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This 'IALP News' comprises: (1) a list of the IALP Board 2004–2007 members; (2) 'Recommendations for Working with Bilingual Children' prepared by the Multilingual Affairs Committee of the IALP, and (3) Announcement of Conferences.

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Recommendations for Working with Bilingual Children – Prepared by the Multilingual Affairs Committee of IALP

Introduction

In the world today, bilingualism and multilingualism are frequent phenomena and this has prompted the Multilingual Affairs Committee of IALP to prepare suggestions for working with children with speech and language delay or disorders in culturally and linguistically diverse communities. These children may be bilingual, multilingual, or monolingual speakers of a minority language. We hope this information will help you to formulate guidelines in accordance with the specific needs of your own community.

Bilingual children, like all bilingual speakers, are a very heterogeneous group. There are many terms to describe the numerous ways children learn two languages and the degree they master them. Two broad categories have been proposed to describe bilingual acquisition: simultaneous and successive/sequential bilingualism. While simultaneous acquisition refers to the regular exposure to two languages since birth, successive acquisition describes exposure to a second language after there has been considerable development in a first language. Regardless of the acquisition pattern, it is important to keep in mind that comparisons of language proficiency among bilingual children warrant the individual attention of each bilingual child's experiences in each language over time, including languages used at home and school, and in the community.

For practical purposes, rather than describing each situation of bilingual acquisition, we use the term bilingualism as referring to the knowledge and/or use of two or more language codes (bilingualism or multilingualism). An individual will be regarded as bilingual regardless of the relative proficiency of the languages understood or used. A minority language is a language, which in contrast to the language used by a larger majority and media, is spoken by a smaller community or group. Some practical recommendations are given throughout these guidelines to tap into individual language experiences that result in proficiency differences in the bilingual child's two languages. These recommendations apply to children exposed to two languages (bilingual environment) or three or more languages (multilingual environment).

The sections below deal with language delay/disorders, phonology and literacy. A bibliography is provided with summaries of some of the relevant research that has been published.

Section 1: Language Delay/Disorders

There are individual differences in all language development and this will apply to children from bilingual, multilingual, and language-minority backgrounds. Therefore, clinical decisions made on the assessment and intervention with any child should take into account these individual differences, i.e. family background, the family's attitudes toward maintaining the home language(s), and also practical considerations regarding the availability of human and material resources to carry out intervention plans.

Bilingual children differ from one another in two very important aspects and these should be considered when treating a child: (1) They may be members of a minority group where the language is less widely spoken, has lower social status, may be associated with less or no socioeconomic power, and may receive less institutional support (e.g., Cantonese in Canada and USA, Spanish in the USA, Turkish in Germany). They may belong to a majority group where the language is widely used, has high social status, is associated with sociolinguistic power, has institutional support from governments (e.g., English in America and Canada; German in Germany). (2) The second factor to consider is whether they have learned two languages simultaneously from infancy (they have been given opportunities to learn two languages from birth, although not necessarily equal opportunities), or have learned a second language after a first has been established. There is no definitive cutoff age demarcating bilingual from second language acquisition but many researchers accept age 3 because a first language is well established at that point. These differences are discussed in the book by Genesee et al. [2004].

It is apparent that the assessment of many aspects of children's speech and language requires specific background and skills. To provide assessment and remediation services in the minority language, it would be ideal if the speech-language therapist could have native or near-native fluency in both L1 and L2. But it is recognized that in many countries this is not possible. Ideally, interpreters trained to work with speech-language therapists are recommended. These interpreters have to receive extensive training on the purposes, procedures and goals of the tests and therapy methods. They should also be taught to avoid the use of gestures, vocal intonation, and other cues that could aid the child during test administration. It would be helpful to use the same interpreter with any given minority language group. The therapist should acknowledge the use of an interpreter in a written evaluation.

Case History

A full language background history should be taken for each language: (a) when each language was first heard at home; (b) what language is used at school; (c) it is important to estimate the amount of input from each parent in each language; (d) the level of language proficiency for each parent should also be established; (e) attitudes to the use of each language in the home and for instructional purposes should be ascertained, and (f) language used with siblings should be noted.

Assessment

Therapists may choose formal or informal assessment materials. However, systematic standardized formal testing is not available in all languages. Practitioners knowledgeable in both the culture and languages of the bilingual/multilingual child can create their own informal testing procedures. These methods lend themselves to the assessment of bilingual individuals more readily than formal methods, as stimulus materials may be freely adapted to the child's language and culture. It is important to stress that test translations should not be used when not adapted to the language and culture of the child. Descriptive assessment materials devised for one population may need careful adaptation or revision to avoid cultural bias when used with another population. Ideally both languages should be tested.

The following best practices for culturally and linguistically diverse populations should be taken into account for all age groups:

- Normative data from formal tests normed on monolingual speakers cannot be applied to bilingual speakers. Currently there are limited tests available for the bilingual pediatric population. If attempting to translate a test into another language, the test should be carefully adapted to that language and culture, preserving idiomatic use of syntactical complexity, and so forth. Interpretation of results should be made with caution and normative data should not be referred to.
- Self-devised tests that are culturally sensitive should be considered for qualitative interpretation and the establishment of a baseline for future reference. Assessment at the level of discourse (narrative, procedural etc.) may be a useful culturally sensitive assessment tool for all age groups. For children who are not yet at this stage of development, a developmental scale of functional communication should be administered for both languages.
- Mode: Consideration should be given to the question whether the assessment should be in monolingual mode (where only one language is spoken) or bilingual mode. Code switching (which has been defined by Romaine [1995] and others as the combined use of two languages, i.e., words, phrases, sentences, etc., within the same utterance) does not necessarily indicate that the child is confusing the two languages. It may in fact be a strategy for effective communication. In such cases it is recommended that an assessment be conducted to determine whether the child can in fact produce the word or syntactic structure correctly in the other language.
- Clinical experience has shown that obtaining a communicative score for a preschool child can be useful. This means taking into account the vocabulary used in L1 while testing in L2 (or vice versa). When a child is being tested in one language and gives answers in the second language these should be taken into account as well. This may indicate the child's ability to communicate when conversing with people who know both languages.

- If possible, the performance of a child on an assessment procedure should ideally be compared to that of an age-matched normally developing bilingual. This matched child should be from a similar background with respect to combination of languages spoken, as well as the amount and type of exposure to each language (for example, a child from the same class or same family).

Therapy

In general, one finds greater carryover of results from one language to the other if the targeted structure is language-universal. For instance, if word order is important for both languages, and word order retains a similar structure for both languages, then targeting a structure in L1 may generalize to L2. On the other hand, there may not be generalization across languages when their structures are very different and the child may need therapy in each of the languages.

- It is now thought that children with language impairment should ideally receive bilingual language therapy instruction in order to maintain and promote their L1 skills while also helping them to learn L2 [Roseberry-McKibbins, 2002, p. 205]. The author believes that children will learn faster and more thoroughly and experience less language loss if they learn in these ideal bilingual situations. Unfortunately, it is not always possible or practical to provide bilingual therapy and so it is recommended that parents receive guidance on how to help develop L1 at home.
- The language of the home should never be changed to adapt to the language of therapy or education, as this will lead to loss of language that has already been acquired.
- The decision as to which language to treat should be done in consultation with the parents. The parents' attitude towards maintaining the home language is very important and must be considered. However, it should be pointed out to them that working in the stronger language initially may be to the child's benefit, even if it is not the language of education.
- The language skills acquired in the treated language may transfer later when the language is targeted in therapy. Working in the stronger language may necessitate making use of interpreter services.
- In the case of children with deficits in the semantic and pragmatic areas of language, it is possible to work in both languages simultaneously as these aspects of language are generalizable across languages and rely on the same cognitive skills regardless of language.
- Parent involvement is critical in working with bilingual children and they should constantly be informed of the principle guiding the choice of language for intervention. The amount and quality of input that children receive in each language will determine how proficient they may become in each language.
- Parents should be well informed about facilitation techniques for language acquisition and should use opportunities for language stimulation if the child is to become bilingual (e.g., telling stories, watching videos, singing songs in the second language).

Section 2: Bilingualism and Phonological Development and Disorders

Typical Development

(1) *Simultaneous and successive bilinguals may differ.* For example, de Houwer's [1995] case study of simultaneous acquisition of Dutch and English showed development that did not differ from monolingual peers in either language. In contrast, studies of successively bilingual Cantonese-English indicate developmental speech error patterns that differ from those exhibited by monolinguals [e.g., Dodd et al., 1996].

(2) *The pattern of research findings is likely to differ according to the language pair acquired.* Most research on bilingual children's acquisition of language has focused on children acquiring two languages from the same language family, e.g., English and French, where the predominant language structures are similar [Zhu and Dodd, in press]. Little is known about bilingual language acquisition involving different 'language pairs'. For example, Navarro et al. [1995] analyzed the phonology of 11 successive bilingual Spanish-English preschool children, concluding

that their acquisition differed from that of monolinguals but that bilingual children were *less* likely to use uncommon error processes. Meanwhile, Holm and Dodd [1999a] and Dodd et al. [1996] report some developmental patterns of bilingual Cantonese-English that were atypical of monolinguals; the latter two languages have very different phonologies.

Disorder

(1) *Evidence of phonological disorder in all languages spoken.* Evidence from case studies of Cantonese/English-speaking bilingual children [Holm and Dodd, 1999b] and 2 Welsh/English-speaking bilingual children [Ball et al., in press] suggests that a single deficit underlies disorder in the two phonological systems of bilingual children.

(2) *Therapy on the phonological system of one language will not affect the other language.* However, intervention that focuses on motor production of speech sounds (articulation therapy) in one language will generalize to the other language [Holm et al., 1997].

Section 3: Assessment of Literacy

Family-based reading risk factors are critical in later literacy acquisition problems in young children. The identification of the risk levels is therefore crucial, in addition to a communication case history of the child (specific language-impaired preschoolers are at high risk for developing reading disabilities in any language).

A. Determine Reading Difficulty Risks via a Questionnaire

The more variables are present the higher the risk [Scheffner-Hammer et al., 2003]: (a) child and family history of learning/reading disabilities; (b) home languages (including nonstandard dialect) that are different from the school language(s); (c) low socioeconomic status and one-parent family; (d) minimal opportunities for verbal instruction; (e) minimal support for literacy development.

B. Obtain a Profile of the Child's Home Literacy Environment

In preschoolers, home language input and literacy support levels were found to be critical in predicting later school success in both monolinguals and bilinguals [Snow et al., 1998]. Develop your own scales to obtain a numeric value for each variable below. Even-numbered scales clearly separate positive or negative values (e.g., 0–3 or 1–4, etc.):

The value placed on literacy: how much the parent reads and writes (for any purpose) and encourages their children to read; the less the parent uses literacy the lower the child's achievement.

The press for achievement: how much direct reading instruction parents provide, e.g., school-related concepts and script, whether they respond to the child's reading interest, belong to a local library or a cultural center that includes home language library, and express their expectations for achievement.

The availability and use of reading materials: how many adult and children's books, newspapers, and magazines (in home languages and/or school language) are there at home.

Parent-child reading frequency: how often and for how long.

C. Observe and Describe the Mother-Child Reading Interaction

- Have the parent bring a few of their child's favourite books to the meeting, in their preferred language, and observe the style of reading and interaction. Is it dialogic, i.e., does the child participate as in two people having a conversation about the book or is he expected to listen only? Does he ask questions about the story? And what is the child's attention span in this activity?
- Does he know the print directionality? Can the child recognize any words? If the language is alphabetic, does the child know the names of letters? Can the child recognize named letters? Can he reproduce dictated letters [Dodd and Carr, 2003]?

D. Obtain a Reading Profile

In preschool children, assess phonological awareness in the family language, via the parent as presenter of the stimuli. In school-age children, determine whether literacy is being taught in the home language. If it is, then interview the child's teacher to obtain information on the child's reading status and mode of learning. Develop an appropriate questionnaire for this purpose: include questions on reading decoding, comprehension, spelling, and writing, and on whether the skills are worse, the same, or better than those of same-language peers.

Determine the language(s) the child will be schooled in and whether it is already one of the child's languages. If it is, then assess reading in the school language:

- Give an oral language test: especially important is the language comprehension portion. A comparison of this result with the reading test results will help you determine the presence of dyslexia versus a generalized reading disability.
- Examine phonological awareness using Dynamic Assessment strategies such as Graduated Prompting [Laing and Khami, 2003] to examine rhyming, first and final sound recognition, syllable and sound counting, segmentation, and blending.
- Give a spelling task based on the word features of the school language: invented spelling is highly correlated with phonemic awareness [Viise, 1994; Lombardino et al., 1997].
- Use an early reading test to determine the child's reading development level in the school language.

Note. When no test exists, collaborate on constructing a test based on the Test of Early Reading Ability [Reid et al., 1991]. Criterion-referenced measures work better with culturally and linguistically diverse children than norm-referenced standards [Battle, 2002]. The former compares a child's performance on specific skills to predetermined criteria, usually based on developmental information. In addition, think of constructing an Informal Reading Inventory [Burns and Roe, 2002]. Obtain the reading standards for all grades from your local school boards or schools. The focus here is profiling the child's reading skills and needs. Share your instruments with other clinicians to obtain performance data.

References

- Ball M, Müller N, Munro S: Phonological development and disorder of bilingual children acquiring Welsh and English; in Zhu H, Dodd B: *Phonological Development and Disorders: A Multilingual Perspective*. Clevedon, Multilingual Matters, in press.
- Battle D: Language development and disorders in culturally and linguistically diverse children; in Bernstein D, Tiegerman-Farber E (eds): *Language and Communication in Children*. Boston, Allyn & Bacon, 2002, pp 354–386.
- Burns PC, Roe BD: *Informal Reading Inventory: Preprimer to Twelfth Grade*. Boston, Houghton Mifflin, 2002.
- de Houwer A: Bilingual language acquisition; in Fletcher P, MacWhinney B (eds): *The Handbook of Child Language*. Oxford, Blackwell, 1995, pp 219–250.
- Dodd B, Carr A: Young children's letter-sound knowledge. *Lang Speech Hear Serv Sch* 2003;34:128–137.
- Dodd B, So L, Li W: Symptoms of disorder without impairment: the written and spoken errors of bilinguals; in Dodd B, Campbell R, Worrall L (eds): *Evaluating Theories of Language*. London, Whurr, 1996.
- Genesee F, Paradis J, Crago MB: *Dual Language Development and Disorders: A Handbook on Bilingualism and Second Language Learning*. Baltimore, Brookes, 2004.
- Holm A, Dodd B: A longitudinal study of the phonological development of two Cantonese-English bilingual children. *Appl Psycholinguist* 1999a;20:349–376.
- Holm A, Dodd B: An intervention case study of a bilingual child with phonological disorder. *Child Lang Teach Ther* 1999b;15:139–158.
- Holm A, Dodd B, Ozanne A: Efficacy of intervention for a bilingual child making articulation and phonological errors. *Int J Bilingualism* 1997;1:55–69.
- Laing S, Khami A: Alternative assessment of language and literacy in culturally and linguistically diverse populations. *Lang Speech Hear Serv Sch* 2003;34:44–55.
- Lombardino LJ, Bedford T, Fortier J, Carter J, Brandi J: Invented spelling: developmental patterns in kindergarten children and guidelines for early literacy intervention. *Lang Speech Hear Sch* 1997;28:333–343.

- Navarro A, Pearson B, Cobo-Lewis A, Oller D: Early phonological development in young bilinguals: comparison to monolinguals. *Am Speech Lang Hear Assoc Conf*, 1995.
- Reid DK, Hresko W, Hammill D: *Test of Early Reading Ability*. Austin, Pro-Ed, 1991.
- Romaine S: *Bilingualism*, ed 2. Oxford, Blackwell, 1995.
- Roseberry-McKibbin C: Principles and strategies in intervention; in Brice AE (ed): *The Hispanic Child: Speech, Language, Culture and Education*. Boston, Allyn & Bacon, 2002.
- Scheffner-Hammer CS, Miccio AW, Wagstaff DA: Home literacy experiences and their relationship to bilingual preschoolers' developing English literacy abilities: an initial investigation. *Lang Speech Hear Schools* 2003;34:20–30.
- Snow C, Burns MS, Griffin P: *Preventing Reading Difficulties in Young Children*. Washington, National Academy Press, 1998.
- Viise N: *Word Feature Spelling: Diagnosis of Processing Word Knowledge*. Charlottesville, University of Virginia Press, 1994.
- Zhu H, Dodd B (eds): *Phonological Development and Disorders: A Multilingual Perspective*. Clevedon, Multilingual Matters, in press.

Annotated Bibliography

- Genesee F, Paradis J, Crago MB: *Dual Language Development and Disorders: A Handbook on Bilingualism and Second Language Learning*. Baltimore, Brookes, 2004.
This book provides an excellent up-to-date summary of research findings and theoretical perspectives on language and culture, the language-cognition connection, bilingual language acquisition, code mixing, second language acquisition in children, schooling in a second language, and a whole chapter on assessment and intervention for children with dual language disorders.
- Gutierrez-Clellen VF: Language choice in intervention with bilingual children. *Am J Speech Lang Pathol* 1999;8:291–302.
The author provides an extensive overview of the available research. She concludes that the literature on bilingual education suggests that children who are learning two languages 'may benefit from a bilingual approach in intervention' and that 'There is no evidence that a bilingual approach in intervention would "confuse" or tax the learning abilities of children with disabilities.' An extensive bibliography is provided.
- Holm A, Dodd B, Stow C, Pert S: Identification and differential diagnosis of phonological disorder in bilingual children. *Lang Testing* 1999;16:271–292.
This paper presents data collected from 35 bilingual children acquiring Pakistani heritage languages and English. The children were assessed in their mother tongue and in English. The phonological processes present are outlined with examples. In addition, detailed data are presented from two children. The data support the suggestion that for any language it is necessary to develop normative data for both monolingual and bilingual acquisition.
- Holm A, Dodd B, Stow C, Pert S: Speech disorder in bilingual children: four case studies. *Osmania Papers Linguist* 1998;22/23:46–64.
This paper presents data from 4 children acquiring Pakistani heritage languages and English. The data supports the idea that bilingual children develop two separate phonological systems and need to be assessed in both languages they speak.
- Thordardottir ET, Weismer SE, Smith ME: Vocabulary learning in bilingual and monolingual clinical intervention. *Child Lang Teach Ther* 1997;13:215–227.
This study used a single-case alternating treatment design to compare the effectiveness of monolingual and bilingual clinical approaches in teaching English vocabulary to a bilingual child with language impairment. The conclusion reached by the authors is that bilingual intervention does not restrict language growth compared to monolingual treatment and is, therefore, desirable since it avoids important negative aspects that result from eliminating either language of children who live in a bilingual environment.
- Wyatt TA: Assessing the communicative abilities of clients from diverse cultural and linguistic backgrounds; in Battle D (ed): *Communication Disorders in Multicultural Populations*, ed 3. Boston, Butterworth-Heinemann, 2002.
This chapter provides guidelines to implement realistic and sensitive services with clients from culturally and linguistically diverse communities. To accomplish this goal, the chapter describes how several important cultural and linguistic areas in the clients' background can have an impact on the various steps of the assessment process (i.e., case-history interview, test administration and interpretation, diagnosis, and report writing). The chapter describes important background areas to consider such as cross-cultural differences in communication styles, views towards health, illness, and disability; nature and prevalence of the communication disorders, and language differences.

- Stow C, Dodd BA: Survey of bilingual children referred for investigation of communication disorders: a comparison with monolingual children referred in one area in England. *J Multiling Commun Disord* 2005;3:1–23.
This paper presents evidence that bilingual children in the UK who speak Pakistani heritage languages and have speech disorders are not being identified by referral agents.
- Stow C, Dodd B: Providing an equitable service to bilingual children in the UK: a review. *Int J Lang Commun Disord* 2003;38:351–377.
This paper gives an overview of all the factors which clinicians need to consider in providing an equitable service to all their clients, no matter what language or combination of languages they speak.
- Stow C, Pert S: The development of a bilingual phonology assessment. *Int J Lang Commun Disord* 1998; 33(suppl):338–342.
This paper describes the process of developing a phonological assessment for Pakistani-heritage languages. This may help in the development of phonological assessments in other languages.
- Yavas M, Goldstein B: Phonological assessment and treatment of bilingual speakers. *Am J Speech Lang Pathol* 1998;7:49–60.
- Zhu H, Dodd B (eds): *Phonological Development and Disorders: A Multilingual Perspective*. Clevedon, Multilingual Matters, in press.
The book takes a multilingual perspective on phonological acquisition and disorders and addresses 12 different languages. It includes chapters by individual researchers or teams examining typical and atypical acquisition data from monolingual or bilingual children. Such data are useful for clinicians providing evidence relevant for clinical assessment and intervention of multilingual children with speech and/or language disorders.

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Marion Fredman (Israel)

Announcement of Congress

Seventh PanEuropean Voice Conference (PEVOC7)

Inclusive Dates: August 29–September 1, 2007

Location: Groningen, The Netherlands

Brief Description: This conference pays attention to all aspects of voice: clinical, aesthetic, different culture and performance contexts, ethnomusical, therapy, diagnostics, etc. All kinds of voice aspects will be discussed for this forum of voice teachers, laryngologists, phoniatrians, voice pedagogues, speech and voice therapists, logopedists, singers teaching in the classical voice tradition, as well as in modern singing. Special workshops on voice aspects will be organised. Festive receptions, a joyful congress dinner, and a concert on one of the famous 7th century Dutch organs will be part of the programme.

Featured Speakers: A series of renowned speakers will be invited.

Expected number of participants: 450–500.

Registration Fee: TBA, but approximately equal to earlier PEVOC congresses.

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