Alberta College of
Speech-Language Pathologists
and Audiologists

Guideline:

Assessment of Linguistically Diverse Clients

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Assessment of Linguistically Diverse Clients

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***Guideline**: Provides guidance to regulated members to support them in the clinical application of Standards of Practice.*

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Introduction

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. ACSLPA members are expected to adhere to the Standards of Practice and Code of Ethics, which apply to all regulated members in all practice settings. Adherence to these requirements enables the public, clients, and stakeholders to be assured that regulated SLPs and audiologists are practicing competently, safely, and within their scope of practice.

Clients' cultural and linguistic backgrounds impact all aspects of speech-language and audiology service delivery, from assessment to intervention. This guideline is primarily concerned with the impact of linguistic diversity, and further explores considerations for the assessment of linguistically diverse pediatric and adult clients. ***Linguistically diverse*** clients are those who do not use the ***dominant language*** of the place where they reside (English in Alberta), or those who have multiple linguistic influences (with varying degrees of proficiency of comprehension and/or expression across languages). This includes clients who:

- use a language other than English, or who do not understand or use English;
- use a ***dialect*** of English that is not the dominant variation of their place of residence;
- use a home language other than English, but have English as their academic language, or the language of their community; or
- use English as a first language and are learning their ***heritage language*** or an additional language.

Consistent with the College's Standards of Practice, when working with linguistically diverse clients, ACSLPA regulated members are expected to:

- Involve clients and their families in decision making and incorporate their needs and goals into the service plan.
- Treat all clients with compassion, dignity, sensitivity, and respect.
- Make efforts to avoid actions that diminish, demean, or disempower the identity and well-being of the client, family, or caregivers.
- Incorporate current evidence, best practices, client and family perspectives, and professional guidelines into service delivery decisions.
- Implement culturally and linguistically appropriate screening/assessment procedures and interventions within their professional scope of practice and the limitations of personal knowledge and ***competence.***

- Use critical inquiry, including information regarding the clients' societal context, social determinants of health, considerations regarding the functional impact of client limitations, and sound professional judgment in the collection and interpretation of formal and informal assessment results to obtain a diagnosis and determine interventions.
- Advocate for clients as appropriate to obtain required resources and services.
- Work collaboratively and respectfully with the client, ***cultural facilitators***, interpreters, and/or translators to facilitate an integrated, client-centered approach to services.

Purpose

This guideline addresses the responsibilities of both speech-language pathologists and audiologists when assessing linguistically diverse clients, including considerations for both pediatrics and adults. The information provided is grounded in current best evidence derived from a broad review of the literature and/or expert opinion.

ACSLPA regulated members should incorporate these principles into their clinical and professional decision making in their individual practice setting. In addition, regulated members can use this guideline to educate clients, caregivers, employers, and others regarding safe, ethical, and effective assessment of linguistically diverse clients.

General Practice Guidance for the Assessment of Linguistically Diverse Clients (For Audiologists and SLPs)

1. Regulated members should assess their own ***competence*** and preparedness for completing assessments for linguistically diverse clients. Consistent with ACSLPA's Standard Area 3.1 Continuing Competence, regulated members must take steps to maintain and enhance their competence to provide accurate and safe assessments to linguistically diverse clients as necessary. Research is ongoing in this practice area, and SLPs should consistently update their knowledge on current, evidence-based research and best practice to inform their service provision.

2. Research shows that ***linguistic bias*** influences clinical judgement and assessment accuracy (Chakraborty et al., 2019; Easton & Verdon, 2021; Evans et al., 2018). Therefore, regulated members should engage in self-reflection on their own understandings and perceptions of linguistic diversity to identify, acknowledge, and address any biases when working with linguistically diverse populations.

   Regulated members may find it useful to review ACSLPA's Anti-Racist Service Provision guideline for more general information and resources on cultural self-awareness, ***cultural humility***, ***cultural safety***, and ***culturally responsive practice*** for working with linguistically diverse clients.

3. According to ACSLPA's Standard Area 1.4 Communication, regulated members are expected to communicate their assessment findings respectfully, effectively, and clearly while incorporating principles of cultural safety and cultural humility as required.

   When working with linguistically diverse clients and their families, communication techniques should be adapted to minimize any communication barriers. For example, regulated members should consider that written reports may not be accessible to all clients and caregivers (e.g., those who are not proficient in the language of documentation). In such situations, verbal discussions with the help of an interpreter or cultural facilitator, as needed, may be the most appropriate method for communicating with clients and families.

4. Consistent with the ACSLPA Standard of Practice 1.3 Client Assessment and Intervention, regulated members must use sound professional judgement in the interpretation of their assessment findings to determine a diagnosis. Members must be able to provide sound rationale for their clinical impressions, providing examples where appropriate. This supports a clear, shared understanding for clients, caregivers, families, and others.

5. When providing recommendations post-assessment, it is the regulated member's responsibility to provide a variety of appropriate options available to address communication concerns, without making assumptions about the client's or caregiver's preferences. Many factors may impact a client's or families' decisions, including:
   - Cultural norms of the client and their family (e.g., communication or child rearing norms),
   - Client, caregiver, family, and/or community views on disability, and/or
   - Family dynamics present (e.g., involvement of extended family members in care, client and family preferences for language use).

   Regulated members are expected to acknowledge and respect client and caregiver/family preferences.

Practice Guidance for SLPs

SLP Scope of Practice and the Importance of Linguistically Appropriate Speech and Language Assessment

Speech and language delays and disorders occur in all populations, cultures, and languages. Given the broad and increasing linguistic diversity in Alberta, it is likely that regulated members will be consulted to provide assessment and intervention services to clients who do not use the same language as them, or clients who speak more than one language.

SLPs receive intensive and specialized education about typical and disordered communication development and functioning, including speech production, language understanding and expression, literacy, stuttering, voice health, and feeding and swallowing disorders. However, it is important to note that education is typically presented using monolingual English norms. In Alberta, SLPs are authorized to diagnose delays and disorders of speech and/or language. This includes a responsibility for differentiating between typical ***language difference*** due to linguistic, social, and cultural factors and underlying ***language delays*** and ***language disorders*** that are impacting a client's ability to develop or use age-appropriate and/or functional communication skills.

True language delays and disorders will be evident in all languages spoken by the client. Appropriate assessment and intervention are guided by general assessment knowledge, knowledge of the typical processes of multiple language acquisition (see Appendix A), and sound clinical and professional judgement (American Speech-Language-Hearing Association [ASHA], n.d.). Accurate identification of communication delays or disorders, regardless of the language(s) used by the client, plays a critical role in the client's communication and health and well-being outcomes. Unaddressed speech and/or language delays or disorders can have ongoing impacts on their communication, daily life, and academic success.

The assessment of linguistically diverse populations is a complex practice area, and research shows that many SLPs do not report receiving adequate preparation and training for providing services to clients who speak a different language as them, or those who speak multiple languages (Hayes et al., 2019; Santhanam & Parveen, 2019). The literature also demonstrates that SLPs self-report lower levels of self-efficacy, competence, and confidence when providing services to linguistically diverse clients, as compared to clients who are monolingual English speakers (Guiberson & Atkins, 2015; Santhanam & Parveen, 2019), which may be a function of the lack of resources for working with linguistically diverse populations (e.g., information on communication development and norms in other languages, unbiased assessment tools, interpreter services, etc.) (D'Souza et al., 2012; Grandpierre et al., 2018; Hayes et al., 2019; Santhanam & Parveen, 2019).

Research has shown that the lack of training and resources for SLPs places linguistically diverse clients at risk of over-identification (whereby features of their linguistic diversity are interpreted as a sign of a delay or disorder) ***and*** under-identification (whereby features of a true language delay or disorder are interpreted as a result of the client's exposure to or use of multiple languages) (Hyter & Salas-Provance, 2019; Keller-Bell, 2021; Levey et al., 2020; Morgan et al., 2015). Either type of misidentification has serious implications for the client and their outcomes, including:

- The client not receiving appropriate services for their communication concerns,
- The client receiving unnecessary services, and
- Lack of referral to other necessary services.

Practice Guidelines for the Assessment of Linguistically Diverse Clients

1. In order to make an accurate differential diagnosis and determine appropriate follow up and recommendations, regulated members should complete a comprehensive assessment of all areas of speech and language, including:

    - Phonology
    - Morphology
    - Syntax
    - Semantics
    - Pragmatics

    Comprehensive assessment should also include consideration of all language modalities used by the client, including gestural, verbal, written, signed, and/or other augmentative or alternative forms of communication, as appropriate.

2. Consistent with the ACSLPA Standards of Practice, ***standardized assessment*** tools must be administered and reported as intended. While standardized assessment tools can be one component of an assessment that contributes to the information required to form clinical impressions of a client's skills, these tools are not appropriate for standardized use with any individual who does not fit the tool's normative samples. In these situations, the stimuli may not be suitable for the individual being assessed due to cultural bias (where an individual is questioned on content that is culturally unfamiliar to them) or linguistic bias (where an individual is required to respond in a language that is not their first and/or dominant language) (Johnson, 2020; Levey et al., 2020; Toeh et al., 2012).

    Standardized assessment tools are created for and normed against the developmental milestones and language norms of the language(s) and regional communities for which they are developed. Therefore, when using standardized assessment tools with linguistically diverse clients, the norms against which the client's skills are being assessed will not be valid or reliable, and the client's total language competence (across all languages used) will not be captured (McLeod et al., 2017; Williams & McLeod, 2012). SLPs are expected to be knowledgeable of the standardized tools they administer and the normative samples within those tools.

    It is important to note that some linguistically diverse clients may use the dominant language of the place in which they reside as *their* dominant language after lengthy and consistent exposure in educational and community settings. However, language dominance should not be equated with proficiency, nor an ability to perform at the same level with language tasks as a monolingual speaker. Therefore, measurement of language skills using standardized language assessments remains inappropriate for linguistically diverse clients who use the societal language as their dominant language, with some researchers suggesting that this remains the case even following six years of formal schooling (Hemsley et al., 2014).

Translation or interpretation of standardized assessments is not recommended, given the wide range of variability between languages (e.g., in vocabulary, morphology, and sentence structures), leading to potential issues with content validity in administration, scoring, interpretation, and reporting (McLeod et al., 2017; Roger & Code, 2011). Standardized tests may be available in other languages for use by SLPs who speak those languages. For clients who use American Sign Language (ASL), trained ASL administrators can administer standardized ASL assessments, the results of which can be used by SLPs in their diagnosis and reporting.

ACSLPA acknowledges that situations may arise whereby funding agencies may recommend or require the reporting of standardized scores, even for linguistically diverse clients. In these situations, it is recommended that regulated members in their assessment documentation:

- Outline clearly why standardized assessment could not be administered. Regulated members may find it helpful to review the ACSLPA Standard of Practice 1.3 Client Assessment and Intervention for more information on the requirements of regulated members for evidence-based and linguistically appropriate client assessment.
- Outline any assessment measures used, along with a rationale for their use, and provide a clear interpretation of the results of those measures. See Practice Guideline #4 of this guideline (page 8) for examples of culturally and linguistically appropriate tools which can be used for linguistically diverse clients.
- Present a strong rationale, based on interpretation of assessment data, for the diagnosis/diagnoses given.

3. Assessment includes consideration of all languages that the client uses or is exposed to, including consideration of the dialect used by the client, if applicable. Accurate determination of whether a client is experiencing a communication difference as opposed to a delay or disorder, and defining the severity of any delays or disorders require an assessment process that includes assessment of the client's total communication skills in all languages that they use, and integration of knowledge of the processes of multiple language acquisition (Appendix A).

   It is not sufficient to assume that an individual passively exposed to a second or subsequent language will become proficient in that language over a certain period of time. SLPs should also consider that there is considerable variation in the language profiles of multilingual individuals, whereby their weaknesses and strengths in the various language domains may vary across languages and across time.

   In addition, different patterns of impairment may be evident in multilingual clients with acquired communication disorders (e.g., parallel impairment, where all languages spoken by the client are impacted similarly; or differential impairment, whereby one language is impacted differently than the other(s) used by the client).

   It is the SLP's professional responsibility to assess and interpret how a client's language history and proficiency support or inhibit the determination of an underlying language delay or disorder.

Considerations for determining proficiency and any concerns in the languages used by the client include:

- Client, parent, and/or caregiver reports of concern with communication.
- For pediatric and adult clients:
  - Client and family linguistic background, including:
    - Language(s) used in the home (by client and family members).
    - Dialectal variations of language(s) used.
    - Level of input/exposure to each language, including the context and frequency of input for each language, and the length of time that the client has been exposed to each language.
    - Client linguistic profile across languages, including:
      - Strengths and weaknesses across languages.
      - Language preference and/or dominance across contexts (e.g., at home, school, or in community).
    - The age of onset of exposure/acquisition of each language used and the manner of acquisition (e.g., ***simultaneous*** or ***sequential multilingualism***).
  - Developmental, linguistic, and cultural norms related to communication based on the client's background and the languages they hear and use.
- For developmental language concerns:
  - Language development history in each language used.
  - Family history with language or developmental delays/disorders.
  - Concerns about pre-linguistic communication (e.g., play, gestures, attention).
  - Delayed universal milestones (i.e., babbling, first words, word combinations).
  - Child's language skills compared to siblings' and/or peers'.
  - Presence of risk factors for language development (e.g., hearing loss, chronic ear infection, concomitant diagnoses).
- For acquired language concerns:
  - Language skills/functioning prior to the onset of communication disorder (in each language). Note that disorders in adults may be acquired (e.g., stroke, brain injury) or degenerative (e.g., dementia).

4. Regulated members should use a variety of culturally and linguistically appropriate tools and techniques as needed and as appropriate for the client. These may include, but are not limited to:
   - Client and/or parent/caregiver report,
   - Report from others involved in the client's life (e.g., family members, other healthcare providers, teachers, etc.),
   - Language sampling,
   - Contrastive analysis (i.e., contrasting the client's communication skills with those of an individual of the same linguistic background),
   - Observation (e.g., observation of communication skills across multiple (and naturalistic) environments and/or over time),
   - ***Dynamic assessment*** (e.g., test-teach-retest),
   - Language processing tasks (e.g., non-word repetition tasks), and
   - ***Criterion-referenced measures***.

5. For pediatric clients, assessment should consider the client's use of conversational and academic language. 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, or classroom/school settings) where applicable. Generally speaking, children who are learning a subsequent language approach monolingual speaker ability for narratives first, followed by vocabulary,

with grammar coming in last (Paradis, 2011). While bilingual children can attain conversational skills similar to their monolingual peers after approximately two years of quality exposure to the second language, a considerably longer time (on average six years with quality, dual-language input) is required to perform at the same level for academic tasks. (Thomas & Collier, 2017; ASHA, n.d.).

6. Regulated members should inquire about dialects or language varieties used by the client, and how their use may impact assessment information. Even when clients report being monolingual in English, their dialectal and ***accent*** features may differ significantly from the locally dominant dialect in a range and combination of phonological, syntactic, morphological, lexical, and discourse-based features (Ball & Bernhardt, 2008; Johnson & White, 2019). Whenever possible, regulated members should work with clients, their families or caregivers, interpreters, and/or cultural facilitators to gain an understanding of the client's dialectal features and how these may impact assessment data.
   Speakers of a dialect of English can be at risk of unnecessary pathologizing of their communication skills, if the locally dominant dialect or variety of English is used as the 'norm' or standard against which their speech and language skills are compared (Mdlalo et al., 2019). This is a particularly important consideration in Alberta, given the variety of First Nations dialects used in the province. More information on First Nations dialects of English can be found in the ACSLPA handout: Differences, Not Mistakes, by Patricia Hart Blundon, PhD. Regulated members may also find it helpful to review ACSLPA's webinars webpage for any current webinars in relation to this topic.

7. Best practice indicates that assessment should evaluate proficiency in all languages used by the client, and so must utilize trained interpreters where appropriate and available. Interpreters are an important resource for assessment, and may support the informed consent process, gathering assessment information and conveying information to the client and/or caregivers (Ng et al., 2022). Trained interpreters may also be able to provide information about language norms of the client's community, as well as social norms and other cultural information that allows for safe and effective assessment (ASHA, n.d.). However, as noted previously, interpretation of standardized assessments is not recommended, so interpreters must not be utilized in this way. Regulated members may find it helpful to review the article by Green (2022) for more information on ways to incorporate interpreters as professional partners.
   The College recognizes that access to interpreter services may be dependent on the regulated member's practice setting, and that in some situations, an individual who is not trained in interpretation must be used to facilitate an assessment. In these instances, it is preferrable to use a professional colleague who speaks the same language as the client. Caution is required when a client's family member or friend must be used to provide interpretation during assessment. Risks of this practice include an increased likelihood of errors during assessment (e.g., message distortion due to assumptions being made by the interpreter, or the interpreter 'filling in the blanks' with information that was not actually provided by the client), particularly when sensitive information must be conveyed, and the risk to client confidentiality and privacy (Green, 2022; Rimmer, 2020).

   Regulated members should evaluate the appropriateness of the interpreter and use their clinical judgement to select the most appropriate untrained interpreter whenever possible. Members should consider (ASHA, n.d.):

   - The overall linguistic ability of the interpreter (colleague or family member or friend) in both languages used during the clinical interaction.
   - If the interpreter is a family member or friend, their age and role within the family should be considered. It is recommended to avoid using minor children (e.g., siblings or minor children of a client) as interpreters.
   - The content of the message (e.g., information about a sensitive diagnosis versus information about management strategies to be used at home).

In situations where an interpreter is not available for an assessment, regulated members should use their professional judgement to determine which clinical measures can be taken accurately and effectively without an interpreter. Assessment reporting should include how the absence of an interpreter may have impacted the interpretation or analysis of assessment findings, as well as what assessment information could not be gathered.

Regulated members should also exercise caution when making decisions about using translation apps available on smart devices, due to concerns about privacy and confidentiality, as well as accuracy and the potential for unreliable translations.

8. Services should support the client and their family to develop and maintain use of their home or heritage language, as requested. SLPs play an important role in providing caregivers with accurate information about multiple language acquisition so that caregivers can make informed choices about home or heritage language use in the home.

   Learning more than one language does not increase the risk or severity of language disorders (Peña, 2016), and has been shown to have developmental, cognitive, academic, and social benefits (Kay-Raining Bird et al., 2016; Verdon et al., 2014). As such, regulated members should also refrain from, and/or counsel others to refrain from recommending that children with language delays or disorders be exposed to one language only.

   More information on multilingualism and language disorders can be found in the Speech-Language and Audiology Canada (SAC) position statement on learning an additional language in the context of language disorder (SAC, 2021).

Practice Guidance for Audiologists

A client's language profile (e.g., the number of languages spoken, and whether they speak the language they are assessed in) may impact their audiological assessment, subsequent diagnosis, and audiological management. Language profiles affect:

- The ability to gather complete and accurate case history information.
- The ability of the client to accurately identify and produce or imitate speech sounds, which impacts the use and selection of speech recognition and discrimination tests.
- Communication with clients about their assessment results and any recommendations (Abreu et al., 2011; Bloom, 2003).

Based on the above, the following practice guidance is provided to regulated members:

1. Obtaining information about a client's linguistic history and functioning is important to ensuring that audiological assessment information is collected and interpreted appropriately and accurately (Shi, 2014; Vincente et al., 2019).

   Audiologists can consider collecting Information about the client's language profile as part of the case history. This should include information on the client's proficiency in the language that the test battery is conducted in, and the use, preference, and dominance of the languages used by the client, across different contexts (e.g., at home, school, work, or in the community).

2. Audiologists should consider whether interpreter or translation services would facilitate information gathering, assist with client understanding of instructions given by the professional, and facilitate the sharing of information and counselling following an assessment (Bloom, 2003; Abreu et al., 2011; Ramkissoon & Khan, 2003). Trained interpreters can also provide information about social norms and other cultural information that allows for safe and effective assessment (ASHA, n.d.). Regulated members may find it helpful to review the article by Green (2022) for more information on ways to incorporate interpreters as professional partners.

Ideally, trained interpreters will be utilized to facilitate audiological assessment. However, the College recognizes that access to interpreter services may be dependent on the regulated member's practice setting, and that in some situations, an individual who is not trained in interpretation (e.g., a family member or friend of the client) may be used to facilitate an assessment. In most instances, it may be preferrable to use a professional colleague who speaks the same language as the client as an interpreter if possible. Caution is required when a client's family member or friend is used to provide interpretation during assessment, given the risks associated with this practice, including the increased likelihood of message distortion, particularly when sensitive information must be conveyed, or the risks to client confidentiality and privacy (Green, 2022; Rimmer, 2020).

Regulated members should exercise caution when an untrained interpreter is used during assessment, and consider:

- The overall proficiency of the family member or friend in both languages used during the clinical interaction.
- The age of the family member or friend, and their role within the family. It is recommended to avoid using minor children (e.g., siblings or minor children of a client) as interpreters.
- The content of the message (e.g., information about a sensitive diagnosis versus information about management strategies to be used at home) (ASHA, n.d.).

Regulated members should clearly document when and how interpreter or translator services are used during assessment. Regulated members should also exercise caution when making decisions about using translation apps available on smart devices, due to concerns about accuracy and the potential to produce unreliable translations.

3. Regulated members should use caution when administering and interpreting speech recognition and discrimination tests as part of the audiological battery for linguistically diverse clients. Multilingual clients do not perform as well on speech perception tasks as monolingual clients at the phoneme, word, or sentence levels, with this effect worsening when speech is presented in noise (Hisagi et al., 2022; Shi, 2014). Speech recognition and perception results are also impacted by proficiency in the language of the test, as well as the age of the client at acquisition and the manner of acquisition of subsequent languages used (ASHA, n.d.; Hisagi et al., 2022; Vincente et al., 2019).

   The differences in speech recognition and discrimination abilities between monolingual and multilingual clients can make differentiating between hearing loss and the impact of multilingualism on speech perception difficult (Shi, 2014; Vincente at al., 2019). Speech recognition and discrimination should be evaluated in a culturally and linguistically appropriate manner, which is consistent with the linguistic background of the client (ASHA, n.d.).

   Based on the language proficiency information collected, the regulated member can make appropriate determinations about how/if speech perception testing should take place. For example:

   - omitting speech recognition and discrimination testing from the test battery (when the client's word discrimination abilities cannot be assessed in the language of presentation),
   - assessing in all languages used by the client, or
   - assessing in the client's stronger or dominant language where possible (Shi, 2014).

   Regulated members should also use their best clinical judgement when interpreting speech recognition and discrimination testing results. Confounding factors, like the client's language background, should be documented in the client file and in any assessment reporting.

Appendix A: Multiple Language Acquisition

Understanding the typical processes and phenomena of multiple language acquisition helps SLPs to accurately distinguish between language differences and delays/disorders. Children and adults who use two or more languages may display typical processes which are not necessarily indicative of a language learning delay or disorder. It is important to note that there is significant individual variation in how individuals acquire multiple languages, due to personal, linguistic, and environmental factors (McLeod et al., 2017).

Some of the common processes in multiple language acquisition are listed below. Regulated members may find this Appendix a helpful standalone document, however the definitions of the common processes below are also listed in the guideline glossary.

Simultaneous Multilingualism

Refers to the acquisition of two or more languages, from birth, or with both languages introduced prior to the age of three. Children who are simultaneous multilinguals typically achieve language milestones at roughly similar ages to monolingual children (Kay-Raining Bird et al., 2016).

Sequential Multilingualism

Refers to exposure to, learning, and acquisition of a second or subsequent language, after proficiency has been established in a first language. Researchers often distinguish that for multiple language acquisition to be considered sequential, exposure to the second or subsequent language should begin after the age of three (Kay-Raining Bird et al., 2016). Typically, sequential multilingual speakers establish their first language(s) in the home environment and are subsequently exposed to and learn additional language(s) at school or in their communities (McLeod et al., 2017).

Additive Multilingualism

Refers to the multilingual context in which a second or subsequent language is developed at no cost to the first language.

Code Switching

Refers to the conscious or unconscious alternation between languages within utterances, phrases, sentences, or conversations. Code switching requires the ability to switch between languages appropriately and allows multilingual speakers to take advantage of their total linguistic repertoire to express a message even when they are not able to do so entirely in one language (Gross & Kaushanskaya, 2022). Code switching should be considered a communication strength.

Dominant Language

The language in which a multilingual speaker is most proficient, and/or the language which they prefer to use. Language dominance/preference may vary by age, speaking partner and/or context, opportunities to develop and use each language, and other sociolinguistic factors (McLeod et al., 2017).

Language Loss/ Subtractive Multilingualism

Refers to an individual's loss of skills or fluency in one language (typically their home language) as their proficiency with another language (typically the dominant societal language) becomes more developed. It typically occurs when one language is not reinforced or maintained with consistent opportunities for input and use. Language loss may impact an individual's first or subsequent languages. Language loss is also influenced by factors such as educators' beliefs about multilingualism and individual or family preference (Verdon et al., 2014). Language loss occurs at the personal, familial, and community levels.

Silent Period

Refers to the initial stage of second or subsequent language acquisition during which the individual focuses on building language comprehension skills through active listening, rather than language production. The individual is able to understand more language than they can produce, and during this time, sufficient spoken language competence does not exist in the second language for expressive communication. There is no established information regarding the acceptable length of time for the silent period to last. It may last for weeks or months and may not be entirely dependent on linguistic competence in the second language. Other factors, like speaker comfort and confidence with using their second language at different levels of proficiency, may impact the length of the silent period.

Transfer

Refers to cross-linguistic influence from the first to subsequent languages, whereby phonological, morphosyntactic, or semantic patterns in the second or subsequent language(s) are a result of transfer from the first language. In simultaneous multilinguals, transfer may occur between all of the languages spoken by the individual. Language patterns in the second/subsequent language that are the result of transference are not an indication of a disorder.

Glossary

Accent	Phonological and prosodic variations that render a person's speech distinctive.
Acculturation	The process by which immigrants and their families learn and incorporate the values, beliefs, language, and customs of the new country that they are living in.
Additive multilingualism	Refers to the multilingual context in which a second or subsequent language is developed at no cost to 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.
Bias	Refers to "an implied or irrelevant evaluation of (an) individual(s) which might imply prejudicial beliefs or perpetuate biased assumptions" (American Psychological Association, 2020).
Code switching	Refers to the conscious or unconscious alternation between languages within utterances, phrases, sentences, or conversations.
Competence	Refers to "the combined knowledge, skills, attitudes, and judgement required to provide professional services" (Government of Alberta, 2000).
Criterion-referenced measures	A process whereby the child's performance is compared to a pre-defined set of criteria or a standard.
Cultural facilitator	A member of a cultural community who can serve as a bridge between healthcare services and the person accessing care. Cultural facilitators are able to broker the use of cultural knowledge and culturally appropriate processes in assessment, diagnosis, treatment, and delivery of services (Henderson et al., 2011).
Cultural harm	Any action which diminishes, demeans, or disempowers the cultural identity and well-being of an individual.
Cultural humility	A process of self-reflection to understand personal and systemic biases, to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.
Cultural safety	The provision of quality care for individuals of cultures outside of the dominant culture; and care provided within the cultural norms of the client, so that all people feel respected and safe when they interact with the health care system. Culturally safe health services are free of racism and discrimination and occur when clients are supported to draw strengths from their identity, culture, and community.
Culturally responsive practice	Practice which takes into consideration the client's cultural perspectives, beliefs, and values into every aspect of service delivery.
Dialect	A variety of language that is associated with a socially defined group (Hyter & Salas-Provance, 2019).
Dominant/preferred/ stronger language	The language in which a multilingual speaker is most proficient, and/or the language which they prefer to use.

Dynamic assessment	A method of conducting assessment 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.
Heritage language	A language different from the dominant language in a given social context. In Canada, the term refers to familial languages other than the two official languages
Language delay	Occurs when a child's language skills are acquired in a typical sequence, but at a slower rate than their same chronological and cognitive aged peers. A child with a language delay may "exhibit a slower onset of a language skill, rate of progression through the acquisition process, sequence in which language skills are learned, or all of the above" (Hari Prasad, 2015).
Language difference	A variation of a communication system used by a group of individuals that reflects and is determined by shared regional, social, and/or cultural factors (ASHA, 1993). Communication may therefore meet the norms of the individual's primary language community but does not meet the norms of Standard English (Hari Prasad, 2015). For individuals learning more than one language, a language difference may be the result of the normal process of subsequent language acquisition and its impact on the development of language.
Language disorder	For the purposes of this guideline, a language disorder may impact the comprehension and/or use of language, and may involve the form, content, and/or function of language in communication. Language disorders may be developmental, acquired, or secondary to a primary diagnosis. In children language disorder is characterized by atypical language acquisition that disrupts communication across settings.
Language loss/ subtractive multilingualism	Refers to an individual's loss of skills or fluency in one language (typically the home language) as their proficiency with another language (typically the dominant societal language) becomes more developed.
Linguistic bias	Bias towards speakers of other specific languages or dialects, or towards multilingual speakers.
Linguistically diverse	Describes individuals who do not speak the dominant language of the place where they reside (English in Alberta), or those who have multiple linguistic influences.
Sequential multilingualism	Refers to exposure to, learning, and acquisition of a second or subsequent language, after proficiency has been established in a first language
Silent period	Refers to the initial stage of second or subsequent language acquisition during which the individual focuses on building language comprehension skills through active listening, rather than on language production.
Simultaneous multilingualism	Refers to the acquisition of two or more languages at the same time, since birth, typically with both languages introduced prior to the age of three.
Standardized assessment	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 the test taker's score differs from the average of the normative sample of the test.
Transfer	Refers to cross-linguistic influence from the first to subsequent languages, whereby phonological, morphosyntactic, or semantic errors in the second or subsequent languages(s) are result of transfer from the first language.

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