

## **Speech and language therapy services to multilingual children in Scotland and England: A comparison of three cities**

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### **Abstract**

This study investigates current speech and language therapy services for multilingual children in three cities in the UK, and examines whether an equitable service is provided to multilingual children in these cities. Through a combination of questionnaires, Census data, and school population data, information was gathered about number and ratio of monolingual and multilingual children in the population, number and ratio of monolingual and multilingual children on therapy caseloads, languages spoken by the multilingual children and therapists, number and ratio of therapists working in languages other than English, availability of multilingual therapy assistants and interpreters, language(s) in which therapy is offered, training/education provided to therapists, and practising therapists' views on service provision to multilingual children. Results show that currently only one of the three cities is providing a fully equitable service for multilingual children and that there are varying levels of support which partly reflect the perceived need in each area. Conclusions drawn include the need for a change in how data on linguistic diversity in society is collected and disseminated so that informed decisions can influence the future of quality services to minority groups.

**Keywords:** *Multilingual children, service provision, UK*

### **Introduction**

The population in the UK is more culturally diverse than ever before, with a minority ethnic population of 4.6 million or 7.9% of the total population in 2001 (National Statistics). Since the last Census (1991) the minority ethnic population in Great Britain has grown by as much as 53% overall (National Statistics) and 62% in Scotland (Scottish Executive, 2004).<sup>1</sup> This growth is particularly evident in the younger population since minority ethnic groups have a younger age structure than the white population, reflecting different fertility patterns. It is estimated that the number of children under the age of 15 amounts to 30% of the minority ethnic population, whereas it only amounts to 19% of the white population (Scott, Pearce and Goldblatt, 2001). This suggests that a growing number of children in the UK are, potentially at least, bilingual or multilingual.<sup>2</sup>

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As the number of multilingual children in the UK continues to rise, speech and language therapists are faced with the challenge of providing equitable services to an increasingly heterogeneous group of clients. Young and Westernoff (1999) identified several challenges professionals are faced with when working with clients from culturally and linguistically diverse backgrounds, ranging from culture, language, and training, to professional matters. These challenges are often perceived to be barriers to providing an efficacious service to these clients. Speech and language therapists are faced with even more challenges than other professionals as they have to respond to the communication needs of a widely diverse population. Nevertheless, they have a moral as well as a legal obligation to provide an equitable service to everyone without distinction (e.g., on the grounds of colour, race, sex, language, religion, or ethnic origin), regardless of the difficulties involved in providing such a service.

The Royal College of Speech and Language Therapists (RCSLT, the UK's professional body for speech and language therapists) has acknowledged the need to provide culturally and linguistically appropriate services by documenting guidelines for therapists in its handbook of professional standards (RCSLT, 1996). These guidelines advise that speech and language assessment should be carried out in all languages spoken by a multilingual client and also highlight the importance of offering speech and language therapy in the client's chosen language. In practice, however, it may be difficult for the speech and language therapy service to achieve these guidelines. This difficulty is most likely due to a combination of factors, including limited education of speech and language therapists on multicultural issues (Raval, Hooke, Martin, Quinn and Anderson, 1999; Winter, 1999); monolingual bias in linguistic and clinical linguistic research, resulting in a lack of studies on the characteristics of normal language development in multilingual populations (Romaine, 1995; Baker, 2000); lack of multilingual practitioners and students (RCSLT, 1999, 2001); scarcity of assessment tools for multilingual populations (Crutchley, Conti-Ramsden and Botting, 1997; Baker, 2000; Pert and Letts, 2003); lack of resources; and limited awareness by practitioners and their managers of the multilingual population present within their area of remit (Winter, 1999).

But even though speech and language therapists are required to 'uphold non-discriminatory practices at all times' (RCSLT 1996: 20), equity in speech and language therapy service to multilingual clients is often not achieved, with instances of over-representation as well as under-representation reported in the literature (Winter, 1999, 2001). The notion of 'equity' in health has been defined and conceptualised in many different ways, as it received interest from a wide range of fields, including public health, medicine, ethics, and economics. Most commonly, definitions of health equity focus on how fairly resources are distributed in relation to the health needs of different groups (Macinko and Starfield, 2002). Differences in health experience and health outcomes between different population groups are usually called health inequalities. Those inequalities that are judged unfair or unjust are considered health inequities. Two types of health equity are being recognised, vertical (preferential treatment for those with greater health needs) and horizontal (equal treatment for equal need), and most research has been concerned with the latter (Macinko and Starfield, 2002). Another common criterion in definitions of equity is that the health inequalities can potentially be resolved, as reflected in the definition of equity adopted by the International Society for Inequity in Health: 'the absence of potentially remediable, systematic differences in one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups' (ISEqH, 2001).

The most straightforward way of establishing whether an equitable service is provided to multilingual children would be to compare the number of multilingual children on speech

and language therapy caseloads to those in the population. Most researchers hold the view that multilingualism does not cause communication disorders, and therefore there is no reason to assume that the number of communication disorders in the multilingual population is any different from that in the monolingual population (Duncan and Gibbs, 1989; Crutchley, Conti-Ramsden and Botting, 1997; Crutchley, 1999; Winter, 1999, 2001; Mennen, Johnston and Stansfield, 2003; Mennen, Stansfield and Johnston, 2005; Pert and Letts, 2003; Stow and Dodd, 2003). Although recent findings from a Sure Start study suggest higher reported rates of concern and a lower vocabulary level in the multilingual participants of the study compared to the monolingual participants (e.g., Law, Harris and Roy, 2003; Law, J., personal communication), this is likely to be due to the fact that these multilingual children lived in disadvantaged areas, and there is evidence of a link between socio-economic disadvantage and language delay (Locke, Ginsborg and Peers, 2002; Broomfield and Dodd, 2004a,b), just as socio-economic disadvantage is closely related with low educational attainment (DfES, 2003).

Since the needs of the multilingual population should be similar to those of the monolingual population (horizontal equity), an equitable service would be provided when the representation of multilingual children on the speech and language therapy paediatric caseloads is proportional to the representation of multilingual children in the population. This is the approach taken by Winter (2001), who focused on issues of access and use of the speech and language therapy service by examining the number of multilingual children on speech and language therapy caseloads in different areas of England and Wales (Winter, 1999, 2001).

Unfortunately, in the UK it is not straightforward to establish accurate data on the multilingual population. Unlike countries such as the United States, Australia, New Zealand and Canada—countries that have evolved from significant immigration and have noteworthy multicultural policies—the census in the UK has only recently (in the last two censuses in 1991 and 2001) introduced questions on language use and has focused exclusively on its indigenous minority languages (Scottish Gaelic, Welsh and Irish Gaelic). This reflects a change of policy to support and finance these languages and also reflects the fact that the countries of their origin now have devolved or decentralised governing bodies. Coleman and Salt (1996) state that there were proposals at the design stage of the 1991 British Census, to add a question on language use to the ethnic group question but these were not followed up. This was a missed opportunity to collect data that could have been used to build a linguistic profile of the UK.

As a result, there are no reliable figures available which directly relate to the number of multilingual individuals in the population in the UK. Census data on ethnic groups give some indication of the linguistic minorities that are present, but this is by no means an unequivocal measure of multilingualism as there will be individuals in the minority groups who are monolingual just as there may well be multilingual individuals in the self-categorised white group.

However, until questions about language use are added to the UK Census and a linguistic profile of the UK is established, the available Census data provide the nearest possible indication of the number of multilingual individuals in the population. Another problem with Census data is the fact that they are organised around geographical areas, whereas data on SLT services are organised around NHS trusts. As a result, information obtained from census data is not necessarily fully compatible with information from trusts (RCSLT, 1998; Winter, 1999, 2001; Mennen et al., 2003; Stow and Dodd, 2003).

Another approach to establishing horizontal equity of speech and language therapy provision to multilingual children is to evaluate the quality of the service provided and

the factors which impede delivery of an equitable service. Stow and Dodd (2003) identified several factors that impede delivery of an equitable service, most of which are to do with a lack of support services and education/training. Among the factors mentioned are: few multilingual therapists, co-workers, or assistants; difficulty with accessing and using interpreters; and lack of knowledge by parents about the nature of speech and language therapy services.

A good starting point for resolving possible inequities in speech and language therapy service to multilingual clients is to gather detailed socio-demographic and qualitative data about the local community (RCSLT, 1998; Stow and Dodd, 2003). To enable a manager to assess the need for a service, to plan what resources are required and the best way to deliver the service they will need to be aware of the multilingual population they are serving. Winter (2001: 466) suggests 'that conducting numerical comparisons may, albeit indirectly, improve bilingual children's representation in SLT'. An awareness of factors which might impede delivery of an equitable service and lead to a failure to conform to RCSLT guidelines would further help such planning. These data can form the basis for a policy which addresses how their service will meet the needs of their clients in linguistic minority communities in the trust. 'The fundamental principle of *equality of service* must orientate this policy, as it does with all speech and language therapy service policies' (RCSLT, 1998: 6).

This study therefore focuses on establishing whether at the time of research, an equitable speech and language therapy service was being provided to multilingual children in the three cities of investigation, in terms of (i) the representation of multilingual children in speech and language therapy services,<sup>3</sup> and (ii) the quality of support services and education/training, both of which are reflected in the services' success in conforming to RCSLT guidelines.

## Methodology

The study used a combination of questionnaires and data gleaned from the UK Census 2001 and Local Education Authorities (LEAs), to address the following research questions:

- Is the representation of multilingual children on the speech and language therapy paediatric caseloads proportional to the representation of multilingual children in the population in the cities of investigation?
- Is the speech and language therapy paediatric service equitable in terms of the quality of support services and training? That is,
  - Are appropriate support services in place to aid speech and language therapists in their dealings with multilingual children (such as the availability of multilingual speech and language therapy assistants, co-workers, interpreting services, and information about the service in languages other than English)
  - Do speech and language therapists and service coordinators receive training on multilingual issues to help them in their dealings with multilingual children?
- How successful are speech and language therapy services in conforming to RCSLT guidelines? That is, do speech and language therapists/service coordinators think that their service is able to meet the RCSLT guidelines?

The inclusion of a research question on the clients' (or their parents') views as to whether they themselves perceived the service as equitable would have been desirable, but was at the time not deemed possible for ethical and logistical reasons.

We used the UK 2001 Census classifications for ethnic and national groups data in our study. The five categories for ethnic group were 'White', 'Mixed', 'Asian or Asian British', 'Black or Black British', 'Chinese or other ethnic group'. All categories were further divided into cultural backgrounds. The 'White' group was further divided into British, Irish, and Any Other White; the 'Mixed' group into White and Black Caribbean, White and Black African, White and Asian, and Any Other Mixed; the 'Asian or Asian British' group into Indian, Pakistani, Bangladeshi, and Any Other Asian; the 'Black or Black British' into Caribbean, African, and Any Other Black; and finally 'Chinese or other ethnic group' into Chinese, or Any Other. However, in order to address the problem of the unequivocal relationship between ethnic origin and multilingualism, the Census data were supplemented with information obtained from LEAs regarding the number of multilingual children and the most prevalent languages spoken in the school-aged population in each of the cities of investigation. The combination of figures obtained from Census data and education authorities provide the nearest possible indication of the number of multilingual children in the population at present.

A service was deemed equitable when our results indicated a positive answer to all of the above research questions. In order to answer them, we collected the following information:

- the percentage of monolingual and multilingual children in the population
- the percentage of monolingual and multilingual children in the school population
- the languages other than English spoken by the pupils
- the percentage of monolingual and multilingual children on the speech and language therapy paediatric caseloads
- the languages spoken by the multilingual children on the speech and language therapy paediatric caseloads
- the languages in which speech and language therapy is offered
- the support services available for therapists working with multilingual clients

The choice of the three cities (i.e. two cities in Scotland and one in England) was motivated by the fact that no published data on multilingual clients in Scotland are available, and we wanted to compare service provision in two Scottish cities to that in an English city which is renowned for its multicultural population. As such, the data presented are only representative for urban areas in Scotland. For representative data of multilingual children in SLT services across England the reader is referred to Winter (1999, 2001).

#### *Interview and questionnaire*

Managers of the NHS trust providing paediatric services within each area were approached in order to identify the service coordinators responsible for service delivery to paediatric multilingual clients within each area, and to give us information about the total number of speech and language therapists working with paediatric clients. This approach was taken as it was thought that the service coordinators would have an overview of the number of monolingual and multilingual clients on speech and language therapists' caseloads and be most aware of the available support services in their trust. It was reported that the total number of speech and language therapists working with children was 73 in S1, 90 in S2, and 70 in E1.

The two large English and Scottish cities (E1 and S2) had service coordinators, which were responsible for service delivery to paediatric multilingual clients within their city. Each of the two service coordinators was sent a questionnaire.

As the smaller Scottish city (S1) did not have a designated paediatric service coordinator, we obtained the number of monolingual and multilingual children on the S1 speech and language therapy paediatric caseload from the manager of the NHS trust in S1 (as we believed that the manager was the most direct source of this information), and sent out questionnaires to a sample of individual speech and language therapists working with paediatric clients. First, we obtained a list of all speech and language therapists working with paediatric clients in the S1 trust (i.e. a total of 73 speech and language therapists), who were assigned to five geographical sectors within the trust. Therapists marked as absent (due to leave or illness) were excluded from the sample. We then took a stratified random sample, i.e. for each geographical sector a third of the therapists were randomly chosen and a questionnaire was sent to them (i.e. a total of 25 questionnaires were sent out to therapists in S1).

Our approach resulted in some differences in the subjects invited to participate in this study across the three cities. In E1 and S2, respondents were speech and language therapists whose mayor role was as service coordinators, whereas respondents in S1 were speech and language therapists without such a role. It is possible that the coordinators were more informed respondents with a better overview of the service provision to bilingual clients. This may have influenced the type of responses obtained.

The questionnaire included both open and closed questions and respondents were encouraged to make comments regarding certain questions as well as to add any comments they felt were appropriate. A total of 27 questionnaires was sent out (i.e. 25 to therapists in S1 and 1 to each of the service coordinators in S2 and E1) and of these twenty completed questionnaires were returned. Overall this was a 74% return rate. The return rate for the coordinators in E1 and S2 was 100% (2/2), whereas for the individual speech and language therapists in S1 it was 72% (18/25).<sup>4</sup>

## Results and discussion

*Question 1: Is the representation of multilingual children on the speech and language therapy paediatric caseloads proportional to the representation of multilingual children in the population?*

### *Population, ethnicity and caseload*

The demographic results in each of the three cities are illustrated in Figures 1–3. In each figure, top panels show the proportion of children from ethnic minority groups in the population under 18 in each of the three cities under investigation; middle panels show the proportion of multilingual pupils of the total school population; and bottom panels show the proportion of multilingual and monolingual English clients. As discussed in the introduction, the first criterion to determine whether the cities of investigation provide an equitable speech and language therapy service to monolingual and multilingual children is that the representation of multilingual children on the speech and language therapy paediatric caseloads is proportional to the representation of multilingual children in the population in the cities of investigation (horizontal equity). When we compare the proportion of non-white ethnic children in the population to the proportion of multilingual children on the speech and language therapy caseload in the three cities (Figures 1–3) it appears that proportions are equal in S1 (Figure 1), roughly equal in E1 (Figure 3),

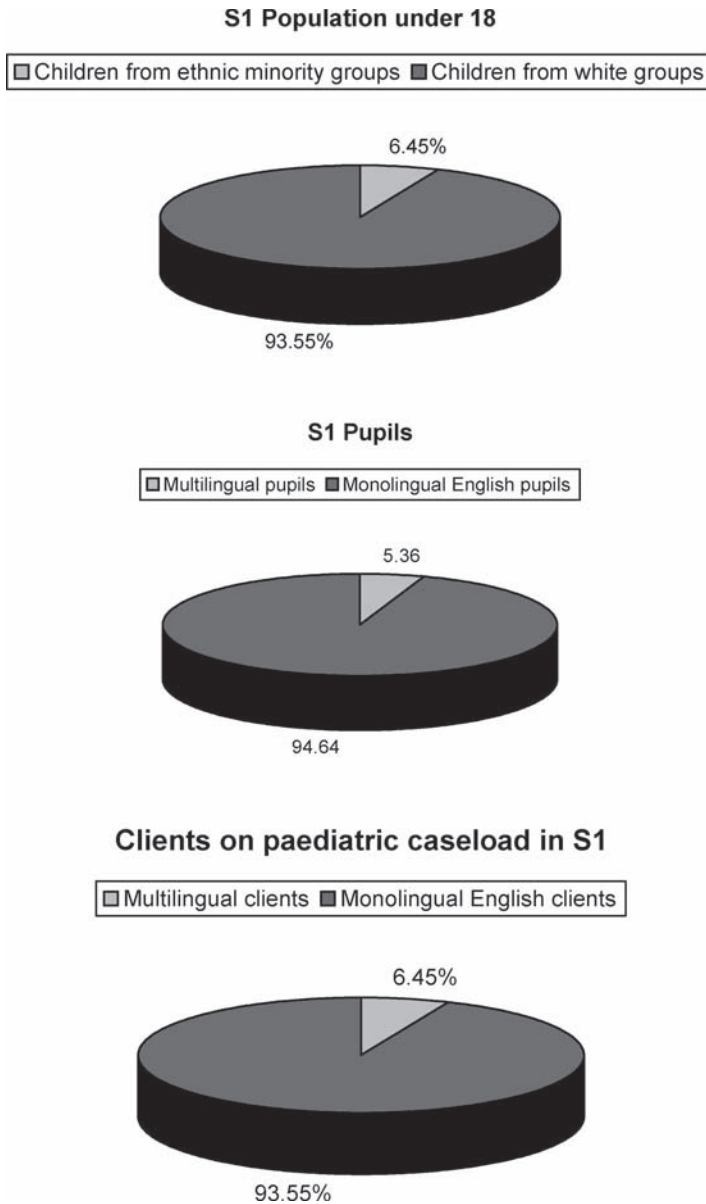


Figure 1. Summary of the data in S1. The top panel shows the children (under the age of 18) from ethnic minority groups as a percentage of the total population under 18. The middle panel shows the multilingual pupils as a percentage of the total school population. The bottom panel shows the multilingual clients as a percentage of the total paediatric speech and language therapy caseload.

but that there are fewer children on the caseload than one would expect from the population data in S2 (Figure 2). This suggests that both S1 and E1 are providing an equitable service in terms of the proportion of multilingual children represented on the speech and language therapy caseloads, but that there is an under-representation of multilingual children on therapists' caseloads in S2, suggesting that some multilingual children may be falling through the net.

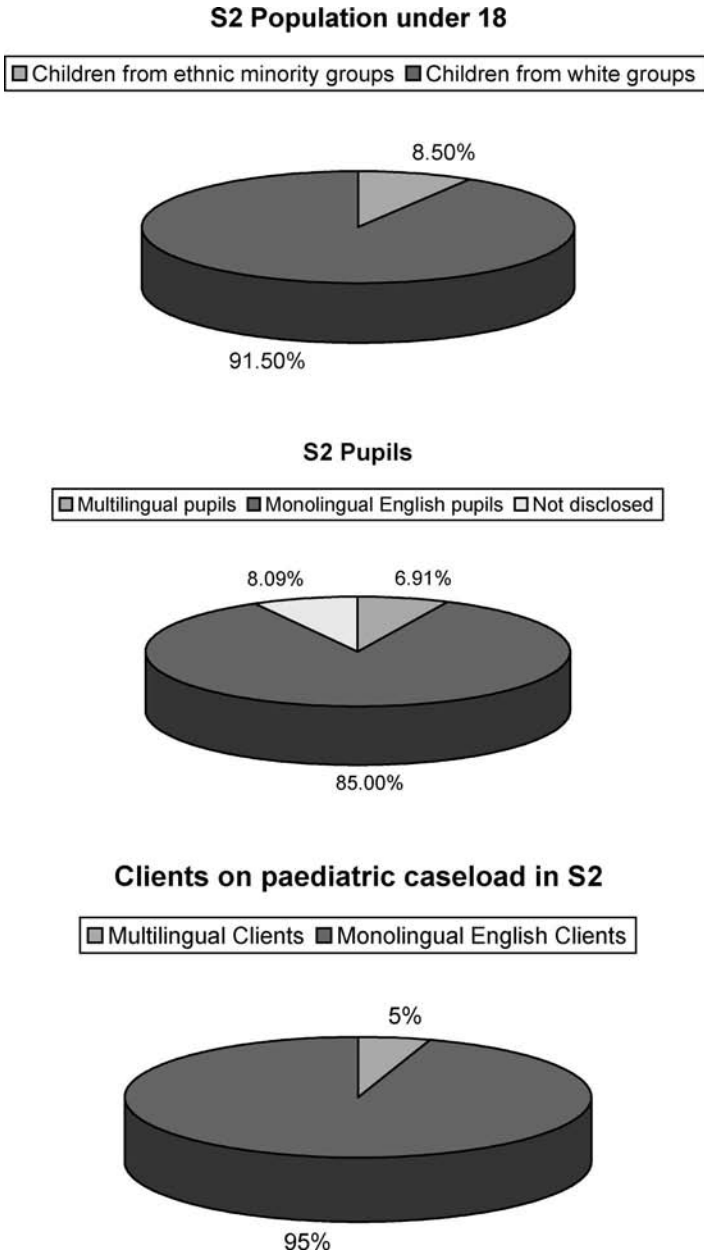


Figure 2. Summary of the data in S2, with the children (under the age of 18) from ethnic minority groups as a percentage of the total population under 18 (top panel); the multilingual pupils as a percentage of the total school population (middle panel); and as a percentage of the total paediatric speech and language therapy caseload (bottom panel).

It must be noted here that the figures for the number of multilingual children on the paediatric caseload in S2 (Figure 2, top and bottom panel) may be a little on the low side, as it appears that some multilingual children—especially those with motor problems or structural abnormalities—are being seen elsewhere in the service. It is unlikely though, that



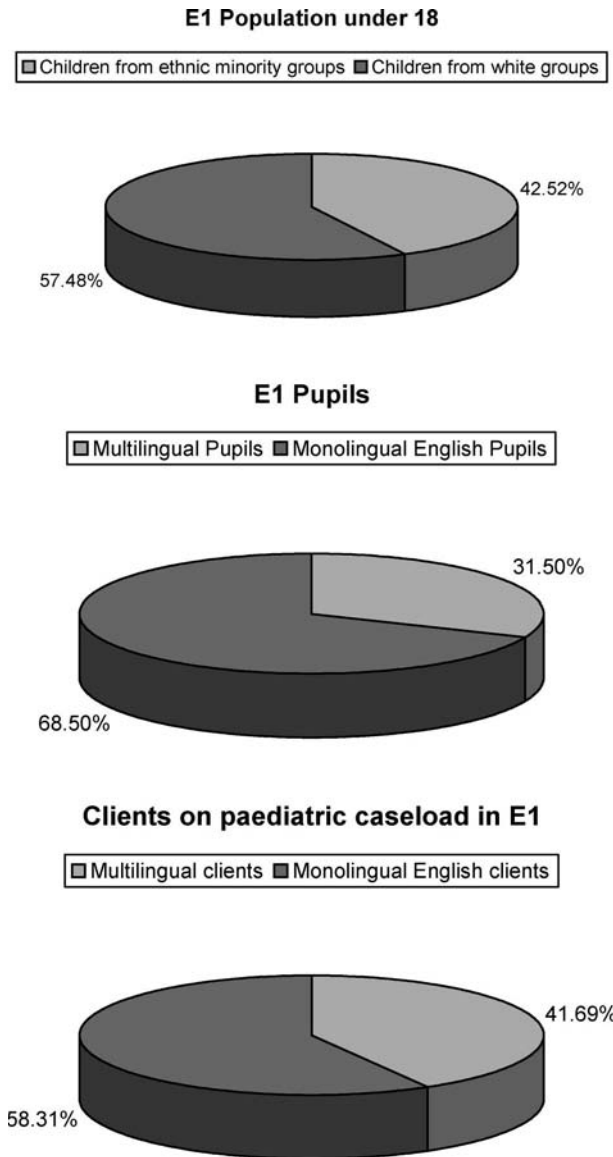


Figure 3. Summary of the data in E1, with the children (under the age of 18) from ethnic minority groups as a percentage of the total population under 18 (top panel); the multilingual pupils as a percentage of the total school population (middle panel); and as a percentage of the total paediatric speech and language therapy caseload (bottom panel).

as many as 3.5% (more than 100 multilingual children) are seen elsewhere in the service (as confirmed by the S2 service-coordinator), and it would not alter our conclusion of an under-representation. Our conclusion of an under-representation is also confirmed by the LEA data which correspond to the population data (Figure 2, middle panel). Note that around 8% of the pupils had not disclosed their knowledge of other languages and it may be reasonable to assume that some of them are multilingual. This would further strengthen our conclusion of an under-representation of multilingual children on the speech and language

therapy caseload. Instances of under-representation are undesirable but not uncommon in the UK, and have previously been reported for different areas of England and Wales (Winter, 1999).

The LEA data (middle panels) also confirm our conclusion of an equal representation in S1, as these data roughly correspond to the proportion of multilingual children on the caseload and in the population. However, if we compare the proportion of multilingual children on the speech and language therapy caseload to the proportion of multilingual pupils in the school population in E1, it appears that there are more multilingual children on the caseload than might be expected from the LEA data. Neither the Census data nor the LEA data provide accurate measures of multilingualism. The categorizations used in the Census are problematic as they do not necessarily give sufficient information about the number of multilingual children in the population. The data obtained from the LEA, on the other hand, might not be as accurate as the Census data, as pupils or their parents are under no obligation to supply this information. Furthermore, pre-schoolers are not included in the LEA data, whereas they are included in the Census. It may well be possible that the discrepancy of roughly 10% between the school data and the population data is due to the large number of preschoolers. In fact, the percentage of non-white ethnic children from 7 to 18 years old in E1 is 28% (Census 2001). This is roughly similar to the percentage of multilingual pupils (31.5%). As speech and language therapists provide services not only to school age children, but also to pre-school children, we believe that it is better to rely on the Census data here. Therefore, we conclude that E1 is providing an equitable service for multilingual children in terms of numbers.

Table I illustrates the ethnicity of the multilingual children under the age of 18. The most prevalent non-white group in all three cities is Pakistani, followed by Indian and Any Mixed.<sup>5</sup> It can be seen that the prevalent groups in the two Scottish cities largely overlap, but that they differ somewhat from those in the English city. For example, E1 has a relatively low prevalence of Chinese and Caribbean groups but a high prevalence of Bangladeshi, whereas the reverse is true in the Scottish cities.

#### *Linguistic diversity in school population and on caseload*

Table II shows a great deal of linguistic diversity in the school population of the three cities. Given that Pakistani and Indian are among the most common ethnic minority groups, it is not surprising that Punjabi or Panjabi<sup>5</sup> appear to be the most commonly spoken languages. Different methods of classifying the languages spoken by pupils are apparent in this table. For example, in the E1 data, a distinction is made between Panjabi and Punjabi, whereas in S1 and S2 the cover term Panjabi is presumably used to refer to both varieties. Punjabi and Panjabi are very different languages (Pert and Letts, 2003) and in order to ensure appropriate support it is vital for speech and language therapists to know which of these languages are spoken in their local community (Stow and Dodd, 2003). Note also that in the E1 data Punjabi is mentioned twice (once as 'Punjabi (Urdu)' and once as 'Punjabi (Urdu) & Urdu', the latter presumably refers to speakers of both languages), and that there is a discrepancy of 0.01% in the E1 data from the source document we received (most likely due to the rounding of figures).

When the data in Tables II and III are compared, different methods of classifying languages also become apparent between education and NHS Health Trusts, as well as between the different Health Trusts. For example, in city E1 the distinction between Punjabi and Panjabi in the LEA data is not maintained in the caseload data. Furthermore,

Table I. Ethnicity of children under the age of 18 in each of the three cities of investigation, expressed in total numbers and as a percentage of the total population under the age of 18.

Ethnic group	Ethnicity of children under 18 (Census 2001)					
	Cities					
	S1		S2		E1	
	No. of residents under 18	% of residents under 18	No. of residents under 18	% of residents under 18	No. of residents under 18	% of residents under 18
White	77,204	93.55	110,171	91.50	147,310	57.48
Non-white	5,325	6.45	10,239	8.50	108,956	42.52
Pakistani	1,421	1.72	5,819	4.83	43,687	17.05
Any mixed	1,243	1.51	817	0.68	16,976	6.62
Chinese	775	0.94	787	0.65	915	0.36
Indian	547	0.66	1,107	0.92	16,115	6.29
Other ethnic	395	0.48	535	0.44	1,843	0.72
African	312	0.38	322	0.27	1,970	0.77
Other South Asian	308	0.37	655	0.54	3,560	1.39
Bangladeshi	228	0.28	56	0.05	9,435	3.68
Black British or Other Black	49	0.06	88	0.07	2,400	0.94
Caribbean	47	0.06	53	0.04	12,055	4.70
Total population	82,529	100.00	120,410	100.00	256,266	100.00%

Table II. Main languages spoken by pupils as a percentage of the total school population in 2001–2002 in each of the three cities of investigation.

Main languages spoken by pupils (2001–2002)					
Cities					
S1		S2		E1	
Language	%	Language	%	Language	%
English	94.64	English	85.00	English	68.5
Punjabi	1.30	Punjabi	2.90	Punjabi (Urdu) and Urdu	12.9
Cantonese/Hakka <sup>7</sup>	0.30	Urdu	2.16	Punjabi (Gurmukhi)	6.8
Bengali	0.25	Arabic	0.41	Bengali	3.9
Arabic	0.22	Cantonese	0.23	Punjabi (Urdu)	1.7
Chinese/Mandarin	0.09	Gaelic	0.10	Gujarati	1.3
Italian	0.07	Italian	0.08	Creole	0.4
Other	3.13	French	0.07	Hindi	0.2
		Other	0.96	Other	4.2
		Unknown	8.09		
Total %	100.00	Total %	100.00	Total %	99.9
Total school population	54,516	Total school population	83,533	Total school population	178,120

the caseload data in the two Scottish cities refer to Hindi-Urdu, whereas the LEA data for S2 refer to Urdu and the LEA data for S1 no mention is made of either Urdu or Hindi-Urdu. It is also noteworthy that the LEA data in S1 fail to count Gaelic speakers in the school population, which explains why Gaelic is represented in the five most prevalent languages on

Table III. The languages spoken by the clients on speech and language therapy caseload in each of the three cities, together with the five most prevalent languages as a percentage of the total paediatric caseload.

	Languages spoken by clients on speech and language therapy caseload			
	S1	S2	E1	
	% of total caseload		% of total caseload	
Total caseload	100.00 (n = 1162)	100.00 (n = 3613)	100.00 (n = 8000)	
Total no. of monolingual clients	93.55 (n = 1087)	94.27 (n = 3406)	58.31 (n = 4665)	
Total no. of multilingual clients	6.45 (n = 75)	5.73 (n = 207)	41.69 (n = 3335)	
Languages other than English				
Punjabi	1.46 (n = 17)	Punjabi	Punjabi	25.00 (n = 2000)
Hindi-Urdu	1.20 (n = 14)	Hindi-Urdu	Bengali	7.50 (n = 600)
Bengali	0.52 (n = 6)	Farsi	Pashto <sup>8</sup>	6.25 (n = 500)
Arabic	0.43 (n = 5)	Swahili	Kokni <sup>9</sup>	0.5 (n = 40)
Gaelic	0.43 (n = 5)	Cantonese	Cantonese	0.5 (n = 40)
Cantonese	0.34 (n = 4)	Chinese/Hakka	Hindko <sup>10</sup>	0.38 (n = 30)
Chinese/Mandarin	0.26 (n = 3)	Serbo-Croat	Vietnamese	0.38 (n = 30)
French	0.26 (n = 3)	Pashto <sup>6</sup>	Arabic	0.25 (n = 20)
Italian	0.26 (n = 3)	Arabic	Gujarati	0.25 (n = 20)
Spanish	0.26 (n = 3)	Turkish	Somali	0.25 (n = 20)
Chinese/Hakka <sup>7</sup>	0.17 (n = 2)	Gaelic	Serbo-Croat	0.06 (n = 5)
Japanese	0.17 (n = 2)	Russian	Chinese/Mandarin	0.06 (n = 5)
Serbo-Croat	0.17 (n = 2)	Chinese/Mandarin	Dutch	0.06 (n = 5)
German	0.17 (n = 2)	German	Kutchie <sup>11</sup>	0.06 (n = 5)
Gujarati	0.09 (n = 1)	Portuguese	Chinese/Hakka <sup>7</sup>	0.04 (n = 3)
Pashto <sup>8</sup>	0.09 (n = 1)	Italian	Greek	0.03 (n = 2)
Czech	0.09 (n = 1)	Spanish	French	0.03 (n = 2)
Thai	0.09 (n = 1)	Danish	Czech	0.03 (n = 2)
			Yoruba	0.03 (n = 2)
			Tamil	0.03 (n = 2)
			Albanian	0.03 (n = 2)
Total no. of languages other than English	18	18	21	

the speech and language therapy caseload, yet does not appear in the school population data. Another difference is the number of languages represented in the category 'other'. In S1 it includes Spanish, Korean, French, Japanese and 'fifty three other languages not further specified', in S2 it includes German, Spanish, Bengali, and 'other languages not specified', and in E1 it includes Arabic, Pashto, Vietnamese and 'many more languages not named' (LEA statistics 2001–2002).

Such differences in classification of languages highlights the need for organisations to work together to come up with an agreement as to how data should be collected in order to ensure that data necessary for service planning are comparable and reliable. This finding is consistent with Winter (1999) who reported similar disparities in data reporting and emphasised the effect of the lack of consistent data reporting and terminology on service planning.

A finding which is not illustrated in the tables is that S2 and E1 service coordinators had noticed an increase in referrals from particular languages or language groups. In S2 an increase in referrals for asylum seekers' languages such as Swahili, Farsi, and Russian had been noticeable in the last 2 years, which—according to the respondent—was due to asylum seekers being referred to the service. This reflects the situation in the UK where there has been a large increase of people attempting to seek refuge in the UK over the last 5 years (<http://www.homeoffice.gov.ukz>, accessed 27.2.04). In E1 a noticeable increase in clients using Bangla (Bengali/Sylhetti)<sup>12</sup> was reported, which was possibly due to the fact that more link-workers had been employed who speak Bangla and this might have made Health Visitors more aware of possible communication problems. No increase in referrals from any particular languages was reported in S1. The reported increase in referral for users of Swahili and Farsi in S2, and Bangla in E1 is reflected in their presence in the top five multilingual caseload languages in the respective cities.

The sheer number of languages and the changes in language groups being referred to the service highlight the challenge service providers are faced with when working with clients from culturally and linguistically diverse backgrounds (Young and Westernoff, 1999). However, knowledge about the number of minority groups and languages in the area of remit may help managers to plan an equitable service and it may serve as a powerful tool to negotiate allocation of resources (Winter, 2001).

#### *Speech and language therapists working with multilingual children*

A finding that is not illustrated in the tables is the number of therapists who had multilingual children on their caseload. Of all respondents to the questionnaires in S1, 77% (14/18) had multilingual clients on their caseloads. Those therapists who had multilingual children on their caseload reported that they represented between 1 and 25% of their total caseloads, with a range of 1–26 multilingual clients. City S2 has a specialist bilingual team, which is responsible for providing speech and language therapy to multilingual children. This means that all staff (currently three speech and language therapists) have multilingual children on their caseloads. The number of speech and language therapists working with paediatric clients in E1 was 70, and it was reported that all therapists are expected to work with multilingual clients.

As anticipated from the literature (Winter, 1999), these results show that the majority of speech and language therapists have at least some multilingual children on their caseloads, although the number of multilingual children they see varies considerably. Winter (1999) found that the higher the proportion of the multilingual population, the more the tendency to spread out the multilingual caseload between more speech and language therapists,

specifically if the minority ethnic population is more than 7%. If it is smaller than 7%, a large variation in the number of speech and language therapists working with multilingual children was noticed. This was only partially confirmed by our results, in that the city with the largest minority ethnic population (E1) had spread out the caseload over all 70 therapists, whereas the second city with a minority ethnic population of more than 7% (S2) had a specialist bilingual service.

*Question 2: Is the speech and language therapy paediatric service equitable in terms of the quality of support services and training?*

#### *Support services*

We were specifically interested in whether, and if so which, support services are in place to aid speech and language therapists in their dealings with multilingual children. It appears from our survey that levels of support vary considerably between the three cities of investigation. As can be deduced from Table IV, the quality of the support services is not as good in S1 as it is in the other two cities. Most specifically, in S1 there was no specialist service coordinator for multilingual clients, no information about the service in languages other than English; no promotion of the service to linguistic minority groups; an absence of multilingual speech and language therapists, assistants and co-workers; a rather limited use of interpreting services; limited record-keeping of the languages used by clients and parents/carers; and an absence of a published policy for working with multilingual client.

Only three of the respondents from S1 reported that they were multilingual (French/English, French/German/English, and French/Spanish/English, respectively), but none of them used these languages other than English to assess or treat multilingual clients. The French/Spanish/English multilingual therapist, however, occasionally uses Spanish to interact with parents/carers. Furthermore, it was reported that there were no multilingual co-workers or speech and language therapy assistants in S1 (72% of respondents stated that there were no multilingual co-workers and 28% stated they were not aware of any). Nevertheless, as many as 28% (5/18) respondents reported that they did not use interpreting services, even though all but one had multilingual clients on their caseload and no speech and language therapy assistants or co-workers were available in their trust. However, Table III shows that there is a great linguistic diversity with a total of 18 languages other than English on the speech and language therapy paediatric caseload, showing that there is a clear mismatch between the languages spoken by the clients and those spoken by or available to the therapists. Such a mismatch influences the choice of language for intervention and assessment (Jordaan and Yelland, 2003), and as a consequence affects the quality of the service provided to multilingual children. It must be noted here, that the questionnaire did not ask whether therapists perhaps had obtained some knowledge of the structure of the relevant languages, for example by accessing published information about these languages or by special training. However, the level of knowledge required for assessment and treatment is high (Lahey, 1992) and it is unlikely that many therapists will have a level high enough to provide therapy in a language other than English without the help of interpreters or multilingual therapists/assistants.

A possible reason reported for not using interpreting services was that therapists had experienced difficulties with using them in the past. These difficulties were consistent with those outlined in Stow and Dodd (2003), including interpreters' lack of training (specifically in carrying out assessments), the time-consuming nature of using these services, and the expense.

Table IV. The availability of support services in each of the cities of investigation.

	Availability of support services		
	S1	S2	E1
Support services			
Specialist service coordinator	No	Yes	Yes
Info on SLT service in languages other than English	Not available	Available	Available
Languages	n.a.	Urdu + Cantonese	Hindi-Urdu, Punjabi, Bengali, Gujerati, Mirpuri
Format	n.a.	Written	Written + Audio
SLT service promoted to linguistic Minority groups	No	Once	Yes, on local radio, community meetings, link workers
Multilingual Therapists	3, but none use languages for therapy/assessment	3	3
SIG membership	no	100% ( $n = 3$ )	10% ( $n = 7$ )
EAL liaison	<i>Ad hoc</i> basis	<i>Ad hoc</i> basis	x
Multilingual SLT assistants/co-workers	Not available	7	10
Languages other than English used by SLT assistants/co-workers	None	Cantonese, Chinese/Hakka, Chinese/Mandarin, Hindi-Urdu, Punjabi, Pashto, Swahili	Hindi-Urdu, Punjabi, Bengali/Sylheti, Gujerati, Pashto
Interpreting service	Available for some languages	Available for most languages	Available for all languages
Record of languages	Casenotes	Casenotes + statistical	Casenotes + statistical
Policy	Not available	Available	Available
RCSLT guidelines	Not met	Partially met	Both guidelines are met

A further question relating to the support available, asked about the therapists' contact with the English as an Additional Language (EAL) service. All respondents from S1 stated that they had liaised with the EAL service, but that this service was not formal or regular, but rather on an *ad hoc* basis. Half of the respondents, however, reported that they had discussed and/or promoted their role as speech and language therapists to the EAL service.

Results further indicate limited awareness by the respondents in S1 of the availability of resources and policies in their trust. For example, only half of the S1 respondents was aware of the fact that no information about the speech and language therapy service is available in languages other than English, a further 39% (7/18) answered that they did not know whether this information was available, and 11% (2/18) believed it was available. However, none of the latter therapists stated in which languages this information was available or in which format (i.e. audio or written). Similarly, only 39% (7/18) of therapists in S1 knew that their service was not specifically promoted to linguistic minority groups, the rest did not know if it was actively promoted. Interestingly, the majority of respondents, 78% (14/18), thought that there was a need to promote the service to linguistic minority groups—even though it appears that multilingual children are proportionally represented on their caseloads (Figure 1). Three therapists, however, answered that there was no need for such a promotion. The question of whether the trust has a published operational policy yielded rather varied responses in S1. Most respondents from S1 (67%) did not know whether such a policy existed, some respondents (22%) reported that there was no such policy, and two respondents (11%) stated that there was a published operational policy for working with multilingual clients. However, when we accessed policy files from the S1 trust we were unable to find such a policy.

Winter (1999) raised a concern about the apparent lack of information about the ethnicity and linguistic background of clients on speech and language therapy caseloads. The results of our study show less reason for concern as the majority of respondents from S1 (88%) reported that the languages spoken by the clients as well as the parents/carers were reported, but only in case notes. However, there is still some reason for concern as it is not available as an easily retrievable statistic.

S2 appears to be doing much better in terms of its support services. It has a designated service coordinator and a published operational policy for working with multilingual clients. The service is able to provide speech and language therapy in a total of nine different languages, through the use of its three multilingual speech and language therapists (covering five languages), its seven speech and language therapy assistants (providing support in seven languages), and its co-workers (who provide support in seven languages). Information about the service is available in written format in two languages (Urdu and Cantonese), and the service is promoted to linguistic minority groups (although not systematically) and to the EAL service (with which they liaise on an *ad hoc* basis). The service also stores information about the languages spoken by clients in statistical records and case notes. Where speech and language therapists, assistants or co-workers are not able to provide therapy or assessment in certain languages, interpreting services are used. However, interpreting services are not available for all languages (most notably Lingala), and they are mostly used only for assessment.

In terms of its support system, E1 appears to be providing an excellent service. Just as in S2, E1 has a designated service coordinator and a published operational policy. Information is available in five languages other than English, and in both audio as well as written format. The service is actively and systematically promoted to linguistic minority groups (through local radio, community meetings, and link workers), but not to the EAL service as E1 does not have such a service according to our respondent. Although, E1 has more multilingual



speech and language therapy assistants than S2 (ten as opposed to seven) and an equal number of multilingual therapists (three), the total number of languages they cover is smaller (five as opposed to nine). However, in E1 all languages can be provided for through the use of interpreting services including all asylum seeker languages if required. Finally, information about the languages spoken by clients as well as their parents/carers is stored in statistical records and case notes.

*Training*

Winter (1999) expressed concerns about the level of training on multilingual issues of speech and language therapists with multilingual children on their caseloads. Our results show that the majority of respondents (56%) in S1 reported not receiving any training on multilingual issues in their undergraduate course. From further analysis of the responses, it became clear that the undergraduate training received correlates with the number of years since qualification, with more training being provided more recently. As illustrated in Figure 4, it appeared that none of the therapists who had graduated between 21 and 35 years ago had received any pre-qualifying training on multilingual issues. However, of those who graduated between 11 and 20 years ago, half had received some training, and this number increased to 63% for those therapists who graduated between 1 and 10 years ago. This therefore suggests that the greatest need for training in multilingual issues would be for those therapists who qualified more than 10 years ago.

Therapists who join the S1 trust are not required to attend in-house training on multilingual issues. Nevertheless, they are all expected to provide services to multilingual clients if they happen to be on their caseload. Therapists responsible for a large proportion of multilingual clients (60% of the total multilingual paediatric caseload) had received some form of postgraduate training on multilingual issues. However, therapists who had received no training on multilingual matters were responsible for 24% of the multilingual caseload.

None of the respondents from S1 are members of the Special Interest Group (SIG)—Bilingualism, not even those with relatively large numbers of multilinguals on their caseload. Some therapists (22%) knew of a designated therapist who could be contacted with queries regarding multilingual clients. That designated therapist was not employed by their own

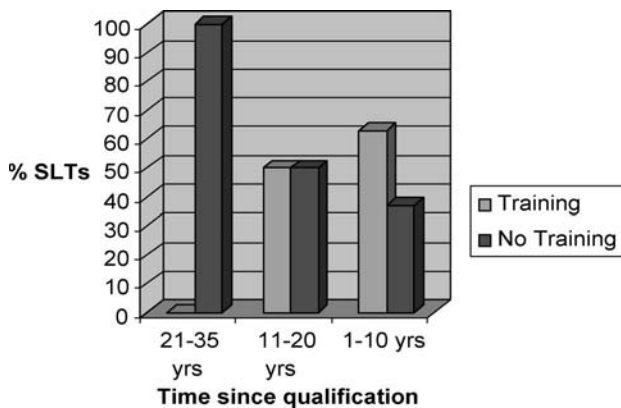


Figure 4. The relation between the number of years since qualification and the training received in multilingual and multicultural matters by speech and language therapists in S1.

trust, but by the S2 trust. However, the majority of S1 therapists (78%) did not know of a designated therapist, either in their own or in any other trust.

In S2, all therapists that join the bilingual specialist service are expected to undertake formal in-house training courses on multilingual matters and cultural and linguistic diversity. Training is also available to other therapists working in the same trust, speech and language therapists from other trusts, co-workers, speech and language therapy assistants, English as an Additional Language (EAL) staff, teachers, medical staff, other Professions Allied to Medicine (PAM) staff and Educational psychologists. However, as our sample did not include speech and language therapists who are not a member of the bilingual specialist service, we are unaware of the total number of therapists in S2 who attended training on multilingual issues.

In S2, all members of the Bilingual Team are also members of the SIG—Bilingualism. They reported that they use the SIG to gather information about certain languages and cultures, to access appropriate assessment material, to find out about further training, and to exchange ideas and information about working with multilingual clients.

It was reported that all speech and language therapists who join the E1 speech and language therapy service are required to attend an in-house course where they receive specific training on multilingual issues. Specific training is also provided to speech and language therapists from other trusts, co-workers and speech and language therapy assistants. In E1, 10% (7/70) of speech and language therapists working with children are members of the SIG—Bilingualism, and they use that group for similar reasons as the therapists in S2.

Despite the fact that more than three quarters of the speech and language therapists in S1 had at least one multilingual client on their caseload, it appears that some of them may not be 'equipped with the knowledge and skills that are required of them in order to give all clients adequate service' (Winter, 1999: 92). It is possible that this is due to different or more pressing priorities within this service. Nevertheless, it is a concern that even though the need for training (at undergraduate and post-graduate level) is being recognised (RCSLT, 1996; Cheng, Battle, Murdoch and Martin, 2001; Stow and Dodd, 2003), the S1 trust does not yet appear to have taken steps to ensure that their therapists have the appropriate knowledge to work with multilingual individuals. There was no need for concern in S2 and E1, where speech and language therapists are well educated on multilingual matters as they are required to attend an in-house course when they join the service.

*Question 3: Do speech and language therapists/service coordinators think that they are able to meet the RCSLT guidelines?*

The RCSLT (1996) advises that (i) speech and language assessment should be carried out in all languages spoken by a multilingual client and (ii) therapy should be offered in the client's or parents' chosen language. The question of whether their service was able to meet the RCSLT guidelines, was answered by less than half (39%, 7/18) of respondents in S1. Of those, all but one, agreed that neither of the guidelines are currently being met. The only respondent who felt that both guidelines were being met had relatively high numbers of multilingual clients on his/her caseload.

The service co-ordinator in S2 reported that the RCSLT guidelines are only partially met by the service, in that the service could ensure that assessment was carried out for all languages, but could not always provide therapy in the clients' language of choice. It was mentioned that increasing pressure on the service due to a rapid increase in asylum seekers and refugees from various countries has greatly changed the language profile of the community (with more Eastern European, Middle Eastern, and African languages).

The E1 service coordinator reported that their service is currently able to meet all RCSLT guidelines, by using speech and language therapists and assistants as well as interpreters. It appears that the higher the multilingual population the more successfully these guidelines are implemented. This may be an artefact of management policy where different needs have led to different prioritisation and allocation of funds. With smaller numbers of multilingual clients on speech and language therapy caseloads and a lack of support services available to help them, therapists may feel that 'this field is somehow beyond the scope of the average therapist' (Mumby, 1987: 8). However, a smaller minority ethnic population and smaller numbers of multilingual clients does not justify the scarcity of a satisfactory service (Duncan, 1989).

## **Conclusion**

There is an increasing recognition by speech and language therapists and their Professional Bodies that speech and language therapy services need to meet the needs of the increasingly diverse population in the UK. This study investigated whether, at the time of research, an equitable speech and language therapy service was being provided to multilingual children in the three cities of investigation. Three main research questions were formulated, and it was argued that a service would be considered to be equitable if our results indicated a positive answer to each research question. Despite the limitations of this study, mainly to do with the sample size, we were able to show various levels of inequity. S1 only appears to provide an equitable service in terms of the first research question, i.e. the proportion of multilingual children on the speech and language therapy caseload which was equal to that of monolingual children. However, the S1 service was not equitable in terms of the quality of the support services and training, nor in its ability to meet RCSLT guidelines. Conversely, the S2 service was inequitable with regards to the proportion of multilingual children on speech and language therapy caseloads suggesting that some multilingual children may be falling through the net. However, in terms of the other two questions it was doing rather well. It appeared the quality of support services and training in S2 is good and the RCSLT guidelines are partially met in that the service is able to provide assessment in all languages, but is sometimes unable to provide therapy in the language of choice. E1 appears to be equitable in all three aspects, with an equal proportion of monolingual and multilingual children on speech and language therapy caseloads, excellent support services/training and the ability to meet all RCSLT guidelines.

From this data it appears that the quality of the service provision may be linked to the size of the minority population: i.e. the larger the minority ethnic population the more equitable the speech and language therapy service. Although this study only addressed speech and language therapy provision in three cities in the UK, it appears likely that multilingual children in smaller cities or rural areas throughout the UK may not have access to a fully culturally and linguistically appropriate service, despite efforts from speech and language therapists to provide such a service. Even though the profession holds the view that it is 'the right of every individual to have access to an appropriate speech and language therapy service for his/her identified needs' (RCSLT, 1996: 150), it still has some way to go towards providing an equitable service to multilingual children, specifically in those areas where the multilingual population is less visible.

It is hoped that this study will form a first step in providing speech and language therapists and their managers with useful information to help them plan or re-evaluate services. Specifically, it is hoped that this study will encourage therapists and managers to collect and record data on the languages spoken by multilingual clients on their caseloads, and that

further surveys will promote equality for multilingual individuals in future speech and language therapy services. We would specifically encourage surveys on speech and language therapy provision to multilingual adults, as no such data are currently available and we suspect that they may not be accessing services.

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### **Notes**

- 1 This excludes data from Northern Ireland as ethnic group data were not collected in the Northern Ireland 1991 Census.
- 2 The need to provide culturally and linguistically appropriate services and the challenges involved in providing such services, equally applies to clients who speak two languages, as to those who speak three or more languages or language varieties. It is for this reason, that in this paper we do not distinguish between bilingualism and multilingualism, nor between biculturalism and multiculturalism (Müller, 2003). The term multilingual is therefore used here to refer to individuals who use two or more languages in any of its modalities, speaking, understanding, writing, and reading, regardless of their relative proficiency.
- 3 There are, of course, other ways in which inequity could be measured which are beyond the scope of this study, such as the duration of therapy, the severity of the disorder, or the age of therapy (cf. Winter, 2001).
- 4 The 72% refers to the return rate of the questionnaires sent out to 25 out of a total of 73 speech and language therapists in S1. This amounts to 25% of the *total* number of speech and language therapists working with children in S1. The 100% refers to the two service coordinators in S2 and E1, who are responsible for a total of 3 and 70 speech and language therapists working with children, respectively.
- 5 Note that in the publicly available Census data for ethnicity by age the different Mixed categories (such as White and Black Caribbean, White and Black African, White and Asian, and Any Other Mixed) were collapsed into just one category 'Any Mixed'.
- 6 Panjabi (also spelled Punjabi) is the language spoken in the Punjab, a region covering parts of north-eastern India and western Pakistan. Although the names Panjabi and Punjabi are often used indiscriminately, sometimes Panjabi is used to refer to the Indian version which is written in the Gurmukhi alphabet (closely associated with the Sikh religion), whereas Punjabi is used to refer to the Pakistani version which has a Perso-Arabic script (just like Urdu, which is the official language of Pakistan).
- 7 Chinese/Hakka is spoken in many parts of mainland China and has the greatest concentration of speakers in eastern and northeastern Guangdong. Other regions in which it is spoken are specifically in Fujian, Jiangxi, Guangxi, Hunan, and Sichuan. Outside China it is spoken in Brunei, French Guiana, French Polynesia, Indonesia (Java and Bali), Malaysia (Peninsular), Mauritius, New Zealand, Panama, Singapore, South Africa, Suriname, Taiwan, Thailand, United Kingdom, and USA (Ethnologue, <http://www.ethnologue.comz>; accessed 14.1.05).
- 8 Pashto (sometimes called Mahsudi, Pakhto, or Pushto) is a language mostly spoken in Pakistan, but also in Iran and the United Arab Emirates (Ethnologue, <http://www.ethnologue.comz>; accessed 14.1.05).
- 9 Kokni, also called Kanara, Kokna, or Kukna is an Indian language mostly spoken in the Gujarat (Ethnologue, <http://www.ethnologue.comz>; accessed 14.1.05).
- 10 Hindko is a Pakistani language spoken amongst others in the Punjab region (Ethnologue, <http://www.ethnologue.comz>; accessed 14.1.05).
- 11 Kutchie also referred to as Kachchi, Kachchhi, Kutchchi, Cuchi, Cutch, Kachi, Katch, Kautchy, Katchi, is a language spoken mostly in India, but also in Kenya, Malawi, Pakistan, and Tanzania (Ethnologue, <http://www.ethnologue.comz>; accessed 14.1.05).
- 12 Bengali (sometimes called Bangla) is the national language of Bangladesh. Sylhetti is another language mostly spoken in the Sylhet region of Bangladesh (Ethnologue, <http://www.ethnologue.comz> accessed; 14.1.05).

## References

- Baker, C. (2000). *The care and education of young bilinguals*. Clevedon: Multilingual Matters.
- Broomfield, J., & Dodd, B. (2004a). The nature of referred subtypes of primary speech disability. *Child Language Teaching and Therapy*, 20 (2), 135–151.
- Broomfield, J., & Dodd, B. (2004b). Children with speech and language disability: caseload characteristics. *International Journal of Language and Communication Disorders*, 39 (3), 303–324.
- Cheng, L., Battle, D., Murdoch, B., & Martin, D. (2001). Educating speech-language pathologists for a multi-cultural world. *Folia Phoniatrica et Logopaedica*, 53, 121–127.
- Coleman, D., & Salt, J. (1996). The ethnic group question in the 1991 Census: a new landmark in British social statistics. In D. Coleman & J. Salt (Eds), *Ethnicity in the 1991 Census Volume One: Demographic characteristics of ethnic minority populations*. London: HMSO, pp. 1–32.
- Crutchley, A. (1999). Bilingual children with SLT attending language units: getting the bigger picture. *Child Language Teaching and Therapy*, 15, 201–217.
- Crutchley, A., Conti-Ramsden, G., & Botting, N. (1997). Bilingual children with specific language impairment and standardized assessments: preliminary findings from a study of children in language units. *International Journal of Bilingualism*, 1, 117–134.
- Department for Education and Skills (2003). *Green Paper: Every child matters*. London: HMSO.
- Duncan, D. M. (Ed.) (1989). *Working with bilingual language disability*. London: Chapman & Hall.
- Duncan, D. M., & Gibbs, D. A. (1989). Mainstream bilingual schoolchildren: a model for remediation. In D. M. Duncan (Ed.), *Working with bilingual language disability*. London: Chapman & Hall, pp. 176–197.
- Lahey, M. (1992). Linguistic and cultural diversity: further problems for determining who shall be called language disordered. *Journal of Speech and Hearing Research*, 35, 638–639.
- Law, J., Harris, F., & Roy, P. (2003). Progress in monitoring population language change in Sure Start UK. *Presentation at the 5th European Congress, CPLOL. Evidence based practice: a challenge for speech and language therapists*.
- Locke, A., Ginsborg, J., & Peers, I. (2002). Development and disadvantage: implications for early years and beyond. *International Journal of Language and Communication Disorders*, 37, 3–15.
- International Society for Equity in Health (2001). Working definitions.
- Jordaan, H., & Yelland, A. (2003). Intervention with multilingual language impaired children. *Journal of Multilingual Communication Disorders*, 1 (1), 13–33.
- Macinko, J. A., & Starfield, B. (2002). Annotated bibliography on equity in health, 1980–2001. *International Journal for Equity in Health*, 1 (1), 1–20.
- Mennen, I., Johnston, S., & Stansfield, J. (2003). Are we meeting the challenge? An evaluation of speech and language therapy services for bilingual children in three centres of population. *Evidence based practice: A challenge for speech and language therapists. Proceedings of the 5th European Congress, CPLOL. CD Rom*. London: Royal College of Speech and Language Therapists.
- Mennen, I., Stansfield, J., & Johnston, S. (2005) Speech and language therapy services for bilingual children in England and Scotland: A tale of three cities. *Proceedings of the 4th International Symposium on Bilingualism*, Somerville MA: Cascadilla Press, pp. 1578–1596.
- Müller, N. (2003). Multilingual communication disorders: Exempla et desiderata. *Journal of Multilingual Communication Disorders*, 1, 1–12.
- Mumby, K. (1987). Clients need treatment in their mother tongue. *Speech Therapy in Practice*, 3(3), 8–9.
- Pert, S., & Letts, C. (2003). Developing an expressive language assessment for children in Rochdale with a Pakistani heritage background. *Child Language Teaching and Therapy*, 19, 267–289.
- Raval, A., Hooke, E., Martin, D., Quinn, T., & Anderson, S. (1999). *Teaching about bilingualism and linguistic minority clients in speech and language therapy courses*. London: Royal College of Speech and Language Therapists' National Specific Interest Group Bilingualism.
- Romaine, S. (1995). *Bilingualism*. 2nd edition. Oxford: Blackwell.
- Royal College of Speech and Language Therapists (1996). *Communicating Quality 2: Professional standards for speech and language therapists*. London: Royal College of Speech and Language Therapists.
- Royal College of Speech and Language Therapists (1998). *Good practice for speech and language therapists working with clients from linguistic minority communities: Guidelines prepared by the RCSLT Specific Interest Group in Bilingualism*. London: Royal College of Speech and Language Therapists' National Specific Interest Group Bilingualism.
- Royal College of Speech and Language Therapists (1999). Ethnic monitoring of College members. *RCSLT Bulletin*, 570, 5.
- Royal College of Speech and Language Therapists (2001). University targets diversity. *RCSLT Bulletin*, 595, 3.

- Scott, A., Pearce, D., & Goldblatt, P. (2001). *Population trends: the sizes and characteristics of the minority ethnic populations of Great Britain—latest estimates*. Office for National Statistics.
- Scottish Executive (February 2004). *Analysis of Ethnicity in the 2001 Census: Summary report*.
- Stow, C., & Dodd, B. (2003). Providing an equitable service to bilingual children in the UK: a review. *International Journal of Language and Communication Disorders*, 38, 351–377.
- Winter, K. (1999). Speech and language therapy provision for bilingual children: aspects of the current service. *International Journal of Language and Communication Disorders*, 34, 85–98.
- Winter, K. (2001). Numbers of bilingual children in speech and language therapy: theory and practise of measuring their representation. *International Journal of Bilingualism*, 5, 465–495.
- Young, T., & Westernoff, F. (1999). Reflections of speech and language pathologists and audiologists on practices in a multicultural, multilingual society. *Journal of Speech-Language Pathology and Audiology*, 23, 24–30.

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