



College of Audiologists and
Speech-Language Pathologists of Ontario

Ordre des Audiologistes et
des Orthophonistes de l'Ontario

GUIDE FOR SERVICE DELIVERY ACROSS DIVERSE CULTURES

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GUIDE FOR SERVICE DELIVERY ACROSS DIVERSE CULTURES

PURPOSE

The purpose of this guide is to broaden understanding of cultural perspectives and how these impact intervention. Heightened awareness of personal, cultural and professional assumptions and expectations augments responsive interventions.

PREAMBLE

This guide uses the pronouns “we” and “our” to promote inclusivity. We also recognise inter-cultural considerations are a shared responsibility.

DEFINITION OF CULTURE

Culture embodies the beliefs, customs, values, forms, arts and ways of life of a particular society, group, place or time¹. It encompasses elements such as: age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital/single status, gender expression, socio economic, gender identity, sex, sexual orientation².

OVERVIEW

We, as audiologists and speech-language pathologists, provide quality care, which is receptive and responsive to the unique needs of patients³, families and significant others. These distinctive needs include complex sociocultural factors affecting intervention. We must determine how elements of culture have an impact on intervention. This will require ongoing knowledge, self-awareness, skill and judgment. Every individual is all of the following:

- Like no other
- Like some others and
- Like all others⁴.

Views, beliefs, opinions and attitudes are based on information from multiple sources: family, friends, colleagues, media, patients, and the community. As regulated health care professionals, we are required to use patient-centered intervention. We need to understand,

¹ adapted from Merriam Webster, 2014

² Ontario Human Rights Code (OHRC), 1990

³ The term “patient” is used to represent the individual who receives health care intervention from a speech-language pathologist or audiologist and is synonymous with “client” or “student”. The use of the term “patient” follows the term used in the Regulated Health Professions Act, 1991 and by the Ministry of Health and Long-Term Care.

⁴ adapted from Laroche, Managing Cultural Differences, 2008

accept and respect diversity. Practices are implemented and reinforced to acknowledge the worth of every individual and their value to their community and to society at large.

Communication between patients, families and communities and ourselves is based on cultural knowledge, human dignity, respect and egalitarian reciprocity⁵. Review organizational values, policies, practices and procedures and, if necessary, advocate for change to ensure inclusivity.

This guide applies to all people we encounter when providing intervention. These will include the patient's family, significant others, as well as colleagues and professionals we collaborate with as part of intervention. To the greatest extent possible, follow these best practices.

UNDERSTANDING CULTURAL PERSPECTIVES

Understanding cultural perspectives is a continual life-long process, enhanced through knowledge, learning, life experiences and interactions with individuals.

Our own culture affects all inter-cultural interactions. Beyond ethnic and linguistic cultures, there are many cultural perspectives that are based on the ways we interact with the world, such as being an SLP or audiologist, our family role, our gender, age, ethnicity, education, life experiences, etc. These affect thinking, and create conscious and unconscious perceptions. By addressing our own conscious and unconscious beliefs, we can implement and reinforce practices that actively embody, accept and respect diversity in all aspects of intervention.

This may be achieved with the following strategies:

- Be responsive to the cultural perspectives each individual brings to the clinical relationship.
- Invite patients to share their perspective: listen and identify what is important.
- Avoid making assumptions based solely on culture. Two people growing up or being part of the same culture can have very different viewpoints and beliefs.
- When patients' behaviour, reactions or decisions are unexpected, consider how cultural dimensions are at play.
- When in doubt, seek clarification, rather than allowing for any cultural misunderstanding.
- Consider styles of communication as a cultural perspective: e.g., direct versus indirect.
- Examine the values and patterns of behaviours shared by subgroups and subcultures, and how these impact patient care and inter-professional interactions. For example, as a CASLPO member, we are part of a subgroup where common vocabularies, communication styles, and values are shared.
- Engage in using tools and resources available online, through employment, and any other learning opportunities to become more informed about culture.

⁵ The *Accessibility for Ontarians with Disabilities Act* (AODA) 2005 outlines four principles in the Accessibility Standards section: dignity, independence, integration and equal opportunity.

INTERVENTION

Gaining knowledge about each other's cultures allows us to anticipate and appreciate where, when and how culture influences intervention. This will help us to determine how to modify our communication style, develop patient-centered goals, decide on materials and manage expectations. Ensure patient's cultural perspectives are reflected in all areas of intervention, when possible.

Standardised assessments and treatment protocols may have based their norms on data that is not reflective of the patient's culture. Non-standardised intervention protocols have a role to play when there are significant cultural dimensions at play.

Intervention will be enhanced by the following:

- Consider inter-cultural communication styles regarding personal space, body language, gestures, humour, silences in conversation, tone of voice, eye contact and touch. Pay attention to social protocols such as greetings when first communicating with a patient, family and other professionals.
- Think about the style of interviewing: asking direct, personal questions versus open-ended general questions.
- Show flexibility in scheduling respecting a patient's diverse needs; for example, secular/religious holidays or health reasons.
- Include open-ended questions in interviews and assessments to elicit patient's perceptions and beliefs as they relate to audiology and SLP intervention.
- Develop assessment and intervention protocols using a combination of methods, from multiple sources. This may include family, culture and community with a focus on the individual's communication needs.
- Examine questions and comments to ensure they are relevant, necessary and culturally appropriate.
- Consider the role culture plays in the patient's decision making, including consent.
- Think about appropriate intervention goals as they relate to culture, e.g., direct eye contact versus indirect eye contact, conversational style between communication partners, and eating and dietary practices.
- Consider consulting with individuals who are knowledgeable about the language and culture of a patient.
- Adapt materials, in consultation with patients, to reflect cultural perspectives and preferences: e.g., meaningful activities, foods, music, dress, important persons or historical figures.
- Collaborate with the patient to plan how the patient's language/s will be addressed in intervention. Focus on functional communication determined by the patient's previous language competence and/or current language development and proficiency and which languages are spoken in different environments.

INTERPRETERS AND TRANSLATORS

Language interpretation, including sign, and translation are used when we do not communicate using the same language. Cultural interpretation assists us in understanding the beliefs and practices of the patient's culture. We are responsible for using the most appropriate methods of interpretation or translation to provide service.

Effective use will be achieved with the following:

- Determine the need for interpretation services in advance of providing intervention.
- For the purpose of ensuring objectivity, reducing risk of harm and reasonable, timely support, consider interpretation options, i.e., the use of professional interpreters versus family members, friends or colleagues. The patient's best interests must be a priority. With activities such as the evaluation of capacity to consent to long-term care placement, the assistance of a professional or an independent interpreter is warranted.
- Personal health information is being collected, used and disclosed so the patient must be comfortable with, and consent to the use of, an interpreter. The interpreter, professional or informal, must understand the importance of keeping information confidential.
- Refer to the [Guide to Obtaining Consent for Services](#) for further information regarding obtaining consent, and be mindful of the best way to fully inform the patient regarding consent. Reasonable steps should be taken to find a practical means of obtaining consent.
- Coach a family member, friend or colleague (informal interpreter) to interpret everything that is being said by all parties, without expanding on what has been said.
- Prepare all interpreters (professional or informal) as to what is required in the session, for example, an open conversation when collecting a medical history versus prescribed instructions in standardized assessments.
- Verify that the person taking the role of interpreter can help clarify culturally specific topics and ask culturally specific relevant questions, while remaining objective in their skills as an interpreter.
- Remain alert to the patient's verbal and non-verbal communication to help determine their understanding and wishes as information is being interpreted. Be informed about cultural differences in non-verbal communication.
- Explain or describe terminology, acronyms and idioms.
- Consider writing down key points to verify information discussed.
- Access CASLPO's Public Register for audiologists and speech language pathologists providing services in different languages, as well as the national and provincial associations' (SAC and OSLA) websites.

EXAMPLES OF CULTURAL DIMENSIONS:

Cultural dimensions reflect diversity, that is, the variety of differences among people. What follows is a list of dimensions⁶ that may form the basis of cultural assumptions, beliefs and attitudes with respect to our patients, family and significant others, including colleagues and professionals with whom we collaborate. They include, but are not limited to:

AGE: people of a certain age or age group.

ANCESTRY: a person's ethnic origin, which includes initiating or comprising a line of descent or a genetic line of descent.

CITIZENSHIP: being a member of a community, place or country and having rights and meeting expectations because of that membership.

CREED: religious and non-religious belief systems that substantially influence a person's identity, worldview and way of life.

DISABILITY: a broad range and degree of conditions, some visible and some not visible. A disability may have been present from birth, caused by an accident, or developed over time. There are physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, mental health disabilities and addictions, environmental sensitivities, and other conditions. Some individuals view themselves as differently abled.

ETHNIC ORIGIN: social groups with common traditions, which can encompass nationality, ancestry, language and beliefs.

FAMILY STATUS: a range of family forms, or perceived familial relationships.

GENDER EXPRESSION: how a person publicly presents their gender. This can include behaviour and outward appearance such as dress, hair, make-up, body language and voice. A person's chosen name and pronoun are also common ways of expressing gender. Pronouns could include: ze/zie, hir, he, she, his, her.

GENDER IDENTITY: each person's internal and individual experience of gender. It is their sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex. Gender identity is fundamentally different from a person's sexual orientation.

IMPAIRMENT/ABILITY: a range of ability or impairment from being fully self-sufficient to entirely dependent on others. Patients can have cognitive, emotional or physical impairments that impact communication and/or hearing. Individuals may identify themselves according to their abilities or impairments.

MARITAL STATUS: being engaged to be married, married, single, widowed, divorced or separated and includes the status of living with a person in a conjugal relationship, including both same-sex and opposite sex relationships.

⁶ Ontario Human Rights Code (OHRC), 1990

RACE: a group of people with shared biological or genetic traits, which may include physical characteristics such as skin, eye and hair colour.

RELIGION AND SPIRITUALITY: people who belong to a wide variety of faith communities, and those who do not belong to organised religious groups but have reverence for some form of higher power.

SEX: categories into which humans are divided on the basis of their reproductive functions, generally male and female.

SEXUAL ORIENTATION: an individual's physical and/or emotional attraction to the same and/or opposite gender. Heterosexuality, lesbian, gay, bisexual, transgender, queer, questioning are all examples of sexual orientations. A person's sexual orientation is distinct from a person's gender identity.

SOCIOECONOMIC STATUS: the social and economic standing or class of an individual or group. It depends on a number of variables including education, income, occupation, and place of residence.

TRANS OR TRANSGENDER: people with gender identities and expressions that differ from those whose gender corresponds to their biological sex (cisgender). It includes, but is not limited to, people who identify as transgender, trans woman (male-to-female), trans man (female-to-male), transsexual, cross-dresser, gender non-conforming, gender variant or gender queer.

COLLEGE STANDARDS

The College, through the Code of Ethics and standards of practice, protects the human rights of all individuals in our care.

1. CODE OF ETHICS

The following principles and standards from the [Code of Ethics](#) are reflected in this Guide:

Principle 2

In the pursuit of patient/client benefits, audiologists and speech-language pathologists (SLPs) have an ethical obligation to respect patients as persons.

4.1 Legal Standards Governing Practice

Audiologists and Speech-Language Pathologists:

4.1.7 will not discriminate in their relationships with either their patients/clients or their colleagues on the basis of race, religion, gender, sexual orientation, marital status, disability, or age.

2. SELF-ASSESSMENT TOOL (SAT) PROFESSIONAL STANDARDS:

CLINICAL SAT:

2.5 I use intervention procedures that are appropriate to the cultural and linguistic background of the patient/Substitute Decision Maker (SDM).

4.2 I communicate in a manner that is appropriate to the cultural and linguistic background of the patient.

NON-CLINICAL SAT:

2.4 I develop, comply, and facilitate compliance with practices/processes that are appropriate to the abilities and cultural and linguistic background of the patient/Substitute Decision Maker (SDM) served.

4.1 I use language that is appropriate to the abilities and the cultural and linguistic background of those with whom I communicate.

3. LEGISLATION

This Guide is consistent with existing legislation and government initiatives relevant to the provision of communication intervention, which is responsive to the cultural considerations of patients such as the Ontario Human Rights Code (OHRC, 1990), *Accessibility for Ontarians with Disabilities Act (2005)*, The Aboriginal Health Legislation and Policy Framework in Canada (2011), Ontario Ministry of Health Anti-Racism Strategy (1995), Equity and Inclusive Education in Ontario Schools (2014), *Canadian Human Rights Act (1985)*, and *Canadian Multiculturalism Act (1998)*.

CONCLUSION

We, as audiologists and SLPs, must endeavour to provide quality care, which is receptive and responsive to inter-cultural considerations and complies with College standards. We must deliver a culturally responsive, patient-centered intervention, using enhanced strategies, tools and techniques, which contribute to positive therapeutic relationships. We are in a life-long learning process enhancing cultural awareness, knowledge and skills through education, experiences and interactions.

GLOSSARY

CULTURE embodies the beliefs, customs, values, forms, arts and ways of life of a particular society, group, place or time⁷. It encompasses elements such as: age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital/single status, gender expression, socio economic, gender identity, sex, sexual orientation⁸.

CULTURAL INTERPRETERS are active participants in a cross-cultural/lingual interaction, assisting the member in understanding the beliefs and practices of the patient's culture, by providing cultural as well as linguistic information.

⁷ adapted from Merriam Webster, 2014

⁸ Ontario Human Rights Code (OHRC), 1990

INTERPRETERS listen and watch as a person speaks or signs, grasp the content of what is being expressed, and then directly relays the meaning using the target language.

TRANSLATORS perform a similar function as interpreters concerning written language.

INTERVENTION for the purpose of this guide: Intervention refers to any member or support personnel involvement in the provision of member services to patients, including, but not limited to, screening, assessment, treatment, management, consultation.

DIFFERENTLY ABLED: an alternative term to disabled, handicapped, etc. on the grounds that it gives a more positive message towards people with disabilities.

PATIENT CENTERED CARE: the active participation of a patient in negotiating treatment goals with the member. Throughout the intervention process, the member enables the patient to make informed decisions and adapts the intervention to meet the patient's needs and choices.

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- World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF) (2001), <http://www.who.int/classifications/icf/en/>

RESOURCES

ASHA Tips for Working with an Interpreter

<http://www.asha.org/practice/multicultural/issues/interpret/>

ASHA Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services

<http://www.asha.org/policy/KS2004-00215/#sthash.Rs4C34uF.dpuf>

Barrier Free Education Reference Guide, Toronto, Ontario: Canadian Hearing Society.

https://www.chs.ca/sites/default/files/uploads/reference_guide_seq_pgs_2013.pdf

Beyond Ableism and Audism: Achieving Human Rights for Deaf and Hard of Hearing Citizens. Toronto, Ontario: Canadian Hearing Society.

https://www.chs.ca/sites/default/files/uploads/beyond_ableism_and_audism_2013july.pdf

CASLPO's public register for SLP/AUD who provide services in different languages

<https://members.caslpo.com/public/register/default.html>

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<http://www.ohrc.on.ca/en/learning/human-rights-101-2014-ed>.

OSLA's register (Find an SLP/AUD) to find private practitioners who provide services in different languages <https://www.osla.on.ca>

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