Alberta College of
Speech-Language Pathologists
and Audiologists

Guideline:

Assessment of Children Who are English Language Learners

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Alberta College of
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Contents

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***Guideline**: Provides recommendations to regulated members that are deemed to be acceptable practice within regulatory requirements. Regulated members are afforded reasonable use of their professional judgment in the application of a guideline.*

Preamble

The Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA) protects the public by regulating the professional practice of speech-language pathologists (SLPs) and audiologists in Alberta. ACSLPA exists to ensure that the public receives competent, ethical speech-language pathology and audiology services.

The recommendations included in this guideline are important considerations for provision of services to children who are English Language Learners (ELL). The intent of this document is to provide SLPs in Alberta with principles that support appropriate assessments and diagnosis of children who are ELL.

To the greatest extent possible, ACSLPA registered SLPs should follow these best-practice principles. The inclusion of a particular recommendation/principle is grounded in current best evidence derived from a broad review of literature and/or expert opinion. SLPs should utilize their professional judgment and consider the environment and client needs when applying these recommendations/principles.

Purpose

Speech and language delays and disorders occur in all populations, cultures and languages. Since Alberta and Canada are linguistically diverse, SLPs are often consulted to provide assessment and intervention services to multilingual children who present with speech-language delays and disorders. Unaddressed speech and language delays can have an ongoing impact for children in their social interactions and academic success. As such, early assessment and intervention for children who exhibit delays and disorders is of vital importance [Speech-Language & Audiology Canada (SAC), 2012].

This guideline addresses the responsibilities of registered SLPs when assessing children who are ELL. In keeping with ACSLPA's role as a professional regulatory body, this document has been written to address the needs of ACSLPA's SLP members and the public they serve.

In response to ACSLPA member and stakeholder questions regarding clinical practice with the ELL population, this guideline aims to provide information for SLPs about:

- The scope and role of SLPs in identifying speech-language needs in the ELL population,
- Differentiating between children who are ELL and have typical language differences (due to linguistic and cultural factors) and those who present with true language learning disorders,
- Common terminology to facilitate communication and understanding among families, caregivers and all other stakeholders.

SLP Scope of Practice

Schedule 28 (sec 3) of the Health Professions Act (HPA) states:

In their practice, speech-language pathologists do one or more of the following:

a) *Assess, diagnose, rehabilitate and prevent communication and oral motor and pharyngeal dysfunctions and disorders,*
b) *Teach, manage and conduct research in the science and practice of speech-language pathology, and*
c) *Provide restricted activities authorized by the regulations.*

The HPA requires that all SLPs be registered with ACSLPA and hold a valid practice permit in order to provide professional services in Alberta.

SLPs receive intensive, specialized education at the Masters' level which ensures their knowledge about normal and disordered speech and language development. They have clinical training and educational background in speech production, language understanding and expression, stuttering, voice health and feeding and swallowing disorders. In addition to their education, SLPs continually acquire and maintain additional skills and abilities related to normal and disordered speech and language development, social development and cognition.

SLPs are specifically trained in processes of normal and atypical development and normal and disordered communication. They access a variety of tools and techniques to assess communication and are knowledgeable in the area of language development for children learning one or more languages.

SLPs play a critical role in differentiating between typical language difference due to linguistic and cultural factors and underlying language delays and disorders that are impacting a child's ability to develop age-appropriate, functional communication skills. Due to the nature of their education and clinical training, SLPs are uniquely qualified to assess the speech and language skills of children who are ELL. In Alberta, SLPs are authorized to diagnose delays and disorders of normal speech and language development.

Standards of Practice and Code of Ethics

ACSLPA members are expected to adhere to all Standards of Practice and the Code of Ethics when providing services to any and all clients, including children who are ELL. Adherence to these requirements enables the public, clients and stakeholders to be assured that registered SLPs are practicing competently, safely and within their scope of practice.

ACSLPA's Standards of Practice (ACSLPA, 2015) and Code of Ethics (ACSLPA, 2017) are interconnected and provide guidance to SLPs and audiologists; acting as a reference to the public about the accountabilities, expectations, continuing competence, decision-making and ethical practice of ACSLPA regulated members. The Standards of Practice and Code of Ethics apply to all regulated members in all practice settings.

SLPs are expected to:

- work in partnership with families/clients to ensure their autonomy is preserved,
- acknowledge and ensure client values and cultures are taken into account when providing services,
- use an evidence-informed approach in decision-making, planning, assessment and intervention,
- collaborate with other service providers to support integrated client-centred care, and
- maintain accurate, complete and timely records.

SLPs:

- incorporate current evidence, best practices and professional guidelines into service delivery decisions,
- use an evidence-informed approach, sound professional judgment and client priorities and needs to determine appropriate screening/assessment procedures, interventions and measurable outcomes, and
- use critical inquiry and sound professional judgment in the collection and interpretation of formal and informal assessment results to obtain a diagnosis and determine interventions.

In addition to the Standards of Practice and Code of Ethics, registered SLPs are expected to maintain and advance their competence throughout their careers.

Background

It is the SLP's professional responsibility to assess and interpret how a child's language exposure and proficiency supports or inhibits the determination (diagnosis) of an underlying language delay or disorder. Identifying a communication disorder in a child learning more than one language requires consideration of the many factors that influence communication skills and development (American [American Speech-Language-Hearing Association (ASHA), n.d.[1]]. Information gathering from many sources enables the SLP to form a sound clinical judgment and diagnosis.

SLPs need to consider not only the length of time that a child has been exposed to all languages learned, including English as a new language, but also the quality of the exposure. It is not sufficient to assume that a child passively exposed to a second language will become proficient in that language in a certain period of time. Regular, continuous, sustained exposure in environments where speakers are proficient in the language and the child is actively hearing and using the language builds proficiency (Genesee, 2007). Although there is limited research about the amount of exposure a child needs, it has been estimated "bilingual children must be exposed to a language during at least 30% of their total language exposure if their acquisition of that language is to proceed normally" (Genesee, 2007, p. 28).

Learning more than one language does not cause language problems. Children all over the world learn to speak other languages with possible cognitive-linguistic benefits (ASHA, n.d.[5]).

Difference versus delay versus disorder

SLPs need to differentiate between a communication difference versus a disorder/delay to ensure the diagnosis is clearly understood and to prevent misunderstanding in determining service eligibility and/or recommending interventions (Shipley & McAfee, 2008).

A *language difference* typically refers to a child whose language learning is different as a result of cultural or linguistic factors. It is "the result of the normal process of second language acquisition and its impact on the development of the second language" (Gillespie, 2015 as cited in Prezas & Jo, 2017, p. 5). This could include developmental errors, errors in phoneme/morpheme usage and/or cultural differences in the patterns between the languages spoken (for example, word order from the first language may be carried over into the second language). A language difference itself is not indicative of a language delay or disorder.

A *language delay* typically indicates that a child's language is progressing in a typical sequence but may be slower than same-age peers. "Children with a language delay may exhibit a slower onset of a language skill, slower rate of progression through the acquisition process, slower sequence in which the language skills are learned or all of these." (ASHA, 2015). Having a language delay does not necessarily mean that a child will "catch up" over time. "For some children, delayed acquisition of language milestones is the first indication of language impairment that will persist throughout childhood, interfering with everyday communication and academic attainment" (Dale, Price, Bishop & Plomin, 2003).

A *language disorder* is a language problem that creates obstacles to communication or learning in everyday life. These problems are unlikely to resolve on their own (SAC, 2018). For children who are ELL, a true language disorder will be evident in all of the languages that the child speaks (ASHA, n.d.[1]).

Typical Processes in Second Language Acquisition

SLPs must understand normal processes and phenomena of both simultaneous and subsequent-dual/multi language acquisition to avoid identifying language delays or disorders where they do not exist (ASHA, n.d.[1]). Using knowledge about typical processes, general assessment knowledge, and clinical judgement, the SLP can determine appropriate assessment and intervention for different learners (e.g., multilingual, additional communication challenges, etc).

Simultaneous and sequential bilingualism

Simultaneous bilingualism refers to the acquisition of two or more languages at the same time or since birth (e.g., one parent speaks French to the child and the other speaks English) whereas *sequential bilingualism* refers to the acquisition of a second/subsequent language after a degree of proficiency has been established in the first language (Paradis, Genesee & Crago, 2011).

Children learning English as a subsequent language (sequential bilingualism) may display normal processes and phenomena (which do not necessarily indicate a language learning delay/disorder) including:

Interference/Transfer
"Communication behaviours from the first language are transferred to the second language" (Shipley & McAfee, 2008, p.30); errors in the second language can be traced back to the first language.

Silent Period
"A period of time when a second language learner is actively listening and learning but speaking little" (Shipley & McAfee, 2008, p.30). Although these children may be reluctant to speak while they gain comfort in a new setting, they continue to communicate in their home language with others who speak that language. Typically, after this stage the child is able to understand more of the new language than they are able to produce (Paradis, Kirova & Dachyshyn, 2009; ASHA, n.d.[1]).

The silent period may last a few weeks to a few months, and children may rely more heavily on gestures to get their message across. Younger children are apt to stay in this period longer than older children (Paradis et al., 2011).

Code-switching
"This occurs when a speaker unknowingly alternates between two languages" (Shipley & McAfee, 2008, p.30) across or within phrases or sentences. Code-switching is often systematic and not random. Code-switching in and of itself is not indicative of a language disorder (Roseberry-McKibbin & Brice, n.d.; ASHA, n.d.[1]).

Language Loss
Some children may lose some skills and fluency in their first language if their first language is not supported, reinforced and maintained (subtractive bilingualism). Some children may go through a transitional phase when their first language has declined but their second language is not yet complete or native-like. Most children do not go through this phase so quickly that they would not be considered to have a functional language – they are usually proficient enough in the second language to satisfy their interpersonal communication needs (Paradis et al. 2011).

Ideally children experience additive bilingualism, where they learn English while their first language and culture are maintained and reinforced (Roseberry-McKibbin & Brice, n.d.; ASHA, n.d.[1]). "The stronger the first (or home) language proficiency is, the stronger the second language proficiency will be, particularly with academic literacy. Maintaining the home language is key to a child's success in school." (Paradis et al., 2009).

ACSLPA Practice Guidelines

It is important to remember that children who are ELL are at risk of being either over or under identified as having an underlying language disorder (Paradis et al., 2011). As such, SLPs must be cautious in their assessment to adequately determine if the child presents with a typical language difference due to linguistic and cultural factors, or, whether a true, underlying language learning deficit that is impacting that child's ability to develop age-appropriate, functional communication skills exists.

The following practice guidelines set out the expectations of ACSLPA regulated members in the assessment/intervention of ELL children:

1. When conducting assessments of children who are ELL, SLPs consider all areas of speech and language development including:
    - Phonology,
    - Morphology and syntax,
    - Semantics, and
    - Pragmatics.

    Comprehensive assessment of all areas of speech and language development enables an SLP to make a differential diagnosis and informed clinical judgements. It further enables the SLP to consider a child's strengths in addition to weaknesses when determining recommendations for future interventions/treatment (Paul, 2007; ASHA, n.d.[1]).

2. Assessment considers the child's use of conversational language and academic language in different environments and situations.

    Conversational language develops before academic language and although a child may have sufficient conversational skills, they may lack the ability to use language in decontextualized environments such as classrooms. SLPs need to be aware of this potential gap between "conversational" and "academic" language and consider language skills across differing environments (e.g., home and/or social situations, at play), and situations including classroom/school settings where applicable. Generally speaking, children who are ELL approach native-speaker abilities for narratives first, followed by vocabulary, with grammar coming in last (Paradis, 2011).

    Bilingual children can attain conversational skills similar to their monolingual peers after approximately two years of quality exposure to the second language, however, a considerably longer time is required to learn sufficient English to perform at the same level for academic tasks. Children require on average six years to achieve grade-level in their second language if they start in kindergarten and receive quality, dual-language schooling in both their first and second language (with at least half of the instructional time in their first language). It can take even longer (seven-10 years or more) if students have not had the opportunity to be schooled in their first language and many in this situation do not reach grade-level achievement (Thomas & Collier, 2017; Paradis et al., 2009; ASHA, n.d.[1]).

3. SLPs support families to maintain and develop the child's home language.

    Normal acquisition of a second language is dependent on the continued development and proficiency of a child's home language. Therefore, it is advantageous for multilingual children to continue to develop and maintain their home language while learning the second language (Shipley & McAfee, 2008).

4. SLPs use a variety of culturally-relevant assessment techniques and tools as needed.

   These may include, but are not limited to parent report, report from others involved in the child's life (e.g., teachers), criterion-referenced tools, language (including narrative) sampling, observation and dynamic assessment.

   Dynamic assessment helps distinguish between a language difference and a language disorder, especially for children from culturally and linguistically diverse backgrounds. Children who are able to make significant changes in short-term teaching sessions likely have a language difference. Children who are unable to make these changes likely have a language disorder (ASHA, n.d.[3]). A child with a typical language learning system (without disability) will be able to benefit immediately from instruction, whereas the child with a disability will have difficulty learning even when explicit instruction is provided (Laing & Kamhi, 2003).

5. Assessment must include evaluation of home language(s) used.

   To adequately evaluate if a child is experiencing a language difference or disorder, exploration and understanding of the child's home language development (i.e., typical or delayed development) is imperative to the SLP's determination of language delay/disorder versus difference.

   When determining home language proficiency, SLPs will consider several factors including, but not limited to:

   - Parent and caregiver reports of concerns in language development,
   - Family history of language or developmental delays/disorders,
   - Concerns about pre-linguistic communication skills (e.g., turn-taking, attending, responding),
   - Delayed universal language development milestones (e.g., two-word combinations, first words),
   - Child's language skills compared to that of siblings or peers,
   - Risk factors for language development (e.g., hearing loss, chronic ear infections, poor social skills, concomitant diagnoses),
   - Normative data (where available) for home languages other than English to compare development, keeping in mind variances when children are learning more than one language, and
   - Exposure to all languages spoken.

   In order to evaluate proficiency in the home language, ideally SLPs use interpreters as necessary, appropriate and available. Interpreters may support the family and SLP in the process of gathering informed consent, aid the SLP in understanding characteristics of the home language (linguistic features) and help the SLP determine cultural appropriateness of any assessment materials selected for use (ASHA, n.d.[2]; Shipley & McAfee, 2008).

6. Consistent with the *ACSLPA Standards of Practice*, standardized assessment tools must be administered and reported as intended.

   Standardized tests can be one component of an assessment that contributes to the information required to form a clinical impression of a child's skills. SLPs are expected to be knowledgeable of the standardized tool/test being administered and the normative sample within that tool. Standardized tests may be available in other languages for SLPs who speak those languages.

   "Standardized tests are almost always inappropriate" for children who are ELL (Shipley & McAfee, 2008, p. 31). Although standardized tools may be used in a qualitative or descriptive manner, quantitative scores are not reported for populations not included in the normative sample.

   Even when children who are ELL have had enough schooling in English for it to be considered the dominant language, it cannot be assumed that it is sufficient for academic success. "Consequently, measurement of skills using standardized language assessments (with monolingual norms) remains inappropriate, even following six years of formal schooling in L2." (Hemsley, Holm & Dodd, 2006, p. 471).

   It is important to note that research is emerging in this area and SLPs should continue to update their knowledge as evidence-based information and research becomes available.

7. SLPs use their assessment findings and clinical judgment to determine a diagnosis.

   SLPs must be able to provide sound rationale for their clinical impressions, providing examples when appropriate. This supports a clear, shared understanding for parents and others.

8. SLPs provide recommendations at the conclusion of their assessment.

   The types of recommendations may vary, but typically include:
   - referrals to other providers or agencies,
   - recommendations about intervention goals, and
   - tips and strategies for family and other caregivers to support the development of speech and language.

9. SLPs are expected to report on their findings in a clear manner.

   Reports are written with the audience in mind and use of jargon should be avoided to facilitate understanding by the reader. Where possible, the SLP will discuss results with the client/family so they are able to ask clarifying questions and to fully understand possible impacts. Written reports are disseminated, as appropriate, to relevant stakeholders including parents/guardians.

Glossary

Active Exposure to a language	Active exposure indicates more than hearing other people use the language, but rather the child is actively involved in using the language themselves.
Additive Bilingualism	A situation where a second language is learned by an individual or a group without detracting from the development of the first language.
Assessment	The rehabilitation process for gathering in-depth information to identify the individual's strengths and needs related to body function, body structure, activity and participation, to understand the individual's goals and then to determine appropriate services and interventions based on these. It is initiated when there are questions about a client's needs and how best to meet these needs. It includes both formal and informal measures ranging from administering standardized assessment tools to observing a client in a specific setting or listening to family concerns.
Bilingualism/Multilingualism	The ability to communicate in more than one language.
Code-switching	This occurs when a speaker unknowingly alternates between two or more languages.
Criterion Referenced Tools	A process whereby the child's performance is compared to a pre-defined set of criteria or a standard.
Dynamic Assessment	A method of conducting investigation that seeks to identify the skills that the child possesses as well as their learning potential. A dynamic assessment focuses on the learning process and may include test-teach-retest methods.
English Language Learner (ELL)	The term used to describe an individual learning English as a new language. The acquisition may be sequential or simultaneous.
Home Language	Refers to the language (or variety of languages) most commonly spoken by the members of a family for everyday interactions at home.
Intervention	A broad term that implies provision of services to change an outcome. In speech-language pathology, intervention is frequently used interchangeably with "treatment."

Language Delay	A delay in the acquisition of language skills compared to one's chronological and cognitive/intellectual age-peers. Children with a language delay may exhibit a slower onset of a language skill, slower rate of progression through the acquisition process, slower sequence in which the language skills are learned or all of these.
Language Disorder	Characterized by persistent difficulties acquiring and using language skills below chronological age expectations that cannot be explained by other factors (e.g., nonverbal intelligence, sensory impairments, autism spectrum disorder). Language disorder, developmental language disorder and specific language impairment are often used interchangeably.
Language Difference	A *language difference* typically refers to a child whose language learning is different as a result of cultural or linguistic factors. It is the result of the normal process of second language acquisition and its impact on the development of the second language.
Language Sample	An assessment technique used to gather samples of a child's language in various naturalistic contexts. The sample is usually recorded and analyzed for key features.
Sequential Bilingual Development	The process of developing a second language after establishing a degree of proficiency in the first language.
Simultaneous Bilingual Development	The process of learning two languages at the same time. Usually implies both languages were introduced prior to age 3.
Standardized Test	An assessment tool that is administered in a consistent, standard manner and has consistent questions, administration procedures and scoring procedures. The testing conditions are the same for all test takers. Standardized tests provide a "standard score" which helps interpret how closely or far a child's score differs from the average.
Subtractive Bilingualism/ Language Loss/Language Attrition	The loss of skills or fluency in the primary language if that language is not reinforced and maintained during the acquisition of a second language. In these situations, the child may never completely acquire their first language. Their first language acquisition may stagnate at a certain level, or they could lose some or all of their competence in their first language over the elementary school years.

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Resources

Typical Language Development

Kindergarten to grade 5
https ://www.asha.org/public/speech/development/communicationdevelopment/.

Birth to 5 years
https://www.asha.org/public/speech/development/chart/.

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