Position Statement

on language impairment in multilingual children

Lifelong Learning Programme

Introduction

Muhammed, 4 years of age, has come to see a speech-language pathologist, referred due to his very slow language development. He has been attending a preschool since the age of two, but his presence has been sporadic at times. According to his parents Muhammed talks very little and has difficulties in understanding both Arabic, and his second language. The assessment tools available are based on results from monolingual children. The speech-language pathologist is confronted with the problem of finding methods to assess both Muhammed's languages in order to create an intervention plan.

I Introduction

In 2014, a project entitled *Multilingual children with SLI – bridging the gap between theory and practice* kicked off, sponsored by the European Commission within the Grundtvig action of the European Life Long Learning Programme. The participants hailed from seven European countries and were mainly Speech Language Pathologists (SLPs), specialized teachers and researchers. The aim of the project was to address the challenges encountered by multidisciplinary teams when managing multilingual children with language impairment.

In all the participating countries similar challenges are faced, although the health and educational systems may be different. This project aims to find joint solutions and examples of 'best practice' that can be carried out within the different health and educational systems. Parents have also been invited to participate in this process.

Due to the fact that terminology varies considerably, the following definitions are used in this Position Statement:

Multilingualism
The term *multilingualism* will be used for any situation in which the child encounters minimally more than one language; thus the term *bilingualism* is subsumed under this definition.

Language impairment in multilingual children
The term language impairment (LI) will be used here to describe any child who is not developing typically all languages (s)he is exposed to and as a result experiences difficulty with the use of language. The main impairment is demonstrably limited to language (see Notes page 3).

Lack of knowledge about language acquisition in multilingual children makes it hard to distinguish between typical development and a language impairment in multilingual children. Multilingualism does not cause Language Impairment, in fact there is evidence that multilingualism gives certain cognitive benefits. Since assessment of both languages is hard to accomplish there is a risk for both over- and underdiagnosis. In the case of underdiagnosis, it can result in persisting language and learning disabilities, and also secondary problems such as socio-emotional difficulties. In the case of overdiagnosis, children receive inappropriate services. In both cases this leads to inefficient use of resources. The mismatch between the languages spoken by professionals and child thus needs to be addressed today.

In most of the participating countries, multilingual children constitute an estimated 40-50 % of total referrals for suspected Language Impairment, and the figure is rising. The majority of SLPs in these countries have a substantial proportion of multilingual children on their case-load.

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Positions taken:

I Multilingual children should have the same access to speech/language services as monolingual children

Why: Equity of access to health care and education is a fundamental right.

II When providing services for multilingual children, professionals must consider all languages. Linguistic background needs also to be extensively explored.

Why: Language impairment occurs in all languages used by the child; each language should be taken into account for a reliable assessment and an appropriate intervention.

III Monolingual norms should not be applied on multilingual children.

Why: Monolingual norms disadvantage bilingual children and do not reflect their linguistic abilities, especially when this is their second language. The focus of assessment should be on language learning ability rather than language proficiency.

IV: Facilitated access to trained interpreters is needed to ensure accurate assessment.

Why: All languages must be assessed in order to provide an appropriate intervention.

V Education/training of professionals about Language impairment in multilingual children is needed.

Why: To provide the best service tailored to individual needs, as intervention for multilingual children differs from intervention carried out with monolingual children.

VI It is imperative to consider cultural aspects when providing services to multilingual children.

Why: Cultural background is a part of the child's identity, and influences communication development. Intervention must meet the cultural and linguistic requirements of the child's environment in order to be effective.

VII Awareness should be raised among all the child's caregivers about multilingual development.

Why: It is important to encourage the use of all the child's languages.

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Notes

This definition is deliberately broad. Multiple terminology is used worldwide to describe language impairment with multiple definitions (Bishop et al. 2014). Specific language impairment is used primarily by researchers to include any child for whom the impairment is demonstrably limited to language development, with other cognitive and motor skills developing typically. This definition is often perceived as too restrictive however, and excludes many of the LI children routinely seen by practitioners (Reilly et al. 2014). The definition of LI is a contentious issue. It should encourage further debate.

Bishop, D.V.M. (2014). Ten questions about terminology for children with unexplained language problems. *International Journal of Language and Communication Disorders, 49*(4), 381-415.

Reilly, S., Tomlin, B. Law, J, McKean, C., Mensah, F, Morgan, A. Golfeld, S. Nicholson, J., & Wake, M. (2014). Specific language impairment: a convenient label for whom? *International Journal of Language and Communication Disorders, 49*(4), 416-451.

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