28	76	71
Supporting communication outside of English	149	30	16	65	26
Securing language assistance services or language-matched service providers	146	35	16	55	32
Locating cultural and linguistic features and normative data for named languages and dialects	133	14	26	54	35
Advocating for resources to support service delivery	89	21	12	25	29
Other (See below.)	10	1	0	5	4

*The weighted sum was calculated by assigning a "3" to the respondent's top challenge, a "2" to their second challenge, and a "1" to their third challenge and adding the total sum across all respondents. The possible range for all respondents was 0-543 (*n* = 181), 0-99 for Monolingual CCC-As (*n* = 33), 0-69 for Bi/Multilingual CCC-As (*n* = 23), 0-204 for Monolingual CCC-SLPs (*n*= 68), and 0-147 for Bi/Multilingual CCC-SLPs (*n* = 49).

Other responses

Monolingual CCC-As

- Time - using an interpreter takes up more appointment time.
- Time intensive is #1

Bi/Multilingual CCC-As

- Pertains to Languages other than Spanish such as Asian /African

Monolingual CCC-SLPs

- All of the above
- Coordination across intake team to consistently use interpreters to initiate services.
- I use mostly video-based interpreter in the hospital. This does not work well with HOH patients or those with cognitive impairments. Also, interpreters are not always trained just to interpret and often I don't know how much assistance they are giving the patient.
- increased time needed in sessions make it difficult to impossible to completed within scheduled session time as evert thing must be interpreted 2x.
- Parent support and/or understanding of what it means for their child to receive language therapy.
- Working with families who are speaking multiple languages in the home and therefore trying to determine the primary language for the child.

Bi/Multilingual CCC-SLPs

- Children are instructed in English (often the second language), lose what native language they had (in my population's case, Spanish), then cannot communicate with their parents, who are most often monolingual Spanish speakers.
- Having written information translated in a timely manner.
- It is difficult when a patient doesn't speak loud enough for the telephone interpreter to adequately hear what they are saying.
- One of the biggest challenges in the school system is that other team members heavily rely on a student being bilingual as a reason for them to not assess. We currently have several students with identified language disorders who only receive speech services because other team members refuse to accept any other data when the student is bilingual. This creates contentious meetings, toxic environments, and lack of access to resources for students due to team members biases.
- The majority of morphological rules cannot be explained in Spanish and Vietnamese

8. From the list below, select the top 3 topics in multilingualism that you would be most interested in learning more about.

Response – Weighted sums presented*	All Respondents	Monolingual CCC-As	Bi/Multilingual CCC-As	Monolingual CCC-SLPs	Bi/Multilingual CCC-SLPs
	#				
Assessment approaches, materials, and tools	479	138	63	127	137
Intervention approaches, materials, and tools	338	61	33	122	113
Differential diagnosis of speech-language and hearing disorders	261	32	15	126	80
Linguistic and cultural features of named languages and dialect varieties	240	29	36	101	71
Collaboration with interpreters and translators	199	60	29	59	36
Second language acquisition and multilingual communication development	197	20	24	96	46
Testimonials or case-based examples of successful implementation of strategies for working with multilingual clients	135	39	11	35	48
Language access laws and rights	87	36	15	19	16
Other (See below.)	7	0	0	6	1

*The weighted sum was calculated by assigning a "3" to the respondent's top topic, a "2" to their second topic, and a "1" to their third topic and adding the total sum across all respondents. The possible range for all respondents was 0-987 (*n* = 329), 0-210 for Monolingual CCC-As (*n* = 70), 0-78 for Bi/Multilingual CCC-As (*n* = 39), 0-448 for Monolingual CCC-SLPs (*n* = 116), and 0-279 for Bi/ Multilingual CCC-SLPs (*n* = 93).

Other responses

<u>Monolingual CCC-As</u>
No comments

<u>Bi/Multilingual CCC-As</u>

- Opportunities to learn another language.
- Pertains to Asian / African languages.

<u>Monolingual CCC-SLPs</u>

- All of these equally
- ASL and aphasia--protocol for treating aphasia through ASL changes due to the language structure of ASL.
- Reviews of multilingual AAC systems among native speakers

Bi/Multilingual CCC-SLPs

- IDEA rights for bilingual/multilingual students

9. Which sources do you look to for guidance, professional development opportunities, evidence-based resources, and technical assistance when working with multilingual clients?

Answer Choices	All Respondents (*n* = 317)		Monolingual CCC-As (*n* = 63)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n* = 112)		Bi/Multilingual CCC-SLPs (*n* = 92)	
	%	#	%	#	%	#	%	#	%	#
FREE ASHA resources	77.6	246	55.6	35	62.5	25	86.6	97	89.1	82
PAID ASHA resources	17.7	56	7.9	5	5.0	2	22.3	25	26.1	24
ASHA WRITTEN content (e.g., Practice Portal documents, live chats, journal articles)	39.1	124	27.0	17	35.0	14	45.5	51	41.3	38
ASHA VIDEO content (e.g., ASHA Stream videos, micro courses, webinars)	12.9	41	11.1	7	5.0	2	17.9	20	12.0	11
ASHA Online Communities	10.1	32	3.2	2	15.0	6	9.8	11	13.0	12
Consultation with ASHA staff	2.8	9	0.0	0	10.0	4	1.8	2	3.3	3
Federal or state government agencies	28.7	91	34.9	22	40.0	16	25.9	29	23.9	22
Multicultural Constituency Groups (MCCGs)	5.4	17	3.2	2	17.5	7	2.7	3	5.4	5
Privately-owned businesses and staffing firms	13.6	43	12.7	8	15.0	6	10.7	12	18.5	17
Related professional associations and non-profit organizations	44.2	140	47.6	30	47.5	19	42.0	47	44.6	41
Other (See below.)	13.3	42	14.3	9	10.0	4	17.0	19	9.8	9

Other responses

Monolingual CCC-As

- AAA
- Audiology Online
- Bilingual Community of Practice
- Employer
- Hospital requirements
- I ask colleagues and audiology based social media.
- Interpreters that work in our hospital
- Work-provided training and materials

Bi/Multilingual CCC-As

- AAA written documents.
- Clinic provided content.
- infanthearing.org's state NBHS pamphlets, which often include speech/language milestones in other languages.

- On-site or video interpreting services

Monolingual CCC-SLPs

- ASHA CEUs from other companies
- Bilingual education staff
- Bilingual SLPs paid to come to our district to conduct evaluations and consult; Bilinguistics website; MNSHA Manual now on MN Dept of Ed website.
- Bilinguistics (2)
- Biolinguistics
- Coworkers
- ELL teacher at my school
- Google
- Google and collaboration with our ELD teacher/staff
- Google search, asking colleagues.
- My school district/employer
- PA Training and Technical Assistance Network (PaTTAN), SLP blogs, resources gathered by other SLPs.
- professional development, ask about resources within my district.
- School district resources and staff
- School district's bilingual SLPs
- Speechpathology.com
- Whatever is Free - or paid through the Township

Bi/Multilingual CCC-SLPs

- Bilinguistics
- City and state guidelines
- Colleagues
- Different websites
- Google search
- I take classes with SLP Impact
- Other bilingual SLPs
- Textbooks, CEUs, colleagues
- University staff

10. Select the top 3 actions you believe ASHA could take to support CSD professionals in service delivery with multilingual clients.

Response – Weighted sums presented*	All Respondents	Monolingual CCC-As	Bi/Multilingual CCC-As	Monolingual CCC-SLPs	Bi/Multilingual CCC-SLPs
	#				
Design accessible and easy-to-use content for clinical analysis and decision making	448	81	53	175	136
Advocate for funding, compensation, and/or reimbursement when additional languages are needed	371	85	56	108	113
Create professional development opportunities focused on multilingual service delivery	364	61	37	142	109
Translate more ASHA content into additional languages	195	62	31	56	36
Offer language-specific CSD courses, content, programming, and language-learning opportunities	173	28	19	59	65
Suggest ways for employers and/or payers to address challenges and provide support	162	45	13	64	40
Share successful caseload/workload management tips	96	24	11	44	13
Ensure that certification holders demonstrate competencies needed for service delivery	81	8	12	15	44
Other (See below.)	8	0	1	4	3

*The weighted sum was calculated by assigning a "3" to the respondent's top action, a "2" to their second action, and a "1" to their third action and adding the total sum across all respondents. The possible range for all respondents was 0-969 (*n* = 323), 0-204 for Monolingual CCC-As (*n* = 68), 0-120 for Bi/Multilingual CCC-As (*n* = 40), 0-345 for Monolingual CCC-SLPs (*n* = 115), and 0-282 for Bi/Multilingual CCC-SLPs (*n* = 94).

Other responses

Monolingual CCC-As

- Help to provide education (what is the law and how do we access support without going into debt to help patients) for small businesses. We don't have access to lawyers and funding to navigate "the system."
- Virtually impossible to be prepared to handle the very large and diverse non-Eng speaking groups.

Bi/ Multilingual CCC-As

- Create credential designation for multilingual providers.

Monolingual CCC-SLPs

- Advocate for better pay, intrastate licensing and caseload caps
- Increase resources available on milestones for learners acquiring multiple languages to support discussions of difference v. disability.
- Make CEUs on this topic FREE and MANDATORY!
- Make the resources above FREE to members. ASHA courses are far too expensive compared to comparable or superior CEUs.

Bi/ Multilingual CCC-SLPs

- Lobby for higher pay for bilingual service providers (implementation of a "bilingual SLP" certificate may be needed)

11. Which of the following Certificates of Clinical Competence do you hold?

Answer Choices	Responses (***n*** = 365)	
	%	#
CCC-A	32.6	119
CCC-SLP	67.4	246
I do not currently hold ASHA certification	0.0	0

12. How many years have you been employed in the CSD discipline? Exclude your clinical fellowship or externship.

Number of Years	All Respondents (*n* = 362)		Monolingual CCC-As (*n* = 72)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n* = 116)		Bi/Multilingual CCC-SLPs (*n* = 95)	
	%	#	%	#	%	#	%	#	%	#
0	0.6	2	0.0	0	0.0	0	0.0	0	1.1	1
1-10	35.9	130	29.2	21	52.5	21	32.8	38	42.1	40
11-20	28.7	104	22.2	16	22.5	9	33.6	39	32.7	31
21-30	21.5	78	20.9	15	12.5	5	25.8	30	16.8	16
31-39	9.9	65	16.7	12	10.0	4	6.0	7	7.4	7
40 or more years	3.3	12	11.1	8	2.5	1	1.7	2	0.0	0

13. Select the one type of facility that best describes where you work most of the time.

Answer Choices	All Respondents (*n* = 363)		Monolingual CCC-As (*n* = 72)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n* = 117)		Bi/Multilingual CCC-SLPs (*n* = 95)	
	%	#	%	#	%	#	%	#	%	#
Educational facility: school, EI center, childcare site, or preschool	40.2	146	1.4	1	0.0	0	69.2	81	50.5	48
Hospital	28.9	105	56.9	41	60.0	24	11.1	13	23.2	22
Home health agency or client's home	4.1	15	0.0	0	0.0	0	5.1	6	7.4	7
Nonresidential health care facility, including audiologist's, SLP's, or physician's office or clinic and telepractice from home office	17.1	62	31.9	23	37.5	15	8.6	10	10.5	10
Skilled nursing facility	4.4	16	0.0	0	0.0	0	4.3	5	6.3	6
Other (See below.)	5.2	19	9.7	7	2.5	1	1.7	2	2.1	2

Other responses

Monolingual CCC-As

- ENT group associated with hospital.
- Physician owned private practice.
- Private Practice (4)
- State agency for children with special needs

Bi/ Multilingual CCC-As

- University

Monolingual CCC-SLPs

- Private clinic
- Private practice

Bi/ Multilingual CCC-SLPs

- Early intervention assessment center
- Inpatient Acute Rehab Hospital

14. Of the time that you spend providing clinical services, approximately what percentage is spent with the following age groups? Total must equal 100%.

All Respondents	Infants-toddlers (ages B-2 years)	Preschool (3-5 years)	School age (6-22 years)	Adults (23-64 years)	Seniors (65+ years)
Median	0.0	10.0	15.0	0.0	0.0
Mean	13.4	19.7	34.1	12.3	20.5
Std. Deviation	24.5	26.2	37.9	17.4	28.3
Range	0 – 100	0 – 100	0 – 100	0 – 80	0 – 100
n =	359	359	359	359	359

Monolingual CCC-A	Infants-toddlers (ages B-2 years)	Preschool (3-5 years)	School age (6-22 years)	Adults (23-64 years)	Seniors (65+ years)
Median	10.0	15.0	10.0	20.0	30.0
Mean	19.0	15.6	14.9	20.8	29.7
Std. Deviation	19.4	12.4	14.0	17.3	24.4
Range	0 - 80	0 - 60	0 - 90	0 - 75	0 - 80
n =	72	72	72	72	72

Bi/ Multilingual CCC-A	Infants-toddlers (ages B-2 years)	Preschool (3-5 years)	School age (6-22 years)	Adults (23-64 years)	Seniors (65+ years)
Median	9.0	10.0	10.0	27.0	37.5
Mean	10.3	12.9	13.9	26.0	37.0
Std. Deviation	11.3	11.5	13.0	15.5	22.5
Range	0 - 40	0 - 40	0 - 60	0 - 55	0 - 85
n =	40	40	40	40	40

Monolingual CCC-SLP	Infants-toddlers (ages B-2 years)	Preschool (3-5 years)	School age (6-22 years)	Adults (23-64 years)	Seniors (65+ years)
Median	0.0	3.0	70.0	0.0	0.0
Mean	10.1	21.4	53.9	5.0	9.6
Std. Deviation	24.8	30.1	42.5	12.2	23.0
Range	0 - 100	0 - 100	0 - 100	0 - 50	0 - 85
n =	117	117	117	117	117

Bi/Multilingual CCC-SLP	Infants-toddlers (ages B-2 years)	Preschool (3-5 years)	School age (6-22 years)	Adults (23-64 years)	Seniors (65+ years)
Median	0.0	10.0	10.0	0.0	0.0
Mean	16.0	23.5	33.0	10.7	16.8
Std. Deviation	30.4	31.2	38.2	19.3	29.0
Range	0 - 100	0 - 100	0 - 100	0 - 80	0 - 100
n =	95	95	95	95	95

15. Which one of the following states best describes where most of your clients are located?

States	All Respondents (*n* = 359)		CCC-As (*n* = 117)		CCC-SLPs (*n* = 242)	
	%	#	%	#	%	#
Alabama	0.8	3	1.7	2	0.4	1
Alaska	0.8	3	0.9	1	0.8	2
Arizona	0.8	3	0.	1	0.8	2
Arkansas	1.4	5	1.7	2	1.2	3
California	10.6	38	6.0	7	12.8	31
Colorado	1.4	5	0.9	1	1.	4
Connecticut	1.7	6	1.7	2	1.7	4
Delaware	0.3	1	0.0	0	0.4	1
District of Columbia	0.6	2	0.0	0	0.8	2
Florida	4.5	16	2.6	3	5.4	13
Georgia	2.5	9	4.3	5	1.7	4
Hawaii	0.3	1	0.0	0	0.4	1
Idaho	0.6	2	0.0	0	0.8	2
Illinois	3.6	13	2.6	3	4.1	10
Indiana	0.8	3	0.9	1	0.8	2
Iowa	0.8	3	1.7	2	0.4	1
Kansas	0.8	3	0.9	1	0.8	2
Kentucky	2.5	9	4.3	5	1.7	4
Louisiana	0.6	2	0.9	1	0.4	1
Maine	0.3	1	0.0	0	0.4	1
Maryland	3.9	14	3.4	4	4.1	10
Massachusetts	3.6	13	4.3	5	3.3	8
Michigan	2.5	9	1.7	2	2.9	7
Minnesota	2.8	10	2.6	3	2.9	7
Mississippi	1.1	4	1.7	2	0.8	2
Missouri	1.4	5	0.9	1	1.7	4
Montana	0.6	2	0.0	0	0.8	2
Nebraska	1.7	6	2.6	3	1.2	3
Nevada	1.1	4	0.9	1	1.2	3
New Hampshire	0.3	1	0.9	1	0.0	0
New Jersey	2.2	8	2.6	3	2.1	5
New Mexico	1.4	5	0.0	0	2.1	5
New York	8.1	29	10.3	12	7.0	17
North Carolina	2.5	9	2.6	3	2.5	6
North Dakota	0.8	3	0.9	1	0.8	2
Ohio	2.8	10	3.4	4	2.5	6
Oklahoma	2.5	9	1.7	2	2.9	7
Oregon	1.4	5	0.9	1	1.7	4
Pennsylvania	5.3	19	6.0	7	5.0	12
Rhode Island	0.0	0	0.0	0	0.0	0
South Carolina	1.4	5	1.7	2	1.2	3
South Dakota	0.0	0	0.0	0	0.0	0

Question 15 Table Continued						
Tennessee	1.4	5	4.3	5	0.0	0
Texas	6.7	24	6.0	7	7.0	17
Utah	0.6	2	0.0	0	0.	2
Vermont	0.3	1	0.9	1	0.0	0
Virginia	2.0	7	0.0	0	2.9	7
Washington	3.1	11	2.6	3	3.3	8
West Virginia	0.0	0	0.	0	0.	0
Wisconsin	2.2	8	4.3	5	1.2	3
Wyoming	0.3	1	0.0	0	0.4	1
Puerto Rico	0.6	2	1.7	2	0.0	0

16. Are you comfortable communicating in a language other than English?

Answer Choices	All Respondents (*n* = 360)		Monolingual CCC-As (*n* = 72)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n* = 117)		Bi/ Multilingual CCC-SLPs (*n* = 95)	
	%	#	%	#	%	#	%	#	%	#
Yes	39.4	142	0.0	0	100.0	40	0.0	0	100.0	95
No	60.6	218	100.0	72	0.0	0	100.0	117	0.0	0

17. In which languages are you comfortable communicating?

- American Sign Language (13)
- Arabic (3)
- Armenian
- Baby sign language
- Basic Spanish (2)
- Chinese/ Mandarin (8)
- English (32)
- Farsi (2)
- French (8)
- Galician
- German (2)
- Gujarati
- Hebrew (3)
- Hindi (2)
- Hmong
- Italian (5)
- Japanese (2)
- Korean (2)
- Marathi and Konkani
- Papiamento
- Polish (3)
- Portuguese (6)
- Portuguese creole (dialect)
- Romanian
- Spanish (110)

- Tagalog (2)
- Telugu
- Turkish
- Urdu

18. If you DO NOT self-identify as a bi/multilingual service provider, how often do you use an additional language for academic, professional, and/or personal purposes?

Answer Choices	All Respondents (*n* = 358)		Monolingual CCC-As (*n* = 71)		Bi/Multilingual CCC-As (*n* = 40)		Monolingual CCC-SLPs (*n* = 117)		Bi/Multilingual CCC-SLPs (*n* = 94)	
	%	#	%	#	%	#	%	#	%	#
Never	19.6	70	25.4	18	2.5	1	30.8	36	0.0	0
Rarely	19.6	70	26.8	19	12.5	5	28.2	33	5.3	5
Sometimes	18.7	67	18.3	13	17.5	7	24.8	29	13.8	13
Often	8.7	31	14.1	10	10.0	4	6.0	7	9.6	9
Always	4.2	15	9.9	7	0.0	0	2.6	3	4.3	4
N/A. I do self-identify as a bi/multilingual service provider.	29.3	105	5.6	4	57.5	23	7.7	9	67.0	63

19. Is there anything else you would like us to know about this topic?

<u>Monolingual CCC-As</u>

- I am consistently concerned that my bilingual patients are not served adequately when a qualified, live interpreter is not present for the assessment.
- I am not bilingual but have tools available to me that I am required to utilize. The use of interpreter services, be it ASL- video or phone makes an already "too little" time appt very very difficult to manage.
- It would be good to gain some knowledge on how to best work when family members are translating, because it seems that often times, they are the decision maker, and do not translate results/information into their family member's language.
- We use a phone line for interpretation, very very difficult with hearing impaired patients!
- You didn't ask "what percentage of your patients are multilingual? I am counting the Deaf population in this category. Our multilingual is <0.5% (I may see 3-5 patients a year who sign) I think your questionnaire makes multilingual appear to be a bigger problem than it really is.

<u>Bi/ Multilingual CCC-As</u>

- Are there certifications available for recognizing bilingual or multilingual service providers?
- As a small, independent private practitioner, I find this topic to be overwhelming. I don't have the time or financial resources to navigate.
- Need for research on materials already developed and protocols for best practice.
- Not sure what "funding" refers to in the questions. State level, community level, or employer.
- The use of video interpreting carts has been very helpful in Audiology practice at a large Audiology facility in hospitals with several satellite locations.

<u>Monolingual CCC-SLPs</u>

- All of the multilingual students I see have an English speaker in the home.

- At this time, the students I am currently working with that I consider as Bilingual are Hard of Hearing students with cochlear implants. American Sign Language is their primary language with English as a second language.
- Consistent challenge in translators interpreting what the patient/child says in their native language (other than English), especially when disordered.
- I feel that there should be more collaboration between EL teachers and SLPs.
- It doesn't matter how much school SLPs know about reducing cultural bias if special education coordinators/directors do not have a background in it and will not support best practices. We have great support now, but a prior admin made the process nearly impossible.
- It is often difficult to decide between a language difference vs. a language disorder with multilingual students. Does testing need to be completed in the student's primary language first?
- Many of our para educators or SLPAs are bilingual, which helps with our students.
- Most of my clients use English as their primary and preferred language in therapy. Those who use an additional language report that they use this language at home with their child but do not prefer that this language be targeted in therapy.
- My clinic sees a large variety of multi-lingual children with poor access to live interpreters and video interpreters. Indiana schools also do a very poor job of addressing language needs in the child's native language - often ignoring all together and children do not get the services they need. This desperately needs to be addressed in Indiana public schools.
- Our team has bilingual SLPs who take the majority of bilingual evaluations especially and the most consistently bilingual schools as well, to help provide services in a child's home language.
- The main challenge I face is communicating with families. Often, they report speaking little to no English in the home but want the child to use only English in the school setting. I have a very difficult time determining speech sound errors vs. native language phoneme repertoires.
- The students I have currently are fluent English proficient as well as their parents. Their parents speak primarily English in the home.
- THRILLED that this is being addressed - really look forward to the outcome!

<u>Bi/Multilingual CCC-SLPs</u>

- Although I use interpreters or bilingual services providers for assessment, I frequently use my non-native languages to communicate with students and family members in an informal setting. I let my families know that they can always request an interpreter, and that I will never hold an IEP meeting without an interpreter. I rarely if ever have difficulty communicating with my families in my non-native languages.
- Although we know best practices, we need help getting administrators to take them seriously and overcoming barriers (usually monetary) to doing what is best for our clients.
- I am proficient in testing and providing services to students whose primary language is Spanish; however, when the language is something other than Spanish or English it is difficult to provide in the primary language. This leaves me to provide services in English which is not always appropriate.
- I believe more education about multilingual individuals and services providing should be required in graduate school.
- I do enjoy my profession!
- I have encountered speech therapists in my field who are not educated or competent to work with multilingual families. These SLPs have advised families against using their primary language with their child, instead to only use English. These SLPs educated families against bilingual language development.

- I struggle with finding my multilingual students are English language learners and misidentified as disordered.
- I think bilingual service providers should be compensated for speaking another language fluently! I often use my Spanish to communicate with parents, conduct assessments, provide cultural considerations, and work at a different capacity than my monolingual peers. If ASHA could advocate for us, that would be fantastic. I work for LAUSD, and we are not compensated or at least given a stipend for being bilingual. Thank you!
- I think creation of a bilingual SLP certificate (similar to the certificate given to Swallowing Specialists, Fluency Specialists, Child Language Specialist, etc.) would be very helpful in increasing reimbursement.
- I think more monolingual SLPs need to know more about bilingual service delivery because many monolingual SLPs are expected to treat multilingual populations.
- It is very hard to interpret in Navajo because the language is so circumnavigational. I've had a hard time training interpreters what I need from them.
- More research studies.
- Most of my bilingual experience was in CA but recently relocated to FL. So, my percentage of bilingual caseload was based on current market 5% vs CA it was 80% of my caseload.
- Need for reliable and valid assessment tools.
- Not know per-se. However, I do not see a reason why bi/multilingual SLPs are not better compensated than monolingual SLPs.
  I can provide quality services in multiple languages - making me able to reach out and provide quality care to more people.
  Yes, we take pride in providing a crucial service to humanity and doing good...however, that needs to be compensated adequately.
  A pat on the back and verbal praise is not an adequate representation of the value I bring to any facility I work at.
  Advocate for higher pay based on languages that services can be provided in.
- Offer opportunities/more accessible pathways for providers to improve their multilingual skills and gain bilingual certification.
- Opportunities for semi-fluent Spanish speakers to become bilingual providers through ASHA coursework.
- We are advocating/negotiating for an additional salary Column (B.A. +75) for those SLP's who have accrued additional college coursework/credit. Bilingual certification is offered for current master's degree seeking students, but nothing for post-baccalaureate (yet). Please help.
- We need more support for multilingual individuals. Language disorders and SLD are so heavily under identified in the schools because there is not enough explicit information on this matter.
- Where I work, there is more infrastructure to support families who are monolingual Spanish-speaking than families who speak other languages. In recent months, all of the families I have met speak English very well but, in the past, it has been a challenge to provide services for example, to families whose home language is Vietnamese, due to the lack of reimbursement for interpreters.
- Yes! It is very difficult to assess students that have English listed as their second language. There is such a range of what their English proficiency is, that it is difficult to figure out what is the dominant language to assess to distinguish if it is a language difference (due to language acquisition) or a true language delay. More assessment materials on these types of students are needed to also say what is acceptable in the areas of syntax/morphology (particularly because rules are different in so many languages). Therefore, what is acceptable in one language that is not English may be something that the student is generalizing in English and therefore found to

be "delayed" or "disordered," which is more of language difference. But not enough info is available to SLPs to know the difference. (Not sure if that made sense).

Appendix C

Review of Existing ASHA Resources Related to Multilingual Service Delivery

Resource Title	Link	Resource Type
Bilingual Service Delivery	https://www.asha.org/practice-portal/professional-issues/bilingual-service-delivery/	Practice Portal Page
"But They Don't Speak English!": Bilingual Students and Speech-Language Services in Public Schools	https://pubs.asha.org/doi/10.1044/sbi4.1.42	ASHA Journals Article
Clinical Management of Communicatively Handicapped Minority Language Populations	Rescinded; not online	Position Statement
Collaborating With Interpreters, Transliterators, and Translators	https://www.asha.org/practice-portal/professional-issues/collaborating-with-interpreters/	Practice Portal Page
Cultural Responsiveness	https://www.asha.org/practice-portal/professional-issues/cultural-responsiveness/	Practice Portal Page
Dynamic Assessment	https://www.asha.org/practice/multicultural/dynamic-assessment/	Micro Courses
Issues in Ethics: Cultural and Linguistic Competence	https://www.asha.org/practice/ethics/cultural-and-linguistic-competence/	Issues in Ethics Statement
Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services	Rescinded; not online	Knowledge and Skills Statement
Learning More Than One Language	https://www.asha.org/public/speech/development/learning-two-languages/	Webpage
Multicultural/Multilingual Issues Courses: A Resource for Instructors	https://www.asha.org/practice/multicultural/faculty/metaanalysis/	Webpage
Multicultural Affairs and Resources	https://www.asha.org/practice/multicultural/	Webpage
New Resources for Audiologists Working With Hispanic Patients: Spanish Translations and Cultural Training	https://pubs.asha.org/doi/10.1044/2014_AJA-14-0027	ASHA Journals Article
Phonemic Inventories and Cultural and Linguistic Information Across Languages	https://www.asha.org/practice/multicultural/phono/	Webpage
Practical Assessment & Treatment Strategies for English Language Learners w/ Language Impairments	https://www.youtube.com/watch?v=xvaVwG6dF68	You Tube Video

Provision of Instruction in English as a Second Language by Speech-Language Pathologists in School Settings	https://www.asha.org/policy/tr1998-00145/	Technical Report
Pre-Referral Procedures: Meeting Unique Needs of English Language Learners	https://pubs.asha.org/doi/10.1044/cds8.1.4	ASHA Journals Article
Resources for the Recruitment of Bilingual Service Providers	https://www.asha.org/practice/multicultural/resources-recruitment-bilingual-service-providers/	Webpage
Serving Clients From Diverse Backgrounds: Speech-Language Difference vs. Disorder	https://stream.asha.org/serving-clients-from-diverse-backgrounds-speech-language-difference-vs-disorder	ASHA Stream Video
Social Dialects	https://www.asha.org/policy/ps1983-00115/	Position Statement
Students and Professionals Who Speak English With Accents and Nonstandard Dialects: Issues and Recommendations	https://www.asha.org/policy/tr1998-00154/	Technical Report
That's Unheard Of	https://www.thatsunheardof.org/	Microsite
What It Takes to Call Yourself a Bilingual Practitioner: Opinion	https://leader.pubs.asha.org/doi/full/10.1044/leader.FTR2.16152011.16	*ASHA Leader* Feature
Working With Internationally Adopted Children	https://www.asha.org/practice/multicultural/intadopt/	Webpage

Note: This ASHA resource review was conducted in September-November 2022.