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Speech Pathology Australia

Position Statement

Working in a Culturally and Linguistically Diverse Society

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Content

1. Background

1.1 Australia's cultural and linguistic diversity

The cultural and linguistic diversity of Australia is increasing and the composition of languages and cultures that make up Australian society are constantly changing. In the 2011 census nearly one quarter of the Australian population spoke a language other than English (23.2%) and 47% of Australians were either first or second generation migrants (Australian Bureau of Statistics, 2012). The top five countries of birth outside of Australia in the 2011 census were the United Kingdom, New Zealand, China, India, and Italy (Australian Bureau of Statistics, 2012). Data regarding recent arrivals showed increasing numbers of migrants from Asia and decreasing migration from European countries (Australian Bureau of Statistics, 2012). The main language spoken in Australia is English. However, there are over 300 languages spoken nationally (Australian Bureau of Statistics, 2012). The most common languages other than English spoken in Australia according to the 2011 census are Mandarin (1.7% of the Australian population), Italian (1.5%), Arabic (1.4%), Cantonese (1.3%), and Greek (1.3%).

In addition to the diversity in language and culture that is brought to Australian society through migration, the Indigenous inhabitants of Australia, the Aboriginal and Torres Strait Islander people are also highly diverse. Prior to European settlement there were over 250 language groups in Australia, speaking over 600 different dialects. Currently, 120 Indigenous languages are still spoken in Australia (Marmion, Obata, & Troy, 2014). Additionally, many Aboriginal and Torres Strait Islander people speak Aboriginal Australian English (Butcher, 2008).

1.2 Multilingualism

Multilingualism has many positive cognitive and social benefits. These benefits include enhanced metalinguistic skills and executive functioning, the ability to form relationships with speakers of the home language (such as grandparents and extended family), the ability to participate in community activities where languages other than English are used, and some studies suggest that multilingualism provides protection against the onset of dementia (Adesope, Lavin, Thompson, & Ungerleider, 2010; Bialystok, Craik, & Freedman, 2007; Park & Sarkar, 2007). Furthermore, a large-scale longitudinal study by McLeod, Harrison, Whiteford and Walker (2016) found that when multilingual Australian children were compared with monolingual English-speaking children, they had similar literacy, numeracy, and socio-emotional outcomes at school.

The ability to communicate in more than one language is an advantage and not the cause or exacerbating feature of disability (De Houwer, 1998). De Houwer (1998) describes the emotional dimension involved in the use of any language, stating that a child develops their first relationships in the language of the home and an adult will have many memories of their homeland and earlier times attached to the home language. Therefore, in addition to the cognitive cost, giving up the home language in favour of using only Standard Australian English has a social and emotional cost, and has not been shown to benefit English language learning. Thus, support for all of the languages spoken by an individual should be provided when delivering speech pathology services.

1.3 Professional and ethical requirements for providing culturally and linguistically appropriate services

The principles underpinning the provision of appropriate speech pathology services to people from culturally and linguistically diverse (CALD) backgrounds can be found in federal government legislation (Racial Discrimination Act ,1975; Human Rights Equal Opportunity Commission Act, 1986). These documents promote equality for all Australians. Australia's multicultural policy (Commonwealth of Australia, 2013) advocates for equity in access to, and quality of, services and programs for all Australians regardless of their cultural or linguistic background. Furthermore, any

form of discrimination against people based on their race, colour, descent, or national or ethnic origin, is deemed unlawful (Racial Discrimination Act ,1975; Human Rights Equal Opportunity Commission Act, 1986).

Speech Pathology Australia's (SPA) core documents encompass a requirement to provide appropriate services to all who seek them. The requirement to provide culturally appropriate services to people from CALD backgrounds is explicit in the SPA Code of Ethics which states " …we do not unfairly discriminate on the basis of race, religion, gender, sexual preference, marital status, age, disability, beliefs, contribution to society or socioeconomic status" (SPA, 2010, p. 1). The Code of Ethics requires speech pathologists to work towards the best possible service for all Australians, to provide accurate up to date information regarding communication, eating and drinking disorders, and the assistance which the speech pathology profession can provide. Additionally, the Code of Ethics (2010) states "We ensure that…our resources (such as assessment tools and communication aids) are current, valid and culturally appropriate" (p. 2).

2. Definition of Terms

Culture is "... the shared, accumulated, and integrated set of learned beliefs, habits, attitudes and behaviors of a group or people or community... the context in which language is developed and used and the primary vehicle by which it is transmitted." (Kohnert, 2008, p. 28).

Culture is an important factor in the development of one's sense of identity. It has been suggested that cultures may be differentiated by nine basic parameters: (1) views on individual versus group importance, (2) outlook on time and space, (3) the roles of men and women, (4) class and status systems, (5) core values, (6) language, (7) rituals, (8) work ethic, and (9) beliefs about health (Tomoeda & Bayles, 2002).

Cultural and linguistic diversity recognises the wide range of cultural groups that are contained within a population group. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language (Australian Government, 2006).

Indigenous is a term used to refer to the original inhabitants of a nation prior to colonisation or migration from other nations. The Indigenous people of Australia are the Aboriginal and Torres Strait Islander people who originate from 250 culturally diverse nations, speaking over 600 dialects (Marmion, Obata, & Troy, 2014).

Majority World Countries are countries that rank the lowest on the Human Development Index (United Nations Development Programme, 2013). These countries account for the majority of the world's population, and are sometimes also referred to as "developing", "low income", "third world" or "resource constrained".

Multilingualism is defined as the ability to "comprehend and/or produce two or more languages in oral, manual, or written form with at least a basic level of functional proficiency or use, regardless of the age at which the languages were learned" (International Expert Panel on Multilingual Children's Speech 2012, p. 1). The terms multilingualism and bilingualism are often used interchangeably (Crystal, 2003). In this position paper, multilingualism has been selected to parallel with the term "multiculturalism" recognising the breadth of cultural and linguistic influences within Australian society.

Simultaneous multilingualism occurs in people who are exposed to, and learn to speak, two or more languages regularly from birth or soon after. Some authors suggest that for a language to be considered a first language, children have begun learning it before they are 3 years old (Paradis, Genesee, & Crago, 2011).

Sequential multilingualism occurs in people who form solid foundations in the acquisition of a first language (sometimes known as the home language) before learning additional languages. This often occurs when children are raised in a community where the home language is spoken to the children until the commencement of schooling, and subsequently the dominant language of the community is taught. It may also occur in migrants who move from a country speaking only their home language to Australia where English is the dominant language.

Subtractive multilingualism refers to the loss of language(s) (usually the home language) as other language(s) (usually the dominant language of the community) become more developed (Roberts, 1995).

Language dominance is the language that a person is most fluent in. Language dominance overlaps with, but is not necessarily equivalent to, language proficiency. It considers the relative importance and use of each language in each of a person's speaking contexts.

Language or dialectal difference is a variation in language use or production impacted by regional, social, or cultural/ethnic factors. Many people from CALD backgrounds display a language or dialectal difference but have typical speech and language abilities. Therefore, a language or dialectal difference should not be considered a disorder of speech or language.

Cultural competence is "…the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes" (Centre for Cultural Competence Australia, n.d., p. 4). Culturally competent systems value diversity, are able to assess the culture of the system, are aware of the effects of interaction between cultures, institutionalise cultural knowledge and adapt service delivery to reflect cultural difference (Australian Government, 2006).

Culturally competent practice "acknowledges and incorporates —at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. 294).

3. The Position of Speech Pathology Australia

3.1 In order to ensure equitable access to appropriate information and services, Australian speech pathology services need to be responsive to our evolving culturally and linguistically diverse (CALD) society.

The Australian population is becoming increasingly diverse due to globalisation and increased migration from a wide range of source countries. Therefore, speech pathology services need to adapt to embrace this diversity in order to remain relevant and effective. It is recognised that a mismatch exists between the culture and languages spoken by Australian speech pathologists and the cultural background and languages of the populations they serve (Verdon, McLeod & McDonald, 2014). Therefore, measures need to be taken to ensure services can provide culturally safe spaces to engage with all people to deliver culturally appropriate services in their home language that are based upon the best available evidence.

One framework for that has been developed to holistically guide services and professionals in this task are the six Principles of Culturally Competent Practice (Verdon, McLeod, & Wong, 2015). The principles are: (1) identification of culturally appropriate and mutually motivating therapy goals, (2) knowledge about languages and culture, (3) use of culturally appropriate resources, (4) consideration of the cultural, social and political context, (5) consultation with families and communities, and (6) collaboration with other professionals. These principles are enacted via practical steps that can be taken to enhance engagement with CALD groups across all areas of practice (Verdon, 2015).

3.2 Speech pathologists need to engage in practice with CALD communities that is based on the best available evidence for each population.

Speech Pathology Australia requires that speech pathologists engage in practice that is based upon the best available research evidence (Speech Pathology Australia, 2010). Robust research evidence on multilingual and culturally diverse populations can be difficult to produce and find given the complexity and diversity that exists within these populations. For example, multilingual development is highly varied depending on age of acquisition of languages, level of exposure to languages and the context in which languages are learnt and spoken. This variability makes it difficult to draw universal conclusions about multilingual development and generate 'norms' for development and differential diagnosis of speech and language difficulties. Therefore, speech pathologists need to draw on the latest research evidence in conjunction with information from a wide range of sources including observations, testing, and consultation with families, communities, and the individuals themselves in order to make diagnostic decisions and to mutually plan effective and culturally appropriate intervention if required.

3.3 It is recognised that effective practice with people from CALD backgrounds may take considerably more time and resources than practice with populations whose culture and language the speech pathologist shares. Without allocation of appropriate time and resources, interventions may not be efficient or effective. That is, not satisfactory for the individual requiring intervention, the speech pathologist or the service provider.

In order to engage in evidence-based practice with CALD populations, extra time and resources are needed. For example, when working with multilingual speakers, assessment and intervention needs to take place in multiple languages, meaning more

time is required to undertake assessments, analyse data from assessments and to plan and implement intervention. Furthermore, when working with people from CALD backgrounds speech pathologists may need to acquire or create extra culturally appropriate resources and therefore may require more time to prepare and use these resources. Speech pathologists working with people from CALD backgrounds may also need to employ the assistance of professional interpreters and translators in the provision of speech pathology services. This is likely to also take considerably more time due to the need to conduct briefing and de-briefing sessions with interpreters and the increased complexities of the logistics of communication during a session facilitated by an interpreter (Hwa-Froelich & Westby, 2003; Isaac, 2005).

Organisations are encouraged to acknowledge the extra time and resources that may be required to provide speech pathology services that are appropriate for people from CALD backgrounds. As a result, organisations may need to set aside funding for CALD appropriate resources (e.g., therapy materials, interpreter booking fees etc.). Absence of such acknowledgement and provision of the appropriate time, funding and resources may render the speech pathology service for people from CALD backgrounds ineffective and inefficient.

3.4 It is recommended that all speech pathology service providers have a written policy on how services will meet the needs of people from CALD backgrounds.

All speech pathology service providers require written policy and procedure documents that explicitly include information regarding how services will meet the needs of people from CALD backgrounds and how services can be accessed by members of CALD communities. For example, policies and access details for interpreter services, details of local languages and community contacts including community elders and liaison services. Departmental policy and procedure development should be guided by a self-assessment of local need whilst being cognizant and aligned with organisational, national, and international guidelines and/or frameworks. Above all, CALD policy and procedure development requires a clear mission statement and leadership.

Provision of CALD services and policy and procedure development should be driven by data and research. Consequently a thorough assessment of service need is to precede all CALD policy and procedure development. Assessment should include, as a minimum, knowledge of the community and work force. Measurement of community demographics may include details of local culture, languages, and age. Assessment of the work force may include the linguistic diversity and cultural competence of staff, access to appropriate interpreter services, and knowledge of community elders and liaison services. Assessment will identify areas for CALD policy and procedure development (e.g., community engagement, staff training). After measurement, the identification of facilitators and barriers to implementation of culturally sensitive practice should guide the development of CALD policy and procedure and annual plan objectives. Finally, regular review of CALD policy and procedure is required in recognition of the changing nature of communities and the workforces that serve them.

3.5 Speech pathologists need to develop culturally and linguistically appropriate resources to support effective speech pathology practice. These resources should be shared between jurisdictions.

Existing resources used for assessment and intervention are typically based on monolingual English-speaking populations and western cultural norms. Such resources may not be appropriate for use with CALD populations. For example, standardised assessments with norms developed on monolingual populations are not relevant or

applicable to multilingual speakers and therefore, the formal scoring systems on these assessments cannot be used for reporting or differential diagnosis (Grech & Dodd, 2007; McLeod & Verdon, 2014). Similarly, resources may be culturally irrelevant or inappropriate for use with certain groups. Therefore, speech pathologists need to take time to learn about the languages and cultures represented on their caseloads and access or develop evidence-based resources that are suitable for the population they serve. Resources (such as informal assessments, activities, books, toys and games) should contain language, concepts, pictures and content that are familiar to the people they are being used with. Such familiarity can make people feel included, safe and welcome in the clinical space, as they see themselves and their culture reflected in the activities that take place.

3.6 Culturally and linguistically appropriate verbal and written information should always be provided to individuals (and their families) from a CALD background. This information may involve use of plain English information, translated materials, and/or photos and pictures to support understanding.

Speech pathologists are responsible for ensuring that all individuals are empowered to make informed decisions about their health care and management (Speech Pathology Australia, 2010b). Culture and/or linguistic background can impact an individual's views of healthcare, and their ability to provide informed consent. Speech pathologists and service providers should provide appropriately targeted methods of supporting an individual's understanding and 'health literacy' in consultation with the individual and/or their caregiver where appropriate. To achieve this it may be necessary to provide written and/or oral information about the services, therapy options and health conditions translated into the home languages of CALD populations. It also may be necessary to employ the use of interpreters or cultural support workers who can act as a bridge between the speech pathologist and CALD individuals to create a safe space for asking questions and seeking help around decision making.

3.7 Development of cross-cultural competence by speech pathologists (including students) is essential to facilitate culturally and linguistically suitable service provision. Education in the area of cultural and linguistic diversity should begin at the university level and continue to be embedded within professional development. The development of cultural competence is an ongoing process and speech pathologists need to engage in this process as lifelong learners.

Each person has their own culture, uniquely influenced by their own upbringing, ethnic heritage, languages spoken, values, and beliefs. Before being able to engage in culturally competent practice with others, speech pathologists need to form an understanding of their own culture and experiences of the world and how these impact upon their perceptions of others and the decisions that they make about in their professional practice. Gaining such an insight is an ongoing process and thus working towards culturally competent practice is also an ongoing process that requires continual reflection, consultation with others and evaluation of practices.

It is also essential that speech pathologists take the time to learn about the languages and cultures of the people on their caseload, so that these can be integrated into assessment and therapy. Awareness of culture and its important role in effective engagement with CALD populations should begin during speech pathologists' university training and should continue for the remainder of their career, through ongoing

professional development. Cultural competency is not an endpoint to be attained but rather a continuous process of learning and adapting to the needs of others.

3.8 Speech Pathology Australia (SPA) recognises the need for further research in specific areas of speech pathology practice with CALD populations.

Australia, as an increasingly CALD society, needs further research which reflects and supports cultural and linguistic diversity. Historically, individuals from diverse backgrounds have been excluded from research either because of researcher barriers such as lack of cultural understanding, concern about language skills, and recruitment practices which deter CALD participants or due to participant barriers such as lack of access to information, mistrust, and fear (George, Duran, & Norris, 2014). Barriers, as well as facilitators to participation for CALD populations should be identified and managed in order to facilitate local research addressing cross-cultural issues. Closing gaps in the evidence base for people from CALD backgrounds is essential to ensure equitable health care for all Australians.

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