POSITION STATEMENT

SERVICE DELIVERY TO CULTURALLY AND LINGUISTICALLY DIVERSE POPULATIONS

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Members are expected to provide quality care, which is receptive and responsive to the unique needs of linguistically and culturally diverse populations. Members are expected to be aware that complex linguistic and sociocultural factors affect communication in order to incorporate this knowledge into their clinical intervention (which includes both assessment and treatment).

ASSUMPTIONS

- Provision of care responsive to multilingual and multicultural issues is consistent with CASLPO's Code of Ethics. The following statements are reflected in this position:

PRINCIPLE 2

In the pursuit of patient/client benefit, audiologists and speech-language pathologists have an ethical obligation to respect patient/clients as persons.

LEGAL CONSTRAINTS ON PRACTICE

Audiologists and Speech-Language Pathologists:
1.7will not discriminate in their relationships with either their patient/clients or their colleagues on the basis of race, religion, gender, sexual orientation, marital status, disability, or age;

- This position statement is consistent with existing legislation and government initiatives relevant to the provision of communication intervention, which is sensitive to the linguistic and cultural, needs of patients/clients (such as Ontario Human Rights Code, (1990, Chapter H.19) Aboriginal Health Policy for Ontario (1994), French Language Services Act (1990, Chapter F.32), Ontario Ministry of Health Anti-Racism Strategy (1995), Antiracism and Ethno cultural Equity in School Boards, Ministry of Education and Training (1993)).
- Culture and language have a profound impact on how the patient/client views assessment and treatment provided by audiologists and speech language pathologists.
- In the course of learning to speak another language, an individual will experience reduced linguistic competency as part of the normal learning process. This reduced competency alone (e.g. grammatical errors, foreign accent, etc.) is not a communication disorder.
- Members are expected to ensure that a patient/client's cultural and linguistic perspective is reflected in their assessment and treatment and to document such endeavours.

GUIDELINES FOR CARE

- In determining the language(s) of intervention, the following should be considered:
  - the patient/client's choice of language;
  - the functional communication needs as determined by the environments in which the patient/client communicates;
  - the extent to which proficiency in first language(s) may contribute to a comprehensive statement of the patient/client's language disability;
  - the patient/client's pre-morbid language competence;
  - other relevant information.
- Where the member's linguistic skills and cultural knowledge in the language chosen for intervention does not match that of the patient/client, the member should endeavour to collaborate with an individual who is linguistically and culturally competent to function as an informant in providing the service.
- Many factors affect the validity of an intervention conducted in collaboration with an informant. A member should consider:
  - the informant's proficiency in oral (and written) communication in the required language(s);
  - the informant's ability to interpret/translate;
  - the informant's capacity to understand and function in a clinical context;
  - the patient/client's level of comfort with the informant;
  - the extent to which the patient/client's linguistic and cultural perspective matches with that of the informant (considering such factors such as, culture, heritage, religion, class, dialect, etc.) ;
  - other factors which are unique to the patient/client.
- It is recognised that time, financial and environmental constraints may interfere with the selection of the ideal informant. Reasonable effort should be made and documented where compromise is unavoidable.
  - The patient/client or substitute decision maker must consent to the use of an informant.
  - Members must be aware of bias in standardised materials and make necessary accommodations to obtain a valid evaluation of communication competence. Examples of such accommodations include utilizing a non-standardised assessment procedure or using materials, which reflect the linguistic and cultural norms of the patient/client.
  - The syntactic and phonological variations of accent/dialect would not normally be addressed unless a patient/client specifically requests assistance to approximate standard accent/dialect and such elective treatment is available.
- Attempts should be made during assessment and treatment to incorporate knowledge of cultural differences in communication and swallowing. For example:
  - nonverbal communication methods such as gesture or direct eye contact may be considered impolite or inappropriate in some cultures;
  - verbal communication styles in contexts such as direct questioning or adult child interaction may vary;
  - cultural practices regarding types of food, meal times, and eating etiquette should be considered in dysphagia intervention;

    - cultural perceptions of disorders should be considered including attitudes towards assistive devices such as hearing and communication aids.
- All procedures, accommodations and rationales should be clearly documented.

CONCLUSION:

CASLPO members must endeavour to provide care, which is receptive and responsive to the cultural and linguistic needs of patients/clients.

REFERENCES

American Speech-Language-Hearing Association (1985) Clinical Management of Communicatively Handicapped Minority Language Populations *ASHA 27* (6) Position Statement IV-1

College of Nurses of Ontario (1999*) A Guide To Nurses Of Providing Culturally Sensitive Care*

Crago, M.B. & Westernoff, F. (1997) CASLPA Position Paper on Speech-Language Pathology and Audiology in the multicultural multilingual context. *Journal of Speech-Language Pathology and Audiology*. 21(3), 35-44.