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Serving Young Children with Communication Disabilities from Latinx Backgrounds and their Families with Equity: Provider Perspectives

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Abstract

Introduction: Latinx children with communication disorders from birth to age 5 and their families are increasingly served in US educational and medical settings where long-standing structural barriers threaten their access to equitable assessment and intervention. However, little is known about providers’ perceptions serving this highly diverse population as they relate to reducing disparities in care for communication disorders.

Methods: This exploratory qualitative study interviewed 24 speech-language pathologists (SLPs) and early intervention (EI)/early childhood special education (ECSE) developmental specialists serving young Latinx children with communication disorders to offer targeted recommendations toward improving equity. The semi-structured interview included questions regarding communication assessment, diagnostics/eligibility, intervention, interpretation, translation, and solutions to enhance EI/ECSE. Interviews were coded with content analysis using elements of grounded theory, and responses from SLPs in medical versus education settings and from EI/ECSE developmental specialists were compared. Data triangulation was used to validate themes.

Results: Analysis revealed the following themes related to provider challenges and resources: family factors, provider factors, cultural and linguistic differences, assessment approaches, eligibility determinations, translation and interpretation, and institutional factors. Few variations in themes between provider types (SLPs vs. EI/ECSE developmental specialists) and settings (medical vs. educational) were found. Providers also offered several policy and practice solutions.

Conclusions: Findings suggest minimal advances in improving equity for young Latinx children with communication disorders over prior decades. Results also indicate that providers may benefit from reflecting on their cultures and biases as well as systemic racism within EI/ECSE.

Approximately 1 in 4 children in the United States is from a Latinx¹ background, making it the largest ethnic group in the country (Kids Count Data Center, n.d.). This population includes children from widely varied socioeconomic, cultural, national origin, and linguistic backgrounds learning variations of English and/or Spanish and/or another language, including indigenous languages of Central and South America. Some of these children will be diagnosed with a disability in early childhood: approximately 27% of children participating in early intervention and 22% in early childhood special education (EI/ECSE) are Latinx (U.S. Department of Education [DOE], 2022). Most Latinx children in EI/ECSE have communication challenges and receive speech and language services from speech language pathologists (SLPs) and/or EI/ECSE developmental specialists (Hebbeler et al., 2007; US DOE, 2022).

The Individuals with Disabilities Education Act (IDEA, 2004) is the US federal law that governs states' provisions of EI and ECSE to eligible children with disabilities. Part C of IDEA, supports children from birth to age 3, while IDEA Part B pertains to children ages 3 to 21. Part C and B similarly require that children receive timely, comprehensive, and multidisciplinary evaluations using multiple measures to determine eligibility (per state-established criteria). Eligible children must receive a written service plan, created by a multidisciplinary team in consultation with parents, prescribing evidence-based services to address children's needs in the natural or least-restrictive environment. IDEA further specifies that evaluations must not discriminate based on children's race or culture and should be administered in the child's home language "unless clearly not feasible to do so" (§303.25). Part B explicitly requires the use of valid and reliable assessment tools. In Oregon, where this study took place, EI and ECSE are contracted by the Oregon Department of Education. Assessments must involve professionals from 2 or more disciplines, typically speech-language pathologists and EI/ECSE developmental specialists (Huerta et al., 2021), or 1 individual with licensure or professional credentials in 2 disciplines. Children can be found eligible by meeting criteria for one of six established disability categories, by demonstrating developmental delay as defined as "two standard deviations or more below the mean in one or more...developmental area, or 1.5 standard deviations below the mean in two or more of the developmental areas", or, for EI infants and toddlers, being diagnosed and referred by a medical professional with "a physical or mental condition that has a high probability of resulting in developmental delay" (ODE §581-015-2780). An Individualized Family Service Plan is developed for all eligible children from birth through age 5. Per scope of practice guidelines (ASHA, 2008; DEC, 2014), both SLPs and EI/ECSE developmental specialists provide intervention for communication-related goals. Interpreters must be arranged for parents in Oregon whose native language is not English for "formal" meetings specific to identification, evaluation, placement, IFSPs, service provision, and transition (ODE §581-015-2190; §581-015-2750). Oregon law does not address translation; yet, IDEA requires translation of specific documents provided to parents, not inclusive of the IFSP.

¹The labels used to indicate ethnic and/or cultural identity change over time, and there is often disagreement among group members. Latinx is a gender-neutral version of the term "Latino" which is considered by some to be a more inclusive term for members of this widely diverse ethnic group. While the terms "Hispanic" or "Latino" are commonly used in the sources cited within this paper, we use "Latinx" instead.

While IDEA (2004) and professional guidelines in EI/ECSE (e.g., ASHA, 2008; 2016; DEC, 2010; 2014) mandate that all young children with disabilities receive nondiscriminatory or culturally and linguistically responsive services that prioritize family involvement, evidence suggests that children and families from Latinx backgrounds frequently do not receive such services (e.g., Clements et al., 2008; Huerta et al., 2021; Morrier & Gallagher, 2011; Raspa et al., 2010). For example, some studies report that Latinx families from varied backgrounds are less satisfied than White families and report poorer family outcomes in EI, particularly when they primarily speak Spanish at home (Bailey et al., 1999; Olmstead et al., 2010; Raspa et al., 2010). In comparison to their peers from any other racial/ethnic background, Latinx children are also more likely to receive EI services and less likely to receive ECSE services (US DOE, 2022). In general, data from the Centers for Disease Control indicate that only 47% of Latinx children with communication disorders receive speech-language services in a given year compared to 60% of White children (Black et al., 2015). Such patterns of over- and under-enrollment suggest inequity in the provision of services to Latinx children that are explained, in part, by racism and linguistic bias embedded within EI/ECSE systems which historically prioritize the standards of the dominant social group (i.e., White, English-speaking) and fail to center children and families of color, including those from linguistically diverse communities (Blanchard et al., 2021).

EI/ECSE providers serving Latinx populations play an important role in addressing several proximal and distal factors that relate to equitable access to speech and language services in early childhood. Equity in EI/ECSE can be defined as all young children having fair access to high quality assessments and interventions and achieved by eliminating barriers that negatively impact traditionally marginalized communities, including people of color in the US (Braveman et al., 2018). Most proximally, providers share knowledge and resources that can empower families and improve access as well as deliver culturally and linguistically responsive speech-language assessments and interventions. This requires providers to be aware of their own biases and cultural perspectives (Hyter & Salas-Provance, 2019). Providers may also navigate more distal challenges arising from the limited evidence base for young children from Latinx backgrounds with communication disorders, such as lack of appropriate assessment tools or interventions and/or restrictive policies (e.g., De Anda et al., 2020; Guiberson & Ferris, 2019; Larson et al., 2020). Therefore, providers' views of resources used to support Latinx children with communication disorders as well as challenges they face in achieving equitable service provision can provide valuable insight to update recommendations for EI/ECSE practice, policy, and research. Such provider perspectives may complement the perspectives of parents and policymakers in efforts to dismantle systemic racism and increase equity of care in EI/ECSE.

1.1 Summary of Prior Research

Although there is mounting evidence of disproportionate representation of Latinx children in EI and ECSE (Clements et al., 2008; Delgado & Scott, 2006; DOE, 2022; Morrier & Gallagher, 2011; Shapiro & Derrington, 2004), research on provider perspectives is minimal, particularly as related to serving Latinx children with CDs. However, given that EI and ECSE providers determine the nature and quality of services provided in EI and ECSE, understanding how they negotiate the complex issues pertaining to CDs among

Latinx children is important. In addition, provider perspectives can be useful in terms of implementation of feasible and acceptable interventions for improving equity for Latinx children with CDs. Existing US studies have predominantly used close-ended surveys and focused on serving all children from culturally and linguistically diverse populations (CLD), as opposed to specific Latinx populations. Four studies have addressed the perspectives of professionals working with CLD children in EI/ECSE programs, including developmental specialists and/or SLPs (Banerjee & Luckner, 2014; Lee et al., 2003; Lee et al., 2006; Steed & Stein, 2021) while most have focused on SLPs serving school-age children (Arias & Friberg, 2017; Caesar & Kohler, 2007; Guiberson & Atkins, 2012; Hammer et al., 2004; Kimble, 2013; Kritikos, 2003; Rosebery-McKibbin et al., 2005).

While close-ended surveys are advantageous for collecting data quickly without the need for a skilled interviewer in a format that supports rapid data analysis, close-ended surveys also have limitations. Due to the nature of close-ended surveys, results included minimal elaboration from providers on the experiences that the researchers deemed as important or relevant when designing the survey rather than issues perceived as pressing by providers. Close-ended surveys also do not involve a conversational exchange. This limits the identification of unexpected or novel insights that emerge from providers' interaction around a topic with their interviewers and opportunities to clarify or deepen answers. Thus, close-ended surveys may miss innovative avenues for increasing equity that providers perceive as crucial. Previous research findings can be summarized in terms of provider factors, workforce factors, and assessment processes.

1.1.1 Family Factors.

One study focused on EI found that some providers believed that families' minimal engagement in services and limited understanding of EI systems were challenges to service provision (Lee et al., 2006). Some providers linked families' perceived lack of participation to cultural norms and beliefs while a small number reflected that providers' poor understanding of family cultures or skills in relationship-building were underlying causes.

1.1.2 Provider Factors.

Existing studies suggest that provider proficiency in the family's home language and provider education, training, and experience with CLD populations may impact services (Guiberson & Atkins, 2012; Kohnert et al., 2003; Kritikos, 2003; Lee et al., 2006; Rosebery-McKibbin et al., 2005). Most US providers do not speak a language other than English (e.g., ASHA, 2021a). Providers often report that they lack knowledge, training, and/or experience to serve CLD clients (Arias & Friberg, 2017; Banerjee & Luckner, 2014; Caesar & Kohler, 2007; Hammer et al., 2004; Kohnert et al., 2003; Kritikos, 2003; Lee et al., 2003; Lee et al., 2006). Providers particularly report limited preparation in working with interpreters, understanding children's heterogeneous home cultures and languages, supporting dual language development, and reflecting on their own cultural views (Arias & Friberg, 2017; Banerjee & Luckner, 2014; Guiberson & Atkins, 2010; Hammer et al., 2004; Lee et al., 2003; Lee et al., 2006; Roseberry-McKibbin et al., 2005). Providers report a pressing need for training in these areas as well as communicating and collaborating with

CLD families (Banerjee & Luckner, 2014). Such training, when available, supports their work (Arias & Friberg, 2017; Caesar, 2013; Guiberson & Atkins, 2012; Kritikos, 2003) and increases their comfort in working with CLD families (Kimble, 2013; Roseberry-McKibbin et al., 2005).

1.1.3 Workforce and Systems-Level Factors.

Providers also report that a lack of bilingual and/or bicultural providers and interpreters hinder service delivery to CLD populations (Banerjee & Luckner, 2014; Caesar & Kohler, 2003; Guiberson & Atkins, 2012; Hardin et al., 2009; Lee et al., 2006; Roseberry-McKibbin et al., 2005; Steed & Stein, 2021). Most SLPs are non-Latinx, White monolingual English speakers (ASHA, 2021a; 2021b). National demographics of EI/ECSE specialists are unknown. While efforts are underway to diversify the workforce of providers who serve children with disabilities (e.g., Allied Health Workforce Diversity Act [H. R. 3637]), progress is slow. In addition, providers have noted limited funding, minimal physical resources and time, and poor communication across agencies and teams as challenges (Lee et al., 2006; Steed & Stein, 2021)

1.1.4 Diagnostic Assessment Factors.

Providers note barriers to assessment of communication development and disorders among children from CLD backgrounds. These include access to measures of communication developed for and/or validated with varied populations, uncertainty about appropriate measure selection, concerns and disagreements about cultural and linguistic bias in measures, limited time required to administer comprehensive assessments across multiple languages, and lack of funding or support for assessment (Arias & Friberg, 2017; Banerjee & Luckner, 2014; Guiberson & Atkins, 2012; Hardin et al., 2009; Kohnert et al., 2003; Lee et al., 2003; Roseberry-McKibbin et al., 2005; Steed & Stein, 2021). Providers further report challenges interpreting assessment data to differentiate a language disorder from a language difference, likely related to knowledge gaps about typical and atypical development among linguistically-diverse children (Guiberson & Atkins, 2003; Roseberry-McKibbin et al., 2005), and making eligibility determinations in light of cultural and/or linguistic differences (Steed & Stein, 2021). In response to these challenges, some providers have reported using standardized measures in conjunction with informal measures, such as parent report, language samples, observations, and dynamic assessment to evaluate clients from CLD backgrounds (Caesar & Kohler 2007; Guiberson & Atkins, 2012; Hardin et al., 2009; Steed & Stein, 2021). Triangulation of multiple data sources that highlight less biased, non-standardized approaches is recommended for differential diagnosis of Latinx children (Castilla-Earls et al., 2020; De Anda et al., 2020). Yet, in general, lack of research on assessment with diverse populations makes it difficult for providers to meet these best practice guidelines (Guiberson & Atkins, 2012).

1.2 Purpose of the Study

This qualitative study was designed to fill a gap in current research regarding challenges and resources in providing services to Latinx children age birth to 5 with communication disorders (CDs). Our primary research question was: what resources and challenges do EI/

ECSE providers perceive as relevant to providing early communication services to children from Latinx backgrounds? Resources and challenges were defined broadly, including material resources and challenges (e.g., programming, funding), informational resources and challenges (e.g., education, training), and workforce and institutional issues. A broad scope of challenges and resources were also considered, ranging from those most proximal to the family/provider clinical encounter (e.g., use of less biased assessment protocols) to more distal factors (e.g., representation of Latinx populations in research). A qualitative interview approach was taken, because as key stakeholders, providers' perceptions reveal details of individual experiences with assessment, eligibility, intervention, and interpretation/translation services with Latinx children and their families that cannot be learned through close-ended surveys broadly focused on CLD communities. This method also supported providers to contribute their ideas about how to better serve Latinx populations in EI/ECSE. This information may be useful in conjunction with prior research findings to develop precise research, practice, and policy solutions that improve equity in EI/ECSE care for children who are Latinx and experience CDs. SLPs and EI/ECSE developmental specialists were included because both disciplines frequently assess communication during the initial evaluation process and provide intervention for communication-related goals and differences in their training, professional credentials, and practice experiences may lead to distinct perspectives to guide discipline-specific solutions.

2. Method

This study was conducted in Oregon in 2019. Oregon's demographics mirror national trends: the percentage of children from Latinx backgrounds in Oregon has grown from 13% to 22% in the last decade (Kids Count Data Center, n.d.), now representing Oregon's largest ethnic minority group. The vast majority of Oregon's Latinx residents are of Mexican descent (85.5%), nearly half are bilingual; about 40% of adults have a post-secondary education, and approximately 35% of Latinx children live under the Federal Poverty Level (Ruffenach et al., 2016). In Oregon, both EI and ECSE services are administered by the Oregon Department of Education, and providers' caseloads may include children ages birth through 5 years. Children with CDs may also receive services in pediatric medical settings.

2.1 Research Team

The multidisciplinary study team involved educational and medical providers experienced in early CD care for varied Latinx populations, disparities researchers, and an EI/ECSE administrator. The study team included individuals who identified as Latinx and spoke Spanish ($n = 3$), individuals who identified as White and also spoke Spanish ($n = 4$), and an individual with a disability related to communication ($n = 1$).

2.2 Participants

This study included speech-language pathologists (SLPs), who hold master's degrees in communication disorders and sciences, national certification, and Oregon licensure as well as EI/ECSE developmental specialists, who per Oregon law hold a bachelor's or master's degree in early childhood, special education, or a related field and hold an education license or state authorization. Both SLPs and EI/ECSE developmental specialists

in Oregon are involved in communication assessments and service implementation in EI/ECSE settings (Huerta et al., 2021) and are expected to have training in special education law, non-discriminatory developmental assessments, and evidence-based, family-centered, and culturally- and linguistically-responsive interventions (ASHA 2008; 2018; DEC, 2014).

SLPs and EI/ECSE developmental specialists (herein providers) from Oregon were recruited through: (1) an email to local EI/ECSE agencies and professional organizations; and (2) snowball sampling (i.e., providers identified other potential participants). Forty-three providers responded. To participate, providers had to: (a) be employed in an Oregon educational or medical setting providing speech-language services to children from birth to age 6 (herein EI/ECSE); and, (b) provide assessment and/or intervention services for communication to at least 5 children under age 6 of Latinx descent in the prior year. Twenty-four providers met the requirements and completed the study.

See Table 1 for participant details. Most providers were female, non-Latinx, and White. Half reported that they spoke Spanish “well” or “very well”, and half reported they spoke Spanish “not well” or “not at all”. Eighteen participants were SLPs, most of whom were employed in educational settings ($n = 15$). Six were EI/ECSE developmental specialists.

2.3 Measures

After reviewing federal laws and professional guidelines for serving CLD populations with communication concerns in EI/ECSE and findings from two studies conducted by the research team that identified lapses in equitable service provision to Latinx communities in Oregon (Cycyk et al., in press; Huerta et al., 2021), the research team developed the initial semi-structured interview guide. Two staff from an Oregon EI/ECSE agency reviewed the guide and gave suggestions on content and scope. The final interview included 18 open-ended questions related to communication assessment, eligibility and diagnostic determinations, intervention, and interpretation and translation services. The interview guide is found in Supplemental Material.

2.4 Procedures

This study was approved by the Institutional Review Boards of the University of Oregon and Oregon Health and Science University. SLP research team members conducted the individual interviews via telephone. Interviews lasted an average of 45 minutes and were audio recorded. After each interview, the interviewer drafted a memo with general impressions of the discussion. Participants received a \$25 gift card as compensation. Audio recordings were transcribed professionally, and transcripts were deidentified and uploaded to Dedoose (2020), an online application for organizing and analyzing qualitative research data.

2.5 Analysis

Four research assistants and three researchers with training in qualitative analysis worked in collaboration to analyze the interview transcripts. Codes were developed in a stepwise iterative process which combined the deductive structural coding and inductive emergent coding elements of content analysis as described by Hsieh and Shannon (2005) with the

constant comparative analysis elements of grounded theory (see Cho & Lee, 2014 for a comparison of these approaches). Deductive structural coding allowed for the development of a discrete number of pre-determined, overarching codes to focus the research team on common challenges and resources identified in prior literature as described in the introduction (e.g., provider factors, assessment tools, interpreters). Inductive emergent coding was used to extract ideas directly from the responses of participants that may not have emerged in prior research. To develop these codes, each coder first independently read a randomly selected transcript and developed a suggested code list. The coding team then met to compare their independent coding lists and establish a starting list of codes and their definitions. To refine codes, this process was repeated with 2 additional randomly-selected transcripts. The revised code list was reviewed by the entire coding team and edits were made for accuracy and clarity. Then, each transcript was assigned a primary and secondary coder. The primary coder independently coded each transcript in Dedoose. The secondary coder reviewed the coded transcript and provided feedback on codes, resolved areas of uncertainty, and suggested new codes as necessary. When uncertainty remained, a third coder reviewed the transcript and provided additional feedback.

The entire coding team also met regularly throughout the data analysis process to discuss and refine the codes and their definitions, and to add new codes as new information emerged. The final coding scheme was reviewed in Dedoose in order to examine coding prevalence and patterns across interviewees. Codes were grouped into themes that described overarching challenges and resources to assessment, eligibility decisions, intervention, interpretation, and translation, as well as general observations about working with Latinx populations and potential solutions for enhancing equitable service provision. In addition, differences in frequency of code occurrence were examined by provider type (SLP vs. EI/ECSE developmental specialist) and by setting (SLPs in educational vs. medical settings). Instances in which coding frequency was disparate by provider type and/or setting were considered in particular detail by reviewing the corresponding coded excerpts. Thus, quantification of codes primarily supported the identification of overall thematic patterns and analysis of differences across provider type and setting. Code counts also guided presentation of the results so that prominence was given to the themes that were most commonly discussed across providers (and, therefore, likely the most representative of the experiences of providers serving Latinx families). However, themes illuminated by one or a few providers are presented, as this study was exploratory in nature and diverse views and exceptional cases may be valuable to policy and practice implications.

Several methods were used to validate findings. A Spanish-speaking Oregon EI/ECSE provider with 9 years of experience serving Latinx children with CDs who was not interviewed for or involved in the study design was recruited. The provider received a summary of the study purpose, the interview guide, and the codes and their definitions. The provider read two randomly-selected coded transcripts to provide their level of agreement with the codes and identify any important content that was not coded. The provider believed existing codes sufficiently captured the perspectives of the interviewees and offered no additions. A research team member who served young Latinx children with CDs in a medical setting, but who was not part of the coding team, also read the interviews of medical providers and provided feedback on themes that were unique from those uncovered

with educational providers. In addition, we compared themes revealed via coding to the post-interview memos. A research team member read all memos and confirmed that the general impressions recorded by the interviewers were reflected in the themes that emerged from the data analysis.

3. Results

Challenges, resources, and solutions discussed by EI/ECSE providers are presented thematically from proximal to distal to the child/family clinical encounter, as previously noted. Minimal thematic differences were observed by provider setting and type. Thus, aggregated results are presented, such that “providers” refers to themes shared by both SLPs and EI/ECSE developmental specialists, unless otherwise noted. While we do not provide quantitative data on the prevalence of themes given the exploratory nature of this study, we qualify the occurrence of themes as discussed by “all providers” (100%; $N=24$), “most providers” (>50%; $n=13$), “some providers” (11–50%; $n=3-12$), “a few providers” (10% or less; $n=2-3$), or “one provider” in the case of unique responses. Although some providers explicitly stated that there were similarities in their experiences with Latinx families and families who were not Latinx, we present results and interview excerpts on themes generally discussed as unique to the target population whenever possible. Representative quotations for all themes and subthemes are found in Supplemental Material.

3.1 Family Factors

All providers discussed how factors related to families influenced their work with Latinx populations. Subthemes included perceived cultural characteristics, access to resources, and trust.

3.1.1 Perceived Cultural Characteristics.—Some providers explicitly referenced the diversity among Latinx communities, for example: “I guess I want to highlight just that there’s such diversity in the Latinx population in terms of family income level, education background, and level of bilingualism”. Yet, some also discussed characteristics that they generally related to Latinx culture. Specifically, providers described Latinx families as warm, friendly, loving, flexible, and welcoming. Latinx families were viewed as eager to have their child participate in EI/ECSE, open to teaching providers about their language and culture, and appreciative of EI/ECSE services. Some providers believed families respected their perceived position of authority and professional expertise, and were likely to follow-through on recommendations:

[Latinx families] ask more questions [than White families] about what it’s [EI/ECSE] about and they seem to be more excited that their kid is in service and oftentimes they’re the best parents that follow through. If we give them, ‘Here’s eight things to do at home,’ then by the time they come back they’ll have done all of that.

As this quotation illustrates, Latinx families were seen by some providers as inquisitive about the EI/ECSE process, participatory, and reliable. Some providers also described that

Latinx families would pursue developmental evaluations recommended by pediatricians, even when the family did not have concerns.

3.1.2 Access to Resources.—Most providers described the impact of inequitable access to material and informational resources on Latinx families of children with disabilities. For instance, families who lack transportation cannot easily attend meetings or access specialized disability resources. Likewise, parents with lower literacy cannot take full advantage of written materials provided in clinical settings. In particular, providers highlighted Latinx families' limited access to information, including information on EI/ECSE processes, children's rights to free disability services, and the US education system generally. Less commonly, providers discussed families receiving limited or inaccurate information about multilingualism and the value of home language maintenance. Providers speculated that reduced informational access leads family to “not understand” or “be confused” about the EI/ECSE process, which providers believed sometimes lead to delays in care or suboptimal care provision. Some providers shared their opinions that parental English language skills, education, or income level also played a role in accessing resources in EI/ECSE. Some providers shared their opinions that the combination of lack of information about EI/ECSE with the aforesaid cultural characteristic of respect for authority adversely affected access for Latinx children, because it was associated with what was perceived as too much deference and reduced parental advocacy. For example:

I often see that those [Latinx] parents in the system get taken advantage of... I feel like those parents that are totally trusting of the system may not get as much as the parents who know to be a squeaky wheel. And I think that the language and the cultural piece definitely impacts some parents' ability to advocate for themselves, especially at...the entry level.

As this provider describes, EI/ECSE is a system in which a parent is either a strong advocate (“squeaky wheel”) or a victim (“gets taken advantage of”). Some parents may not be able to advocate due to limited English proficiency (“the language piece”) or do not advocate due to their trust in the system (“the cultural piece”).

3.1.3 Trust.—Though families might be trusting of providers' child development advice, even when they did not agree, most providers discussed that some families seemed reluctant to share personal information with unfamiliar providers. For instance, some families may not readily discuss the languages of the home or preferences for intervention before “developing a relationship” with the provider. Trust was sometimes linked to the anti-immigrant climate in the U.S. and to caregivers' citizenship status, which influenced decisions around EI/ECSE access:

I think there could be families that are reluctant to access services, depending on what their status is in this country. And fearful of potentially...letting the government be aware of them and their children, and not knowing what the role of early childhood, special education or early intervention is. And whether that would, potentially, put them at risk or not.

As this quotation indicates, providers viewed families as struggling to disentangle the provider's role as a trusted developmental expert from their role as an employee of a government service that might take legal action against them or their children if sensitive information was revealed. As a result, Latinx families' trust in EI/ECSE providers was sometimes perceived as limited.

3.2 Provider Factors

Three themes emerged specific to provider characteristics. All providers discussed the impact of their Spanish skills and/or education and training on the services they provide to Latinx families. Most providers also discussed engaging in advocacy to support this population.

3.2.1 Spanish Proficiency.—Most providers discussed Spanish proficiency as both a resource and a challenge. Providers with more self-reported fluency in Spanish used Spanish to complete assessments, deliver language interventions, and communicate directly with parents, which they believed supported efficiency and relationship building. Yet, even providers who reported speaking Spanish “well” or “very well” described the challenge of delivering services in their non-dominant language, for example, finding it more difficult to develop examples on-the-fly. Providers with moderate Spanish skills described using Spanish to confirm the accuracy of interpreters. Providers with minimal Spanish proficiency valued using key words and phrases in Spanish with children and families, but they were unable to assess children independently in Spanish and could not ensure that interpreters were conducting assessments with fidelity.

3.2.2 Education and Training.—Most providers discussed their education and training as relevant to serving Latinx families, including graduate coursework, post-graduation professional development from local universities or state/national credentialing associations, informal learning opportunities through their workplace, and collaborations with bilingual and/or bicultural colleagues, including interpreters. For example, one provider shared the following:

We regularly have a group of professionals. We meet to share research. Some of those are at the university, others are working at other agencies, and so [we are] meeting with them, sharing materials, [and] going to trainings to continue professional development.

As this provider stated, interdisciplinary collaboration around current best practices for treating Latinx children was a regular occurrence. Yet, some providers nonetheless reported specific knowledge gaps in understanding developmental norms for communication in contexts where Standardized American English² is not spoken. Others described a lack of confidence in applying research or professional development to practice. A few providers wondered to what degree they should be using their Spanish in intervention.

²We use the term Standardized American English rather than Standard or General American English to highlight that the designation of this English variety as the standard in the U.S. is an artificially imposed social construction by those in power, not a timeless or neutral standard (Hudley & Mallinson, 2010).

Most providers also had concerns about limited education and training among their colleagues in health and educational sectors outside of EI/ECSE. For example, one provider perceived a knowledge gap among pediatricians who served children from Latinx homes, saying: “[Pediatricians are] not knowing how bilingual language development works, I don’t think that’s knowledge that a lot of doctors have readily available.” Other providers worried that families were being told to limit Spanish or that colleagues were delivering inappropriate services.

To mitigate limitations in education or training, most EI/ECSE providers used digital and print resources, including those found on the American Speech-Language Hearing Association (ASHA) website, via search engines, or through social media accounts focused on services to children from CLD backgrounds with disabilities. Some SLPs in medical settings discussed having limited access to supportive materials; this was not a concern expressed by EI/ECSE developmental specialists or educational SLPs.

3.2.3 Advocacy.—Most educational providers specifically described efforts to advocate on behalf of Latinx children with disabilities and their families, including sharing their knowledge, training, and resources with colleagues. Some SLPs and one EI/ECSE developmental specialist also described providing family education about child communication and home language maintenance.

3.3 Cultural and Linguistic Differences: Families and Providers

All providers described cultural and linguistic differences relevant to assessment and/or intervention. This included differences in personal identity as well as culturally-informed views on development and disability, parenting practices, and service delivery. Some providers explicitly stated that their responses applied “generally” or “a lot of times” to Latinx families but not to all Latinx families given the diversity represented in the broader Latinx community.

3.3.1 Personal Identity.—Most providers’ discussed characteristics of their personal identity that they perceived as challenges or resources to building rapport, specifically their ethnic, racial, and language background. A non-Latinx provider observed that children were less likely to speak to her in Spanish than English, limiting support for Spanish during assessments and interventions. In contrast, providers who spoke Spanish and especially those who spoke Spanish and identified as Latinx, were more likely to describe how a shared language and/or cultural identity facilitated trust-building.

3.3.2 Views on Development and Disability.—Most providers described differences in Latinx families’ views on normative development and disability as compared to those of other families served, to the views of providers, or to expectations upheld on standardized assessments of development. One provider shared how this manifested in initial EI/ECSE referrals:

There’s less concern about language delay as early as a White English-speaking family might have. [Latinx] families would usually come in around age 2 or 2½ with a concern that their child wasn’t speaking as much. And with the general

group of referrals, we would often get children in earlier with concerns about language delay, I think around 16 to 18 months.

As noted here, some providers viewed families of Latinx descent as having a “wait and see” mentality – parents believed children would catch up to peers or were particularly accepting of their child and their disability, and this led to differences in service access per providers. Some providers spontaneously marked these perspectives as different from the culture of families who they described as “white”, “English-speaking”, “monolingual”, “Western”, or “American”.

In contrast, a few providers believed that some Latinx families did not accept some communication-related diagnoses, especially autism. One provider reported that they had “found that, culturally, there was quite a bit of resistance to a child being labeled with a disability that was anything more than a language delay,” an experience shared with another provider who said:

This is a stereotype so it’s not across the board... There is a barrier for autism, so kids often come in for social communications and they want speech therapy, but this kid to us very clearly has autism and parents don’t want to talk about it at all. It’s like not on the table for discussion. They’re not autistic. So, there is some kind of cultural stigma.

This perceived stigma also applied to specific treatment approaches. A few providers described families as reluctant to use alternative and augmentative communication (AAC) devices, in particular, and one provider believed families were less interested in functional communication goals (e.g., developing conversational skills) than academic goals (e.g., drilling color names). A few providers noted similar views on disability and services across cultural communities.

3.3.3 Parenting Practices.—Some providers also discussed Latinx culture as relevant to the practices perceived to support young children with and without disabilities. A few providers recounted that Latinx families had shared the view that adult-child play was “a barrier” and “outside of her [the mother’s] personal culture”, although other providers noted that the concept of play-based therapy was a challenge for families in general. One provider noted that Latinx families were less likely to put their infant in “tummy time,” or prone positioning, “than any other racial category” they had served.

3.3.4 Service Delivery.—Most providers discussed Latinx families’ views of how EI/ECSE services should be delivered. Medical providers believed that Latinx families expected a hierarchical medical model of service delivery, in which all medical personnel are viewed as experts. Thus, some providers noted that families often asked them questions about the child’s diagnosis and prognosis that they viewed as more appropriate questions for medical doctors. Conversely, educational providers who followed a collaborative “coaching” service delivery model of EI/ECSE believed that this was not the model that Latinx families expected or preferred, which a few providers noted was common for families new to EI/ECSE in general.

The model that we worked under... It's really a collaborative, more of a consultation parent coaching kind of model. I think that often took a lot of encouragement to get parents not just to sit with us on the floor, but to actually actively get involved in that kind of therapeutic process. Because, the idea was more like, "Well, now that you're here can you provide the treatment?" But I think once they've self-valued as a teacher, their child's main teacher really, that worked fairly well.

As this quotation demonstrates, providers perceived that Latinx parents sometimes were surprised and/or suspicious of the "parent coaching" and "parent as teacher" model in EI/ECSE as they expected more of a dyadic clinical encounter. Differing expectations regarding service delivery models meant that some Latinx parents seemed to take a less active role than providers intended. As noted in the quote above, some providers believed that part of their job was to get parents from all backgrounds to shift perceptions of service delivery models and see themselves as their children's primary teacher to encourage involvement in services.

Relatedly, a few providers worried that some parents agreed to services that they did not feel were needed or appropriate and hesitated to express disagreement with eligibility or treatment decisions. As previously discussed, some providers related this to their view of Latinx culture as respectful of expert opinions or to families not having sufficient information about EI/ECSE.

3.4 Developmental Assessment of Child Communication

Most providers discussed factors that impacted assessment of child communication. These centered on themes of testing conditions, multilingual assessment, and tools.

3.4.1 Testing Conditions.—Some providers discussed the challenge of engaging young children from any background with an unknown assessor in an unfamiliar testing environment. There simply was not enough time allocated to evaluations to build the rapport providers thought was necessary to ensure that child performance was representative of communication skills.

3.4.2 Multilingual Assessment.—A few SLPs (but no EI/ECSE developmental specialists) also shared challenges determining the language(s) of assessment, accounting for multiple languages and Spanish dialects specifically in assessment, interpreting variations in communication skills by language, and conducting assessments in indigenous languages. Thus, assessment of multilingual Latinx children was considered more time-consuming and complicated when compared to children who speak English only (regardless of ethnicity).

3.4.3 Use of Standardized Assessments.—Most providers described using standardized measures to assess Latinx children, which is required per Oregon state policy for educational eligibility. One provider described standardized tests as useful for monitoring progress in communication, but most providers believed that these tools posed the most significant challenge to evaluating Latinx children. Providers expressed frustration at the lack of suitable assessments in EI/ECSE, stating, as examples, "there isn't a good

standardized test to use for children who are multicultural,” and “there is not really a measure of [a] bilingual child.” Most providers questioned the validity of existing measures in Latinx cultural and linguistic contexts, the inadequacy of their norming samples (i.e., underrepresentation of Latinx children), and their tendency to overidentify children exposed to multiple languages. SLPs in educational settings believed the state’s requirement that a child show a specified score discrepancy on a standardized tool to receive services for developmental delay was problematic and led to needless work and frustration. One said, “we had to use the scores, but we didn’t wanna use the scores.”

3.4.4 Alternative Assessment Approaches.—Providers described four approaches they used to overcome challenges posed by standardized assessments as well as some drawbacks of such approaches. First, most providers adapted standardized administration procedures and scoring, by omitting or substituting items, alternating the language of prompting, or allowing parents to present stimuli. A few providers criticized this approach because modified scores were difficult to explain or deemed useless for norm-based comparisons needed to satisfy eligibility requirements. Second, most providers relied on informal assessment. Family report, in particular, was highly valued for learning about children’s language(s) and language variations (i.e., dialects), communication skills and routines, and areas of concern. Still, some providers worried about the accuracy of family report, particularly when family reporters were not proficient in all of the child’s languages or were asked for personal information (e.g., home language use). Additional informal measures thought to be beneficial included referral documents, child observations, language samples, dynamic assessment, provider-created checklists, and collaboration with family members, teachers, childcare providers, and/or pediatricians. The third approach was data triangulation. Some providers described using a variety of formal and informal measures to “piece it all together into a whole picture” of child communication skills in all languages. Finally, some providers described their prior clinical experiences with Latinx children as helpful to assessment and interpretation of results. For example, discussing how they determined developmental status in the absence of appropriate tools, one provider stated, “I’ve been doing this for, gosh, 17 years, maybe. So, over that much time, and you literally see hundreds of kids a year, I’ve started to see patterns.” As this provider indicates, when appropriate standardized tools are lacking, the role of professional expertise in diagnostics becomes paramount.

3.5 Eligibility and Diagnostic Determinations

Three subthemes emerged regarding eligibility and diagnostic decisions for Latinx children: (1) differential diagnosis as a challenge; (2) concerns about misidentification; and, (3) role of parents in eligibility. Recall that eligible children birth to age 5 in Oregon receive an Individualized Family Service Plan (IFSP). Most providers reported particular difficulty in differentiating the presence and severity of a communication disorder for multilingual Latinx children, due to limitations in training and assessment tools, the complex nature of multilingual language development, and questionable or limited normative data. Some providers also considered whether lack of skills were due to lack of child experience with activities typically included in assessments (e.g., naming letters), possibly due to cultural differences in parenting. As a result, providers expressed concerns of over- and

under-identification of multilingual Latinx children as well as inaccuracies in the specific developmental diagnosis given (e.g., diagnosing a child with a communication disorder as having a behavior disorder instead). One provider shared, “in our attempts to be culturally sensitive and not over-label, we have under-labeled... Basically, either the kids get identified immediately for behavior issues or they aren’t identified because we’re like, ‘Oh, they’re just a language learner.’” It is unclear what this provider meant by “behavior issues”. Some providers in educational settings stated that parents should have an “equal role” in eligibility decisions as valued team members, though a few described Latinx families taking a “passive” role in eligibility meetings. Descriptions of how parents were included generally only specified asking parents if they agreed or disagreed with eligibility.

3.6 Interpretation and Translation Services

Some educational providers used interpretation services only periodically, as they considered their own Spanish-speaking skills adequate. For those who did use interpreters, several subthemes emerged. Skilled and well-trained interpreters were viewed as assets to establishing relationships and communicating with families, determining children’s dominant language, facilitating the delivery of culturally- and linguistically-responsive communication assessments and interventions, and advising on eligibility determinations. Spanish-proficient providers also appreciated that interpreters alleviated the demand often placed on bilingual providers who were not trained interpreters to interpret in eligibility meetings.

Yet, some providers had no access to interpreters outside of assessments or eligibility meetings or had access to those with insufficient Spanish skills, training, and/or experience. This led to disruptions in delivery of assessments and interventions. Interpreters’ unfamiliarity with EI/ECSE jargon or with children generally was a challenge in eligibility meetings, especially when discussing autism. Some providers noted that some interpreters did not show up when scheduled or did not translate accurately or completely, leading one to worry about the interpreter overstepping roles:

There was an interpreter who had been working for years and so she just wouldn’t even rely on the service provider. She would just say a spiel. I don’t know what she said. Would it be what I would want her to say? But she just kind of had her own thing, which was kind of dangerous because she wasn’t a speech path[ologist]...

Relatedly, some providers described how using an interpreter challenged the social dynamics of assessment and intervention as well as efforts to build relationships with families. As an example, one provider described the complexity of communicating through an interpreter as a challenge to accurate assessment: “They’re [children] used to someone talking to them in their own language, not someone talking through another person.” Another provider shared: “It can get a little awkward talking through someone, especially if the parent keeps... talking to the interpreter instead of me.” The challenge interpretation enacted on social dynamics was pronounced when a telephonic interpreter was used, as discussed by medical providers only.

Most providers said they had written translations of the documents required by federal or state law and/or their specific agency available to families. A few providers also mentioned

that their agencies created “family-friendly” brochures or newsletters; yet, most providers felt these resources were inadequate. Providers expressed frustration that Spanish documents were poorly translated, lacked comprehensiveness, or were written at an inaccessible literacy level. Important documents, such as assessment reports and intervention materials, were not regularly available in Spanish. Translation could be requested, but providers worried this caused more work for overtaxed bilingual colleagues. A few providers met these challenges by writing abbreviated notes to families in Spanish or sharing videos.

3.7 Additional Systems-Level Factors

In addition to the aforementioned “systematic requirement” to report standardized scores for eligibility and the general lack of bilingual and bicultural personnel, four subthemes emerged that captured providers’ perceptions of systems-level factors that significantly impacted EI/ECSE services to Latinx children and families: (1) agency climate, (2) demands on families, (3) bias, and (4) limited research. One provider remarked, “sometimes it’s the... system requirements and the agency requirements that can be the most frustrating for me”.

3.7.1 Agency Climate.—A few providers referenced their agency’s general support for Latinx families and flexibility in assessment policies as resources. One provider shared that their employers “seem to be very supportive when it comes to making sure that families’ linguistic and cultural backgrounds are both valued and accounted for in the evaluations.” This included prioritizing staffing the agency with skilled bilingual and bicultural personnel. However, lack of support was more commonly referenced, exemplified through a few providers’ perceptions that the effort and time they put toward appropriate service provision for Latinx populations were not valued. Providers cited minimal time on their caseload to prepare for assessment, to assess and treat in two languages, to further their professional development, to collaborate with interpreters, and to secure resources to support Latinx populations that were not made available by their agency. Some described using their personal, unpaid time to accomplish these activities. A few educational providers specifically expressed concerns about agency requirements to use specific tools for evaluation and progress monitoring: “I always wonder how valid they are and how developmentally appropriate they are for the [Latinx] families I’m working with”.

3.7.2 Demands on Families.—A few providers worried about the demand on families to navigate the “complicated” and “confusing” bureaucracy of governmental entities to “access providers and schedulers” and to complete the paperwork necessary to make or follow through on a referral, get an evaluation, and set up services for children. As one provider stated “there’s a tremendous amount of process to just get the simplest service. Forms to be filled out, and then you didn’t get it in on time... It’s just a bureaucracy, and a process that can be pretty overwhelming.” One provider believed demand was highest in complex cases:

This [COUNTRY OF ORIGIN] family I work with right now... has a lot of medical appointments. He’s very complex, and what’s been really difficult is how slow, and unresponsive the full system is. The full system of care. So, referrals for hearing evaluations, referrals for hearing aids, referrals for [AGENCY] developmental evaluations, like, being able to answer the question: Is this autism? Like, every

appointment, these schleps to [CITY], and these poor people. You know, the father's working back breaking work, and has to take off, no pay, every time this child needs an appointment in [CITY].

As this provider suggests, the parental burden of obtaining needed developmental evaluations may not be possible with parents' work demands or benefits. One provider also cited long wait lists and travel times that reduced families' access to services.

Some providers also discussed the challenges families faced navigating the complexity within and across systems of care, especially due to reduced access to personnel who speak languages other than English. In particular, a few medical providers discussed the complexity of managing medical referrals from the primary care system to the education system which oversees public EI/ECSE services. One provider expressed that this is the point in the process "when we lose a huge chunk of kids who never even make it in the door of the EI programs". A few educational providers thought transitions from EI to ECSE and from bilingual ECSE services to English-only services in elementary schools were confusing to parents and, as a result, risked service continuity and support for families' home languages.

3.7.3 Bias.—A few providers pointed toward bias in educational and medical systems that decreased equity for Latinx children. For example, one provider shared, "I also find that there's a lot more racial profiling, in terms of, less responsivity... and literally, being completely ignored. Like, families who are trying to communicate what they need or want to a doctor, and there's just no responsivity." Systemic misidentification of children with communication disorders who are multilingual and multicultural was also acknowledged by a few providers, including one who questioned, "whether we aren't accurately labeling students of color in general but also of Latinx backgrounds... I mean, we know that's a national phenomenon of the preschool-to-prison pipeline". One provider believed that some intervention proposals stereotyped Latinx families, such as assuming the family had no car and recommending transportation. One provider described bias beyond EI/ECSE settings: "sometimes I don't think that my community's very accepting... of Latinx people and there's not a lot of stuff that's in English and Spanish".

3.7.4 Limited Research.—Some providers referenced the limited research available with Latinx children with communication disorders. The lack of research on norms for communication development in Latinx and Spanish-English contexts, appropriately-normed standardized assessment tools, communication interventions, and culturally- and linguistically-responsive intervention materials posed challenges to providers working with this community. Emphasizing their desire for more research to support practice, one provider stated:

I think the main thing is that we want more information. We want to know. We don't want to do a bad job here. We want to help these families with exactly what they need, not any more, not any less... We want to help all students be successful.

3.8 Solutions to Improve Equity in EI/ECSE

Providers shared their solutions for improving practice for Latinx families, as described next. Many believed that their suggestions would benefit all children regardless of background.

3.8.1 Build Workforce Diversity.—Building the diversity of the professions serving Latinx children with disabilities was identified as a pressing need. Most providers emphasized hiring Spanish-speaking and Latinx professionals to provide interpretation, direct service provision, and/or case management. One provider suggested building capacity among Latinx women running home-based daycares who “would be a natural segue to sort of, bring them out and into these fields of early childhood, and intervention.” Yet, this provider also worried that “some very hardline cultural values around women working, and women staying home” could impede this approach. A few educational providers suggested a certification process or Spanish proficiency test to confirm that non-native Spanish speakers could provide services in Spanish.

3.8.2 Improve Community Outreach and Collaboration.—Most providers advocated for outreach to parents, pediatricians, teachers, and the community at large, to increase access to information on early childhood communication and disability services. In particular, outreach about multilingual language development to families and pediatricians would support accurate and timely referrals, and could improve eligibility determinations and family trust. One provider suggested that these efforts would also help reduce bias and disability stigma.

3.8.3 Offer Public Preschool.—A few providers in educational settings only believed free or low-cost public preschools would support Latinx children. They suggested that children without preschool started kindergarten at a disadvantage, and that children in preschool were more likely to be referred to EI/ECSE at an early age by their teachers.

3.8.4 Improved Support for Assessment.—Some providers suggested that development of culturally-responsive formal and informal assessment tools and/or provider trainings were needed. A few providers also recommended decreasing administrative emphasis on standardized measures for eligibility and having more time and flexibility for administering and interpreting assessments.

3.8.5 Increase Funding.—Some providers referenced funding as the catalyst to realizing the solutions above. More EI/ECSE funding was needed to train providers, purchase responsive assessment and intervention materials, access interpreters, and hire bilingual/bicultural providers.

4. Discussion

This study explored barriers and resources that EI/ECSE providers perceive as impacting services for children from Latinx backgrounds with communication concerns. Providers’ views, combined with those of parents and policy makers, are essential in improving equity, i.e., care that is just, individualized, and responsive to families’ needs, in EI/ECSE.

4.1 Current State of Practice in EI/ECSE

Our findings can be compared with those identified in survey research completed over the last two decades. Providers continue to note challenges related to their proficiency in families' home languages, limitations of their knowledge and training, general shortages of bilingual and bicultural providers (including interpreters), and lack of appropriate standardized assessment tools (Arias & Friberg, 2017; Banerjee & Luckner, 2014; Caesar & Kohler, 2007; Guiberson & Atkins, 2012; Hammer et al., 2004; Kohnert et al., 2003; Kritikos, 2003; Lee et al., 2003; Lee et al., 2006; Rosebery-McKibbin et al., 2005; Steed & Stein, 2021). To meet these challenges, similar to colleagues in other US settings (Arias & Friberg, 2017; Caesar & Kohler 2007; Guiberson & Atkins, 2012; Kritikos, 2003; Lee et al., 2006; Steed & Stein, 2021), many providers are proactively collaborating, sharing resources, and engaging in current best practices to support accurate diagnosis of multilingual children. The ingenuity of providers and their attention to best practice is heartening. Yet, given that some of this research was conducted nearly 20 years ago (Kohnert et al., 2003; Kritikos, 2003; Lee et al., 2003), it appears that the resources needed for equitable clinical practice for CD care have not greatly improved over time despite increased attention to efforts to diversify professions, improve training, and develop assessment measures for young Latinx children.

In addition to supplementing prior research with providers, the findings should be triangulated with Latinx families' views on EI/ECSE. Families have shared that cultural and linguistic differences, reduced access to information and material resources, problematic referral and evaluation approaches, lack of bilingual personnel and interpreters, and institutional bias and demand impact the services they receive (e.g., Bailey et al., 1999; García et al., 2000; Hardin et al., 2009). The current study shows that providers agree. Providers further illuminated precisely how cultural and linguistic difference impacts delivery of CD care within the prevailing family-centered collaborative model in early childhood. Specifically, cultural variations in perceptions of child development, disability, and parenting practices were linked to the timeliness of referrals and realization of suggested intervention activities, respectively, while variations in cultural views of authority and family roles in EI/ECSE were thought to impact diagnostic and eligibility decisions as well as intervention delivery. The impact of linguistic diversity on EI/ECSE access and services was also discussed. The differences identified by providers here align with broad trends that distinguish Latinx cultures from the dominant cultural perspective that underlies English-dominant US medical and educational systems (e.g., Greenfield et al., 2006). Yet, discussions of culture and language, at times, revealed notable threats to equity in EI/ECSE.

First, while many providers celebrated cultural strengths of Latinx communities and sought to leverage these strengths to promote outcomes, some providers held a deficit view of Latinx families. Pointing toward low parental literacy, poverty, limited English, or lack of understanding of EI/ECSE procedures as impeding involvement in disability services places blame on families for supposed shortcomings. In particular, some providers mentioned Latinx parents' apparent "passivity", whereas being an advocate or a "squeaky wheel" was required for their child to access optimal services. However, some of the providers who discussed this issue did not realize or acknowledge that this "squeaky wheel system"

is a cultural construct that may be unfamiliar to or uncomfortable for Latinx parents. Furthermore, Latinx parents may face racism, discrimination, and prejudice when they attempt to “be the squeaky wheel” and advocate strongly for their child (Angell & Soloman, 2017), and thus a more passive approach may actually be successful for them. Likewise, the suggestion that “hardline cultural values around women working” are impeding development of a diverse early childhood workforce ignores the multitude of educational, linguistic, and legal barriers that prevent Latinx women from obtaining skilled employment. As discussed by Blanchard et al. (2021), failing to contextualize such issues as manifestations of structural racism and social stratification that disproportionately disadvantage people of color, people who speak languages other than English, and immigrants in the U.S., suggests that families, not systems, must be “fixed” in order to achieve success in EI/ECSE.

Likewise, while several providers noted the wide diversity represented within the Latinx communities they served and acknowledged that some of the challenges they described were consistent across populations, some providers did not. Instead, these providers tended to discuss Latinx families as if they were a homogenous group with low education and incomes. Similarly, providers rarely mentioned the many language variations (i.e., dialects) of Spanish spoken by Latinx families or that some families speak indigenous languages. Latinx children only exposed to English were never discussed. Thus, some providers may conflate cultural differences with linguistic differences. A lack of recognition of the diversity in any group united by a certain identity can lead to stereotyping, which, at the very least, threatens the intent of EI/ECSE to be family-centered and individualized. Worse, stereotypes can perpetuate discriminatory behavior.

Finally, providers readily discussed their perceptions of Latinx culture but infrequently acknowledged their own culture or that the systems within which they operate are informed by a distinct cultural lens as well – one that centers White supremacy and, as such, that of middle class, educated, English-speaking, Anglo-Europeans. Providers largely upheld the perspectives and practices of EI/ECSE as the normative standard, and those of some Latinx families as non-normative and problematic. In other words, there was little recognition that the EI/ECSE system is socially constructed to benefit White, Anglo-European families and hinder families of color (Blanchard et al., 2021). Relatedly, there was little mention of the universality and neutrality of cultural beliefs and practices around childrearing and disability. For example, some providers saw Latinx parents as reluctant to “get down on the floor” and “be the teacher” without reflecting on the cultural nuance of this expectation or that parents may not agree with dominant Anglo-centric approaches to learning. Self-awareness is a keystone to delivering culturally- and linguistically-responsive care (Hyter & Salas-Provence, 2019) and essential for meaningful change in EI/ECSE (Blanchard et al., 2021). Thus, family satisfaction and engagement with EI/ECSE is likely influenced by the degree to which providers recognize how their own cultural beliefs, values, and practices link to the services they provide and their willingness to adapt to meet such diversity. Systems can empower providers to adapt by revising policies and practices that inherently marginalize Latinx children and families. The onus is on EI/ECSE providers and systems to adapt assessment, eligibility, and intervention approaches to best align with individual families’ perspectives and practices on child communication, not the other way around.

4.2 Implications for Provider Training, Policy, and Research

While we focused on the specific context of serving the Latinx community, many of the proposals below may benefit other communities facing marginalization and inequities in receiving CD care in medical and educational settings. Several suggestions echo those in previous research (e.g., García et al., 2000; Kummerer, 2012; Lee et al., 2003).

4.2.1 Provider Training.—Providers in this study often expressed enthusiasm for learning how to better serve Latinx children with CDs and a commitment to improving equity in EI/ECSE. To start, we suggest that providers who may not have had key training in cultural responsiveness be provided with training. Cultural responsiveness begins with the recognition that all cultures have value and a willingness to learn from families (i.e., cultural humility) and proceeds with self-awareness (Hyter & Salas-Provance, 2019). We encourage providers to develop skills to engage in the long-term, continuous work of reflecting on how their cultural and linguistic identities inform their beliefs, values, and practices surrounding disability, to challenge their implicit biases and the status quo, and to identify alternatives. Without cultural humility and self-awareness, we simply cannot expect providers to deliver culturally- and linguistically-responsive care. We also reiterate prior recommendations that providers receive training on less biased assessments and interventions, differential diagnosis in multilingual and multidialectal contexts, and collaboration with interpreters. Because providers play a crucial role in navigating the complicated and notoriously underfunded public educational and medical systems, we also suggest training in advocacy, building empowering family partnerships, collaborating across disciplines (e.g., pediatricians, social workers), leadership, and outreach. We applaud the many providers who participated in this study who are already engaged in this work. Furthermore, while we highlight the need for continued professional development for practicing providers, robust training on culturally and linguistically responsive practice must be available to undergraduates and graduates pursuing degrees in communication sciences and disorders and early childhood studies. Such training must take care not to stereotype Latinx families or present a deficit view of Latinx communities if we are to shift the disciplines involved in EI/ECSE toward equity.

4.2.2 Policy.—The results of this study suggest several institutional impediments to culturally- and linguistically-responsive CD services outside of providers' immediate control. First, the federal educational statutes that govern EI/ECSE are unclear. Clarification of IDEA's (2004) mandate that services be provided in the client's home language "unless clearly not feasible to do so" is of particular interest. The accuracy of CD assessment is improved when testing is completed in both languages for bilingual children (Anaya et al., 2018; Bedore, et al., 2010; Castilla-Earls et al., 2020), and outcomes are enhanced for children with communication disabilities when all of their languages are addressed in intervention (Durán et al., 2016; Larson et al., 2020). However, providers noted that families often lack access to their home languages in EI/ECSE due to workforce shortages and time and material constraints. A strict and narrow definition of "lack of feasibility" in IDEA might encourage state programs to hire, train, and retain diverse staff capable of providing services in children's home languages, including interpreters, and to provide EI/ECSE providers with access to and training on well-developed and validated assessment tools.

These efforts could be supported by rewarding multilingual proficiency and/or specialized training with compensation and professional recognition.

Second, we implore state policy-makers to make state educational eligibility requirements for EI/ECSE consistent with federal law. For instance, Oregon's rule specific to eligibility for developmental delay in particular suggests that norm-referenced tests must be used (ODE §581–015–2780); yet, IDEA Part B and C do not. Moreover, Part C explicitly states that evaluations must be “selected and administered so as not to be racially or culturally discriminatory;” similar language is included in Part B. While the intent of these state rules may be to improve the quality of assessments, many EI/ECSE measures, including those available in Spanish, have not been developed for or validated with children from Latinx backgrounds in the US (De Anda et al., 2020). Further, using arbitrary cut-off scores from norm-referenced measures of child communication can lead to misdiagnosis (Spaulding et al., 2006). Thus, such requirements contribute to diagnostic disparities. With additional training, we are confident that providers can successfully use less biased assessment approaches and clinical judgment for diagnoses while appropriate measures for Latinx children are under development.

Third, we recommend that additional federal and state funding be allocated to dismantle barriers to equity in CD care in EI/ECSE. Increased university funding could be used to recruit and retain Spanish-speaking and Latinx students, provide specialized training in serving multilingual and multicultural children with CDs, and to support interpreter and bilingual provider certification programs. EI/ECSE agencies could use additional funding to outreach to communities with information on their programs, attract and retain skilled bilingual/bicultural employees, purchase assessment and intervention materials, sponsor professional development opportunities, and reduce caseloads for those providing services to families who are CLD.

4.2.3 Research.—Research is needed to establish developmental norms and less biased, flexible assessment and intervention approaches for diverse children under age 5. This work must account for the wide variability in cultural, linguistic, and contextual experiences of Latinx children. Innovative approaches such as latent profile analysis (e.g., Halpin et al., 2021) and computer adaptive testing (e.g., Abedi, 2014) are examples of promising avenues for addressing such heterogeneity and achieving equity in evaluation. Implementation research is recommended to understand barriers that impact delivery of existing responsive assessments and interventions and to support transmission of science to practice and policy. Similar to practice, researchers should also follow culturally and linguistically responsive and anti-racist frameworks to promote strengths instead of furthering deficit-based views on CLD populations, including Latinx communities (Love & Beneke, 2021; Soto-Boykin et al., 2021).

4.3 Limitations and Future Directions

While this study is the first to provide an in-depth account of resources and challenges experienced by EI/ESCE providers serving young Latinx children with CDs and their families, it has limitations. A relatively small number of providers participated, all of whom

were in Oregon and most of whom were White and female. Although this is representative of current provider demographics nationwide (ASHA, 2021a; 2021b) and the findings align with prior research, providers from other backgrounds and/or in other states may differ in resources and challenges. Similarly, this study relied on input from providers with sizeable caseloads of Latinx clients, mostly in educational settings. Thus, this study may not represent the views of providers who have less experience with Latinx clients or those who work in medical settings. Moreover, it was not possible to obtain demographic details of the children served by providers, which prevented an examination of how caseload characteristics may influence provider perspectives (e.g., providers with more homogenous caseloads may perceive the Latinx community as less heterogenous). We also explicitly focused on challenges in serving the Latinx population of children with CDs, based on our prior research in Oregon that suggested inequity in practices and outcomes. It is possible that this focus led providers to over-generalize and/or focus on Latinx cultural deficits rather than strengths. However, this approach may have also given providers the opportunity to speak frankly about personal beliefs and observations without fear of judgement by the research team. In addition, this study focused only on the perspectives of providers. The study did not incorporate Latinx families, administrators, or policy-makers' perspectives, which are equally important in addressing service equity. Future research should seek to replicate these findings in diverse settings and to prioritize the voices of the many stakeholders involved in EI/ECSE. A robust mixed-methods approach that extends qualitative inquiry to providers nationwide and the diverse Latinx populations they serve and integrates these findings with quantitative data on providers' caseload as well as providers' and families' background characteristics (e.g., race, ethnicity, language proficiency, experience with EI/ECSE) is recommended. Finally, several members of the research team were White. While this might have inferred benefits in terms of shared experiences with some interviewees, it is also possible that researchers' backgrounds led to biased or leading questions or to effects on coding. For instance, the way questions were framed may have encouraged providers to stereotype Latinx families. We tried to mitigate this risk by using multiple interviewers and coders, including those of Latinx descent, by triangulating findings, and by cross checking interview transcripts and memos.

4.4 Conclusion

This study offers precise information on the current state of EI/ECSE practice relevant to supporting communication development and disorders experienced by children who are Latinx, and contextualizes and expands findings from survey research. This information supports targeted suggestions for practice, policy, and research to improve equity in CD care for Latinx children with disabilities from a range of backgrounds. We hope that providers, administrators, policymakers, and researchers use these findings to support equity in service provision, improve family outcomes, and retain dedicated and skilled providers.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Highlights

- SLPs and EI/ECSE specialists were interviewed about serving young Latinx children
- Providers described many challenges and resources to equitable service provision
- Challenges and resources did not vary widely by provider type or practice setting
- Improved training, policy, and research are needed to achieve equity in EI/ECSE
- Providers may benefit by reflecting on their cultures, biases, and systemic racism

Table 1.Demographic characteristics of participating providers ($N = 24$)

	<i>n</i>	%	<i>M</i>	<i>SD</i>	Range
Provider type and setting					
EI/ECSE developmental specialist ¹	6	25.0			
Speech-language pathologist	18	75.0			
Employed in educational setting	15				
Employed in medical setting	3				
Education					
Master's degree	23	95.8			
Doctoral degree	1	4.2			
Gender identification					
Female	23	95.8			
Male	1	4.2			
Race/ethnicity					
White	21	87.5			
Latinx	2	8.3			
White and Latinx	1	4.2			
Spanish proficiency					
Very well	6	25.0			
Well	6	25.0			
Not well	8	33.3			
Not at all	4	16.7			
Years of experience					
Working with children birth to age 3 in any state			9.4	8.1	0–27
Working with children ages 3 to 5 in any state			12.0	7.5	1–27
Caseload Characteristics (as shared by providers) ²					
% of prior month's caseload who were Latinx			44.7	23.7	15–100
% of prior month's caseload who spoke Spanish			40.3	25.5	14–100

Note. EI = early intervention, ECSE = early childhood special education

¹All EI/ECSE developmental specialists were employed in educational settings

²21 of 24 respondents provided this information.