Alberta College of
Speech-Language Pathologists
and Audiologists

Guideline:

Anti-Racist Service Provision for Speech-Language Pathologists and Audiologists

January 2022

Alberta College of
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Navigating this Guideline

This guideline specifically addresses the responsibilities of the registered speech-language pathologist (SLP) or audiologist for providing anti-racist care. This document utilizes the following icons:

The **Tools and Templates** icon provides the SLP or audiologist with checklists and documents that can be used to assist them with anti-racist service provision. Click on the bolded title of the document to view/print the tool and/template.

The **Magnifying Glass** is used to identify the first time that a key term is mentioned. The key term is italicized, bolded, and defined in the Glossary of Terms.

The **Link** icon references resources that the SLP or audiologist may want to review. These are typically external additional resources that may be helpful and can be accessed by clicking on the bolded title.

The **Reflection** icon identifies information to help support self-reflection on issues related to anti-racism.

Acknowledgement

ACSLPA would like to thank the dedicated volunteers who shared their expertise and their thoughtful review and revisions on this guideline by participating on the Anti-Racism and Anti-Discrimination Advisory (ARADA) Committee.

***Guideline**: Provides guidance to regulated members to support them in the clinical application of Standards of Practice.*

Introduction

The Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA) is the regulatory body for the professions of speech-language pathology and audiology. ACSLPA carries out its activities in accordance with provincial legislation. It protects and serves the public by regulating and supporting speech-language pathologists and audiologists to ensure competent, safe, and ethical professional practice. Speech language pathologists (SLPs) and audiologists have been regulated under the *Health Professions Act* (*HPA*) in Alberta since July 1, 2002. The HPA directs the activities of ACSLPA and outlines the regulatory responsibilities of the College required to protect and serve the public.

College guidelines provide guidance to regulated members to support them in the clinical application of *Standards of Practice*.

Background on the Anti-Racism and Anti-Discrimination Committee

ACSLPA's Anti-Racism and Anti-Discrimination Advisory (ARADA) Committee was formed in September 2020. This committee has a mandate to comprehensively review ACSLPA's requirements, systems, processes, policies, and practices to identify any real or perceived instances of systemic ***racism*** and ***discrimination*** either caused by, perpetuated by, or left unaddressed by the College. As part of this mandate, members of the ARADA committee completed reviews of the College's *Standards of Practice* and *Code of Ethics*, reviewing for:

- Any use of overt or potentially racist, discriminatory, ***stereotypical***, or insensitive terms,
- Any messages or themes that might suppress, deter, or adversely impact ***underrepresented racial, ethnic, or linguistic minority (URELM)*** communities and individuals from engaging or being engaged with the College or the professions it regulates,
- Contradictions to current best practices, research, theory and scholarship into racism and discrimination, and their sources, causes, or impacts,
- Lack of consideration about health, welfare, economic, and other systemic disparities, and
- Omissions that could intentionally or unintentionally perpetuate racist or discriminatory conditions.

Overview and Purpose of the Guideline

Following the ARADA committee's review, changes were made to both the *Standards of Practice* and *Code of Ethics* which:

- Make the documents more inclusive to ***equity-seeking*** communities and individuals,
- Acknowledge cross-cultural differences in access to services and experiences when accessing services,
- Acknowledge cross-cultural differences in processes that impact service delivery (e.g., health seeking behaviours, communication norms),
- Acknowledge considerations required for SLPs and audiologists when working with ***clients*** whose cultural and linguistic backgrounds differ from their own,
- Acknowledge the wider social, economic, and political contexts of ***racialized*** groups in the context of service provision by regulated members, and
- Make the documents more in-line with ***anti-racism*** service provision best practice approaches.

These guidelines are intended to provide more information to help members abide by the *Standards of Practice* and *Code of Ethics* regarding anti-racist service delivery. Principles of equity, diversity, inclusion, social justice, and anti-oppression are infused throughout the pending *Standards of Practice* and *Code of Ethics* (see above), and this guideline addresses these new concepts which will permeate these key guiding documents.

> *Standard of Practice* Update:
>
> *Standards of Practice* must be submitted to the Ministry of Health for feedback before they can be adopted by ACSLPA. The proposed amended *Standards of Practice* have been submitted but are pending until feedback is received. The current and pending versions of the *Standards of Practice* are both available on the ACSLPA website.

Specifically, this guideline provides the information required to help regulated members:

- Understand the need to widen their knowledge base to include social justice, ***equity***, and power perspectives, in order to provide equitable services,
- Understand the issues faced by equity-seeking groups when accessing or receiving services from health professionals,
- Understand the importance of anti-racist service provision,
- Effectively and safely negotiate cross-cultural boundaries in their clinical interactions, and
- Understand and implement principles related to anti-racist service provision during service delivery.

In addition, regulated members can also use these guidelines to support advocacy for systems and/or policy changes, in instances where employer policies and procedures create barriers to safe, effective, and anti-racist client service provision.

Guiding Principles

This Guideline is founded upon the following Guiding Principles:

- ACSLPA recognizes the existence of systemic racism and discrimination and holds a zero-tolerance stance towards any misconduct of this nature by regulated members.
- Diversity, inclusivity, tolerance, and equity are shared values which are reflected in ACSLPA's *Standards of Practice* and *Code of Ethics*. ACSLPA regulated members are expected to be fully informed on any changes to these key College documents regarding anti-racist service provision.
- It is expected that ACSLPA's regulated members, staff, and volunteers practice in accordance with the above documents, regardless of their role, practice area, or practice setting. Breach of these documents may constitute professional misconduct.

Understanding the Need for an Anti-Racist Service Provision Framework

Equity in service provision occurs when all individuals, families, and communities have fair and universally comparable access, experiences, and outcomes with services. However, oppression, racism, and discrimination have been shown to create health disparities and ***inequities*** in outcomes when accessing and engaging with social service institutions, like the health and education systems, and including the types of services provided by ACSLPA regulated members. It is important for regulated members to be aware of how the various cultural, social, economic, and political aspects of the client's context impact their health and daily life, and how any oppression, racism, or discrimination may impact service delivery.

Racism as a Determinant of Health

Health is influenced by many factors, including genetics, lifestyle choices, and social determinants. ***Social determinants of health*** are the non-medical factors that influence health outcomes and are the wider set of social and economic forces and systems which influence the conditions of daily life. Social determinants of health include employment and working conditions, childhood experiences, physical environments, access to health services.

There is now consistent evidence in the literature that racism is also a social determinant of health. This is demonstrated by the inequities and barriers caused by racism, which include:

- Inequitable access to social institution services (e.g., healthcare, education),
- Lack of culturally competent/sensitive practitioners and providers,
- Lack of culturally congruent services, and
- Inequitable outcomes and quality of life for racialized individuals and communities.

Another result of structural racism is the racial hierarchy, which is a system that stratifies people into social hierarchies based on their proximity to the dominant white culture. Under this classification system, racism that is experienced is dependent on how closely an individual or group resembles the dominant white culture. This hierarchy explains why anti-Black racism and anti-Indigenous racism are particularly prevalent in the education and healthcare systems, and why Black and Indigenous people accessing these services may experience more overt and explicit forms of discrimination that other racialized or marginalized people.

People who are new to the anti-racism journey often think of racism as the extreme and violent forms, e.g., the South African apartheid, or the genocide of Indigenous peoples around the world by colonial powers. However, racism has several levels. Individual racism is the assumptions, beliefs, or behaviors, existing within an individual, based on the thinking that one's own racial group has superior values, customs, and norms. Individually held racist beliefs may result in interpersonal racism, which is the discriminatory action directed from an agent to a target of racism. Racism at the institutional level refers to institutional practices that perpetuate racial inequality, while structural racism is racism that is backed up by societal power. These are policies and procedures entrenched in across social institutions, leading to racialized outcomes, the root of which are difficult to isolate.

Individual clinicians may not hold racist beliefs themselves, or personally act as agents of racism or discrimination in their therapeutic interactions with their clients. But, by virtue of operating with societal institutions and structures, like healthcare and education, in which structural racism persists, they may play a role in the continuation of policies and procedures that are racist and discriminatory. Additionally, when working within such systems where racism and discrimination exist at the structural level, being anti-racist (i.e., actively working to understand, challenge, and counter racism, discrimination, and inequity) has far more impact on the public than 'not being racist'.

The Biomedical Model

Healthcare education in Canada and around the world typically centers around the ***Eurocentric*** healthcare culture, which is associated with the concept of Western medicine, and in which biomedical science is the main way of knowing.

The biomedical model focuses on individual pathophysiology, which results in standards of practice and codes of ethics which focus on biomedically defined aspects of health and wellbeing, while ignoring the sociological perspectives that have profound impacts on health and wellbeing (e.g., social determinants of health, societal power imbalances). In this way, exclusive use of the biomedical model in service delivery is an indirect way of furthering the bias, discrimination, and racism faced by clients.

While the allied health knowledge and research base is one of the pillars of evidence-based care, clinicians should also consider *where* the knowledge they use to inform their clinical practice comes from. For example, while the evidence base of allied health is thought to be research based and objective, in reality much of the empirical data on which practice is based is itself based on ***dominant culture*** norms, or white cultural norms, as in Canada and Alberta, the dominant culture is white, middle class, Christian, and cisgender. Under the biomedical model, the dominant culture norms, or white cultural norms are used as the basis for understanding and treating health issues. Because whiteness is the norm under the biomedical framework, when it is used as the framework for understanding and working with clients is used for racialized clients, any difference from this 'norm' may either be viewed as a disorder.

The biomedical model also promotes scientific objectivity and neutrality, which anti-racism advocates now consider to be both not possible, nor desirable in healthcare. This is because objectivity and neutrality or 'treating everyone the same' ignores the unique considerations that are required for providing safe and effective services for ***culturally and linguistically diverse (CLD)*** individuals. For example, considering religious dietary restrictions during feeding and swallowing care, or how a client's religious wear may impact their hearing assessment or wearing their hearing aids.

Traditionally, healthcare education has promoted the idea that clinicians *should* 'treat everyone the same'. However, not everyone is the same, and the reality is that not all clients *are* treated the same by the healthcare system. Treating everyone the same ignores important cross-cultural differences that are meaningful to CLD individuals and the health and wellbeing. Being able to acknowledge and understand cross-cultural differences is a key skill for clinicians when providing culturally and linguistically appropriate and suitable care.

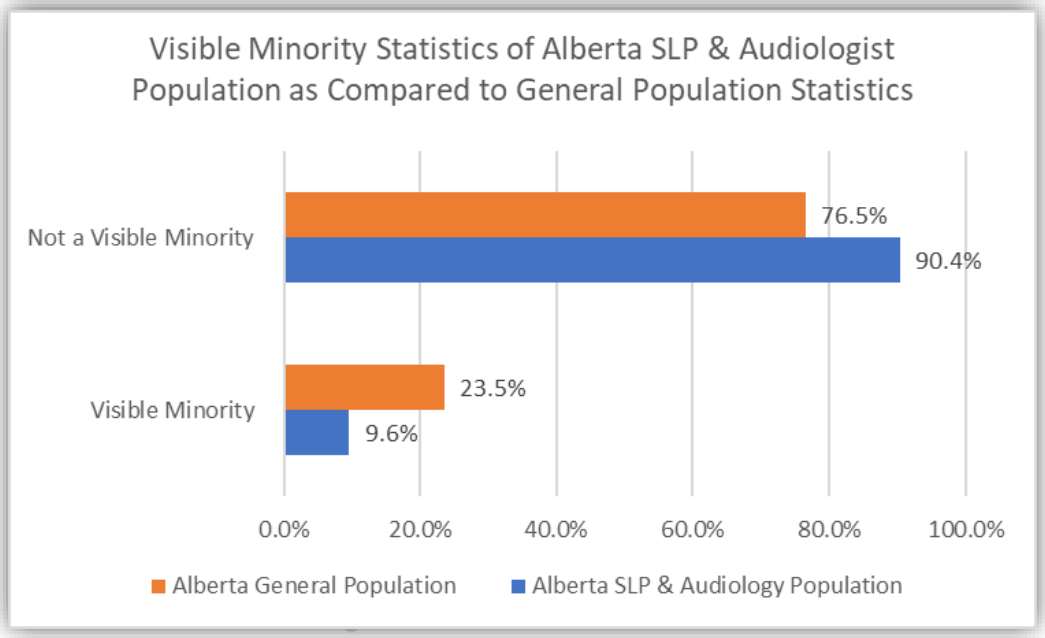
Many SLPs and audiologists may have had little exposure to perspectives of health beyond the biomedical viewpoint. Moving forward with anti-racist service provision requires members to consider the wider contexts in which they practice and to use these as a framework with which to understand their client and to plan services, while also engaging in situated practice and practicing cultural humility themselves (see below). Although everyday practice often involves working on a one-to-one basis, the delivery of SLP and Audiology services unfolds within larger socio political and economic contexts and within the context of systemic racism in social services institutions (e.g., health and education).

Suggestions for Regulated Members:

The ***biopsychosocial model*** is an alternative inter-disciplinary model that can be utilized by regulated members. This framework recognizes the interconnections between biological, psychological, and social functioning. Specifically, the biopsychosocial model acknowledges the impact of social factors (e.g., cultural practices and knowledge, socioeconomic status) on health outcomes, and recognizes that the client holds expertise on their own experience and well-being.

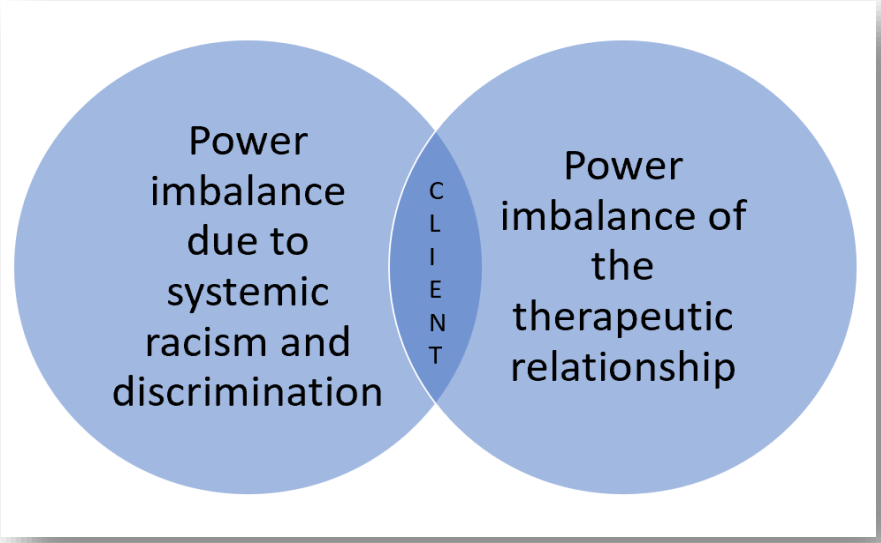
Racism as a Source of Power Imbalance in the Therapeutic Relationship

In Alberta, most regulated members of both the SLP and audiology professions are white (90%), with 9.6% of regulated members identifying as a visible minority. This statistic is indicative of a workforce of members that is not representative of the general population of Alberta, in which 23% of people identify as visible minorities (Statistics Canada 2016 data).



Also, regarding workforce diversity, research by D'Souza et al. (2012) demonstrated a significant mismatch in the profile of languages spoken by SLPs and the profile of languages spoken by their clients. Grandpierre et al. (2019) identified language barriers as a major challenge in the delivery of hearing loss services in Canada.

The lack of diversity in the professions translates into a lack of ***experiential knowledge*** of the needs of racialized and marginalized clients, and systems which are not truly responsive to the needs of these clients and communities. Clinicians should also consider that within the context of the therapeutic relationship, racialized people encounter two sources of power imbalances when seeking care: the power and privilege of structural racism in society (as discussed previously) and power and privilege of therapeutic relationship, where in Western health models, service providers have a power-over differential by virtue of the nature of healthcare work.



The therapeutic relationship is the relationship between a regulated member and a client. This relationship is different from a personal non-professional relationship, as the regulated member must consider the client's needs primarily. In the therapeutic relationship there are three key components that are important for the regulated member to understand. These include power, trust, and respect.

Power: The therapeutic relationship involves an imbalance of power between the regulated member and the client. This imbalance of power is due to numerous factors:

- The regulated member has greater clinical knowledge, authority, and influence in the health system.
- The regulated member has access to personal information about the client.
- The client is dependent on the regulated member for the professional services provided.

The imbalance of power may be compounded when racialized clients receive services from white regulated members. As a result of the power imbalance, the client may feel vulnerable and avoid confronting the regulated member for fear that the services they need will be compromised or withheld. It is the responsibility of the regulated member to recognize and take steps to reduce the power imbalance by ensuring the client feels safe and empowered to be an active participant and to exercise their agency (the capacity to act independently and make their own free choices) within the therapeutic relationship.

Trust: The therapeutic relationship between the regulated member and the client is based on trust. The client must trust that the regulated member has the necessary competence, will act in the client's best interest, and will do no harm. Some populations groups have significant mistrust in social service systems (e.g., healthcare and education institutions) given the historical contexts of oppression and discrimination against them. It is the responsibility of the regulated member to be sensitive to the vulnerability of the client and take the necessary steps to build and maintain trust.

Respect: In the therapeutic relationship, the regulated member has the responsibility to acknowledge and respect all clients, regardless of background, gender, sexual orientation, culture, language, and beliefs. While the regulated member is the expert in the clinical content of the therapeutic relationship (i.e., they hold the technical, scientific, and clinical knowledge related to speech language pathology or audiology), the client is the expert on the context of their own life, experiences, symptoms, strengths, and the inequities they experience, and how these impact their communication health and well-being.

Issues Specific to SLP and Audiology Service Provision

Systemic racism and discrimination in social service institutions like education and healthcare result in inequities in access and experience for equity seeking groups when accessing SLP and audiology services. These include:

1. Access barriers, whereby:
    - The lack of diverse representation of public facing professionals, and resulting perceived irrelevance of services, can serve as a barrier to access and result in underutilization of services by URELM clients,
    - Under-referral of CLD clients to services can occur when access is determined by referral from non-racially concordant professionals. This is due to the use of dominant culture norms when determining pathology, a lack of understanding of cultural norms, and conscious and unconscious bias, and
    - The lack of trust or fear of public service systems in some population groups due to unaddressed historical contexts of systemic racism may also result in decreased usage of professional services.
2. Negative experiences of CLD clients when accessing services, whereby:
    - There is an increased potential for CLD clients to experience ***cultural harm***, racism, discrimination due to the inherent power differentials of both the provider/client therapeutic relationship and the dominant-subordinate culture dichotomy of broader society, and
3. Inequities in assessment and treatment exist, including:
    - The lack of culturally and linguistically appropriate assessment and intervention materials and resources (e.g., speech sound recognition tests, language assessments),
    - The over-referral of CLD clients to unnecessary services because of the use of dominant culture norms when determining pathology,
    - Intervention practices which use dominant culture norms and promote ***assimilation*** to dominant culture norms (e.g., coaching parents to 'play' according to Western standards), and
    - The lack of empirical evidence to support use of 'best-practice' approaches normed on dominant culture with other cultures.

The Anti-Racist Service Provision Framework

The complexity of culture and diversity in Alberta calls for approaches to healthcare/education that reach beyond the biomedical model and Eurocentric meanings of health and wellbeing. Anti-racist service provision requires professionals to be aware of the structural inequalities (in institutions such as healthcare, education, and government) that determine the health of communities, families, and individuals. Lack of knowledge of the dynamics of cultural differences, power imbalances, and racism may lead to inadequate service provision and perpetuate additional harms.

The healthcare literature defines the anti-racist framework for practice as ethical service provision based on:

- A broad foundation of experiential, practical, and Indigenous knowledge, incorporated with empirical evidence from the conventional literature, while recognizing that the individual client is most often the most reliable and accurate source of experiential knowledge,
- An awareness of the biologic and genetic determinants of health, in addition to the social determinants of health and the socio political and economic contexts of the individual client, and
- An implementation of anti-oppressive principles in practice.

Practicing Cultural Humility

Cultural humility is a lifelong approach of self-reflection of one's own assumptions, beliefs, and personal and systemic biases. For regulated members, this includes reflection on how these assumptions impact their clinical interactions and their service provision. Although it is *self*, rather than other focused, practicing cultural humility also requires that members seek knowledge respectfully from clients regarding the cultural and structural influences that affect their care, rather than assuming knowledge or an expertise on their client's experience. Recognizing that the client holds knowledge and expertise outside of the scope of the regulated member, and that the client holds power over their own personal information allows the member to provide services to all clients regardless of how much specific information the member has about the client's particular culture. When cultural humility is practiced, learning in the context of the clinical relationship is bidirectional and mutually beneficial to both the client and the clinician.

Practicing cultural humility allows regulated members to:

- Redress power imbalances in provider/client relationship,
- Develop an understanding of how cultural influences affect clinical interaction and service provision,
- Develop mutually beneficial clinical partnerships, where clients work in collaboration with regulated members to take responsibility for their care and outcomes,
- Develop interpersonal sensitivity within clinical relationships,
- Acknowledge and address inequities through collaboration with and learning from clients, and
- Advocate for clients and communities to enact structural changes towards equitable services.

Situated Practice

Situated practice involves examining one's own identities, beliefs, and culture by locating the self in terms of various identities and locations. *Situated practice involves consciously reflecting on one's own identity and where one's identity is situated in relation to the dominant culture in society.* The figure below shows some aspects of social location that can be reflected on, but it is not exhaustive; it is meant to prompt thinking around social locations. This will help regulated members understand how their backgrounds and social environments shaped their experiences, assumptions, and biases; and helps members understand that individuals who do not have the same background will have experiences, knowledge, and assumptions that are different to theirs.

When situating themselves, regulated members should consider how both the biomedical worldview AND their identification with the dominant culture in society have affected their biases, perspectives, and values.

The University of British Columbia's Social Identity Worksheet is a guided self-reflection on social identity which can help clinicians better understand their own social location and life experience.

In social service systems in Canada, the status quo is often viewed as unbiased and objective (i.e., that everyone is treated equally). However, research indicates that differences in social location and the differential experiences of providers and clients in terms of social class, gender, education, and racial dominance do implicate themselves during the therapeutic relationship and affect the provision of quality services. The social locations of both the provider and the client, and the power dynamic between them (especially between a white provider and racialized client) affect service provision and outcomes, and so must be addressed to the point where care is centered on the client's culture.

Cultural humility also involves attempting to understand the reasons for mistrust between vulnerable populations and social service providers, including healthcare and education providers. This includes an awareness of the historic realities of violence and oppression against certain groups of people, and the lived experiences of disrespect and harm when accessing social services.

Overall, the purpose of cultural humility is to increase our understanding of others, through increased awareness of one's own values and beliefs that result from their social location. Beyond situated practice, regulated members can practice cultural humility by:

- Practicing humility in the assumptions they make about clients, and about knowing the world from the client's perspective,
- Understanding how their own background impacts their interactions with clients and their service delivery,
- Motivating themselves to learn more about their clients' backgrounds, cultures, health beliefs, and practices,
- Incorporating this knowledge into their therapeutic relationships and service delivery, and

- Emphasizing respect in all aspects of their service delivery, including in situations where the client's cultural norms around communication and hearing health may be in conflict with their own.

Practicing cultural humility has no endpoint. Rather, it is an ongoing and lifelong transformative process of learning and recognizing that clients bring valuable insight and knowledge to their service provision; regarding their personal history, preferences, and the cultural contexts in which these are experienced.

Providing Culturally Safe Services

Cultural safety is a process that regulated members can engage in that acknowledges and addresses the power imbalances inherent to the delivery of clinical services to URELM and/or racialized clients. The concept was developed in Aotearoa New Zealand, in the field of nursing education, in acknowledgement of the significant health inequities faced by Māori communities, and the need for drastic change in educating healthcare providers on addressing the long-terms impact of colonization and oppression on Indigenous individuals and communities.

Cultural safety is understanding and respecting that other cultures have different ways of seeing and doing. This understanding is the basis of the provision of quality clinical services for people of cultures different from the dominant culture and ensures that services are provided within the cultural values and norms of the client. Thus, practicing cultural humility (and situated practice) is the foundation of achieving cultural safety. Ideally, this results in a clinical environment and interactions which are free of racism and discrimination, where all clients feel safe when receiving care.

The College of Alberta Psychologists practice guideline Working With Indigenous Populations and Communities: A Guide to Culturally Safe Practice and Humility includes a Cultural Safety Checklist on page 10.

There are four principles that regulated members can use to implement cultural safety during service delivery (adapted from Ball, n.d.):

Protocols:

- Acknowledging that cultural factors critically influence the relationship between regulated members and clients. For SLP regulated members, this should include acknowledging the unique role of communication (the expression of which is culturally bound) within the therapeutic relationship, where it is sometimes both the medium and the focus of the clinical interaction,
- Finding out about and respecting cultural forms of engagement (e.g., showing respect by asking for permission/ informed consent),
- Seeking cultural knowledge from the client during assessment and intervention.
- Demonstrating reciprocity (i.e., learning that goes both ways) in learning protocols and norms for interactions, and
- Finding allies or mentors in the community of practice (e.g., other clinicians familiar with the client's culture).

Examples of using protocols in SLP and Audiology include:

- Finding out what constitutes initial relationship building in the client's culture and engaging in this relationship building before or during clinical services, as appropriate,
- Finding out and implementing the culturally appropriate ways to address clients and how to have them address you.

Personal Knowledge:

- Becoming aware of one's own cultural identities and of how our own beliefs and values, families, and community influence how we interact with others and our delivery of clinical services,
- Reflecting on one's implicit bias,
- Reflecting on the power dynamic inherent to the clinical relationship, which places the clinician in a position of power over the client,
- Becoming more aware of one's socio-historical and political contexts, and how these relate to our clients,
- Being open-minded and flexible in our attitudes towards people who are different from ourselves,
- Recognizing that acknowledging and protecting the cultural identity of the client is a responsibility of the regulated member, and
- Providing services within a framework of recognizing and respecting the difference of any individual. This does not mean having to be familiar with all ethno-specific norms and values, only a willingness to learn from any client how their culture influences their care and wellbeing.

For example, members can reflect on the following, how they may differ across cultures, and how they respond when their clients have different norms and values from them regarding:

- Views of disability,
- Views of independence,
- Trust in health and education systems and professionals,
- Understanding of the role of the clinician and the client, and
- The role of the family in decision-making and care.

Partnerships:

- Balancing the power differentials between yourself and the client,
- Allowing the client to describe their social location and how it may affect care, instead of making assumptions based on stereotypical information,
- Promoting collaborative practice, which recognizes clients as carriers of essential information and joint problem solvers and decision makers,
- Sharing knowledge instead of 'telling,' and avoiding one-way interactions
- Working alongside clients to negotiate and change services that better align with their unique needs,
- Engaging in building relationships, mutual learning, and cultural exchange,
- Frequent checking in to ensure that proposed speech-language pathology or audiology supports 'fit' with client's values, preferences, lifestyles, and needs, and
- Allowing the client to decide what safety means, and whether they feel safe with the services that have been provided.

Examples of working in partnership with clients include:

- Ensuring that interpreter and translating services are available for clients as necessary,
- Ensuring that the client has ample opportunities to speak on matters that affect their care,
- Inquiring with the client on who needs to be involved with decision-making and care and ensuring that all decision-makers have the opportunity to be involved in care, and
- Working in consultation with the client or community advisors to learn how to incorporate cultural protocols, values, and goals.

Positive Purpose:

- Ensuring that positive cultural options exist for the client to achieve their goals. This would involve incorporating the client's language and culture into their goals in a culturally affirming and relevant manner that does not view any differences as 'deficiencies' in need of remediation, and
- Ensuring that the clinical interaction and subsequent action plans avoid inflicting cultural harm (i.e., any action which diminishes, demeans, or disempowers the cultural identity and well-being of an individual).

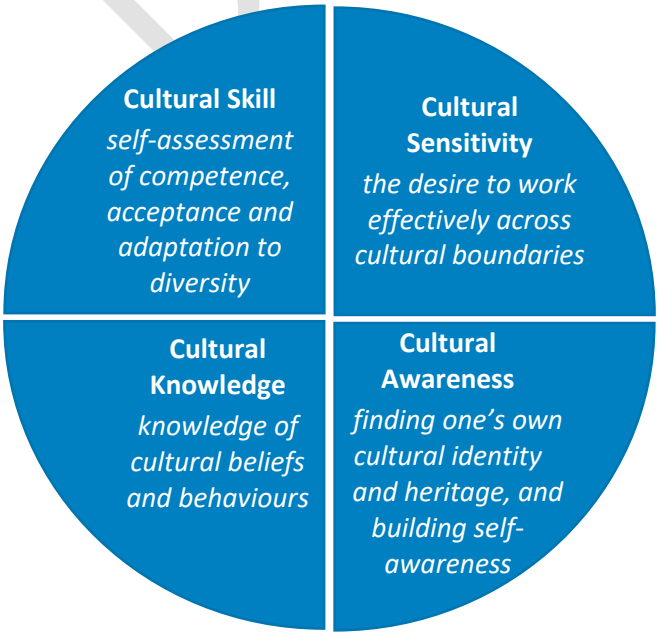
Examples of ensuring positive purpose include:

- Working to ensure that the client's development and use of their home language(s) are supported,
- Choosing meaningful words and phrases from the client's first or home language as targets in treatment,
- Including foods typically eaten in the home for clients who require modified texture diets, and
- Working with clients who wear religious head covering to ensure optimal comfort and usage of hearing aids.

Considerations Related to Cultural Competence

Cultural competence is defined as a set of behaviors, attitudes, and skills that enable professionals to work effectively in cross-cultural situations. This approach to multicultural service provision emphasizes knowledge, i.e., learning about the traits and practices of diverse groups. The assumption is that the more knowledge that the regulated member has about other cultures, the greater their competence in clinical practice, and the less likely it will be that misinterpretations and misjudgments will occur during the clinical interaction that negatively impact on the clinical relationship. Compared with cultural humility, which emphasizes a 'process', cultural competence emphasizes a 'product', i.e., specific cultural knowledge.

Cultural competence involves the following:



The Knowledge Transfer Process

The goal of any cultural competency training or education is to ensure that providers have the specialized knowledge required to serve clients whose cultural backgrounds are different from their own. This knowledge is often thought of as lists of group characteristics, which can be taught or learned, and achieved through attending workshops and presentations, self-study, etc. Although providers may 'complete' cultural competency activities for professional purposes, engaging in further learning does not predict changes in their behavior. Becoming culturally competent should be viewed as a developmental process. No matter how proficient a regulated member may become, there will always be room for growth.

Regulated members should also consider that culture is usually thought of in terms of ethnicity and race, and little attention is given to other components of culture such as gender, class, geographic location, country of origin, or sexual orientation, and how these components interact with each other to affect quality of life. Members should recognize that within group differences exist, and avoid stereotyping based on a client's culture.

It is important to acknowledge that the cultural competency learning is often presented through the dominant culture's perspective, leading to several limitations of the cultural competence model, including that:

- Culture is assumed to be possessed by the patient or client or the 'other,'
- Education about the 'other' is key to developing cultural competence,
- Mainstream white English speakers are viewed as the 'standard,' and
- Culture is considered a confounding variable that white providers must control for when they care for people of different races than themselves.

The Cultural Competence Continuum

Cross et al.'s (1989) seminal work on the cultural competence continuum provides indicators for the many ways of responding to cultural differences:

Cultural Destructiveness

- Attitudes, policies, and practices which are destructive to cultures and the individuals who identify with that culture,
- Viewing one culture as superior and one as lesser,
- Racist/discriminatory attitudes combined with power differentials that allow for disenfranchisement, control, or destruction of 'lesser' group,
- E.g., residential schools.

Cultural Incapacity

- Attitudes, policies, and practices which do not intentionally seek to be culturally destructive, but which lack the capacity to help URELM clients and communities,
- Internal attitudes are still biased, believing in the superiority of one group, and adopting paternalistic and patronizing attitudes towards the 'lesser',
- E.g., lack of access to interpreter services to clients who do not speak English, the under and over referral of URELM clients due to the use of dominant culture norms as the referent for diagnoses.

Cultural Blindness

- Expressing a philosophy of being unbiased or the belief that race or culture make no difference and that all people are the same,
- 'Helping' approaches traditionally used by dominant culture are thought to be universally applicable,
- Ignoring cultural strengths, outcomes are measured on how well URELM clients can assimilate to dominant culture,
- E.g., parent coaching on language stimulation or early intervention hearing loss strategies that are based on dominant culture expectations of parent-child interactions.

Cultural Pre-Competence

- Realizing weaknesses in services to diverse populations,
- Acknowledging culpability and responsibility when acting in a culturally biased manner,
- Attempting to improve some aspect of services to specific populations,
- Characterized by a desire to deliver quality services and a commitment to civil rights and social justice,
- E.g., engaging in training around cultural sensitivity.

Cultural Competence

Characterized by cultural knowledge that allows for:

- Acceptance and respect for diversity,
- Adjusting of interpersonal skills to allow for effective cross-cultural communication,
- Continuing self-assessment regarding culture,
- Careful attention to the dynamics of difference,
- Continuous expansion of knowledge and resources,
- Variety of adaptations to service models to meet needs of diverse populations,
- E.g., providing culturally and linguistically appropriate assessment and intervention for SLP and Audiology clients, seeking consultation from specific population groups regarding appropriate service delivery.

Cultural Proficiency

- Holding culture in high esteem,
- Adding to knowledge base by conducting research, developing new therapeutic approaches based on culture, disseminating results,
- E.g., systems wide implementation of policies and procedures that enable efficient cross-cultural care, working with community groups to develop culturally appropriate care.

Although the continuum is presented as a set of discrete steps, cultural competence is not a linear progression. The stages may overlap, and a clinician's place on the continuum is also dependent on context. For example, a clinician may be at a different stage of the continuum for each diverse cultural group they work with, based on their experience, knowledge and comfort working with each group.

The American Speech-Language-Hearing Association's Cultural Competence Checklist was designed to help clinician's develop an awareness of how they view clients from cultural/linguistic backgrounds different from their own.

Using an Integrated Anti-Racist Service Provision Framework

An anti-racist framework for service provision requires that regulated members integrate cultural humility, cultural safety, and cultural competence in their practice. By improving cultural competence, regulated members can become more familiar with the values, beliefs, and practices of population groups and individuals who come from a different culture than their own. However, this understanding cannot occur unless members are aware and reflective of their own culture.

By incorporating cultural humility (i.e., the awareness of one's social location and the bidirectionality of culture) and cultural safety (i.e., working in true partnership with the client to ensure safe and effective service delivery), regulated members are able to acknowledge and understand that culture is not fixed, and that there are considerable variations of values, beliefs, and behaviors within cultural groups themselves. This reduces stereotyping of clients during service provision. In addition, when members can acknowledge and understand their own culturally bound assumptions, beliefs, and biases, this can mitigate any unintentional othering of clients, and the assumption that the dominant culture is the 'norm' to which others are compared.

Thus, it is only through a commitment to moving through the cultural competence continuum towards competency, and practicing cultural humility and cultural safety, that regulated members are better able to provide safe, effective, and equitable care.

Culturally Responsive Practice

Integrating the principles and concepts described above allows regulated members to engage in culturally responsive practices, which are practices which take into consideration the client's cultural perspectives, beliefs, and values into every aspect of service delivery. Being culturally responsive requires members to:

- Value diversity,
- Further their knowledge of cultural perspectives that are different from their own, and
- Engage in service delivery where diversity is respected.

Practicing cultural responsiveness requires:

- Gaining an awareness of one's own cultural positioning (through practicing cultural humility and reflecting on one's social location),
- Consideration of the client's wider social, political, and historical contexts (through incorporating cultural humility),
- Working in partnership with clients to create culturally safe and inclusive therapeutic relationships and environments (through incorporating cultural safety principles), and
- Using clinical knowledge and knowledge of client's culture (cultural competence) to identify and implement culturally appropriate assessment and intervention methods, resources, and goals.

Advocacy for Equitable, Safe, and Effective Service Provision

Barriers to service accessibility and to safe, effective, and equitable care exist at both the individual and organizational levels. Organizational barriers include:

- Culturally inappropriate models of service (e.g., promoting self-sufficiency and independence in children to all families despite cultural differences in child rearing),
- Lack of adequate resources (e.g., interpreters, assessment tools in other languages),
- Lack of diversity in workforce and organizational leadership (resulting in a lack of the experiential knowledge required to design systems suited to culturally and linguistically diverse groups),
- Lack of staff training in culturally responsive or anti-racist service provision,
- Institutional racism (i.e., policies, practices and procedures of organizations that intentionally or unintentionally discriminate against certain population groups), and
- Bureaucracy (e.g., long wait times, forms, and communications available in English only, or requiring clients to travel to urban centers for services, at their own expense).

Suggestions for Regulated Members:

Addressing these barriers can and should be aimed at both the individual provider **and** organizational levels. Regulated members can become more culturally aware, sensitive, and competent (using the concepts described above) to provide safe, effective, and equitable care to individual clients. Members can also play a critical role in advocating for change and proactively challenging organizational barriers to service provision. Some examples of organizational systems that regulated members can advocate to make more equitable in their workplaces or organizations include:

- Service marketing (e.g., having informational materials available in languages other than French and English, making changes to explicitly state that service provision extends to culturally and linguistically diverse clients),
- Anti-racism and cultural responsiveness training for all staff,
- Waitlist management strategies that allow clinician to build and maintain connections while clients are waitlisted for services,
- Actively recruiting and engaging Black, Indigenous, and people of color to join the professions,
- Availability of interpreters and other language services (e.g., translation of written materials), and
- Prioritization of research topics involving equity seeking clients and communities.

True reductions in service provision inequities will only occur when barriers are addressed at the provider and organizational levels.

References

Alberta Human Rights Commission. (2018, April). *Protected areas and grounds under the Alberta Human Rights Act*. https://www.albertahumanrights.ab.ca/Documents/ProtAreasGrounds.pdf

Anti-Racism Advocacy Group for Speech-Language Pathology and Audiology. (2020). *Report on the impacts of systemic racism in the speech-language pathology and audiology professions in Quebec*. https://drive.google.com/file/d/1-8SWTjbAff7cfJEhS35a2QrmCpqYVIGl/view?fbclid=IwAR342g04LJ4uTRTymvEPXB3kNDKi0YWYY5XreiNPPKWOG7lgRNqUWd5dk0s

Ball, J. (n.d.). *Cultural safety in practice with children, families and communities*. Early Childhood Development and Intercultural Partnerships. http://www.ecdip.org/culturalsafety/

Ball, J. (2009). Supporting young Indigenous children's language development in Canada: A review of research on needs and promising practices. *Canadian Modern Language Review*, *66*(1), 19–47. https://doi.org/10.3138/cmlr.66.1.019

Ball, j. & Lewis, M. (2011). "An altogether different approach": roles of Speech-language Pathologists in supporting Indigenous children's language development. *Canadian Journal of Speech-Language Pathology and Audiology*, *35*(2), 144-158

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*(4), 293–302. https://doi.org/10.1016/S0033-3549(04)50253-4

Brewer, K. M., & Andrews, W. J. (2016). Foundations of equitable speech-language therapy for all: The Treaty of Waitangi and Māori health. *Speech, Language and Hearing*, *19*(2), 87–95. https://doi.org/10.1080/2050571X.2015.1122876

Carter, J. A., Lees, J. A., Murira, G. M., Gona, J., Neville, B. G. R., & Newton, C. R. J. C. (2005). Issues in the development of cross-cultural assessments of speech and language for children. *International Journal of Language and Communication Disorders*, *40*(4), 385–401. https://doi.org/10.1080/13682820500057301

Centeno, J. G. (2015). Assessing services with communicatively impaired bilingual adults in culturally and linguistically diverse neurorehabilitation programs. *Journal of Communication Disorders*, *58*, 58–73. https://doi.org/10.1016/j.jcomdis.2015.10.005

Cheng, L. (1990). Recognizing diversity: A need for a paradigm shift. *American Behavioral Scientist*, *34*(2), 263–278. https://doi.org/10.1177/0002764290034002014

Crago, M., & Westernoff, F. (1997). *Position paper on speech- language pathology and audiology in the multicultural, multilingual context*. https://cjslpa.ca/files/1997_JSLPA_Vol_21/No_03_145-228/Crago_Westernoff_JSLPA_1997.pdf

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care.* Georgetown University Child Development Center. https://spu.edu/~/media/academics/school-of-education/Cultural%20Diversity/Towards%20a%20Culturally%20Competent%20System%20of%20Care%20Abridged.ashx

667 Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural
668 safety rather than cultural competency is required to achieve health equity: A literature review and
669 recommended definition. *International Journal for Equity in Health*, *18*(1), 1–17.
670 https://doi.org/10.1186/s12939-019-1082-3

671 D'Souza, C., Kay-Raining Bird, E., & Deacon, H. (2012). Survey of Canadian speech-language pathology
672 service delivery to linguistically diverse clients. *Canadian Journal of Speech-Language Pathology and*
673 *Audiology*, *36*(1), 18–39. https://cjslpa.ca/files/2012_CJSLPA_Vol_36/No_01_1-87/D_Souza_Kay-
674 Raining_Bird_Deacon_CJSLPA_2012.pdf

675 Foronda, C., Baptiste, D-L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis.
676 *Journal of Transcultural Nursing, 27*(3), 210-–217. https://doi.org/10.1177/1043659615592677

677 Farrugia-Bernard, A. M. (2018). Speech-language pathologists as determiners of the human right to
678 diversity in communication for school children in the US. *International Journal of Speech-Language*
679 *Pathology*, *20*(1), 170–173. https://doi.org/10.1080/17549507.2018.1406002

680 First Nations Health Authority. (n.d.). *Creating a climate for change: Cultural safety and humility in service*
681 *delivery for First Nations and Aboriginal peoples in British Columbia.*
682 https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-
683 Booklet.pdf

684 Greene-Moton, E., & Minkler, M. (2020). Cultural competence or cultural humility? Moving beyond the
685 debate. *Health Promotion Practice*, *21*(1), 142–145. https://doi.org/10.1177/1524839919884912

686 Government of Canada. (2020, October 7). *Social determinants of health and health inequalities.*
687 https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-
688 health.html

689 Gregory, K. (2020, August 10). *Moving forward as a profession in a time of uncertainty*. ASHA Leader.
690 https://leader.pubs.asha.org/do/10.1044/leader.FMP.25082020.8/full/

691 Guiberson, M., & Atkins, J. (2012). Speech-language pathologists' preparation, practices, and perspectives
692 on serving culturally and linguistically diverse children. *Communication Disorders Quarterly*, *33*(3), 169–
693 180. https://doi.org/10.1177/1525740110384132

694 Hammond, C., Mitchell, P., & Johnson, M. (2009). Academic and clinical preparation for cultural and
695 linguistic diversity in speech-language pathology: Program director perspectives. *Contemporary Issues in*
696 *Communication Sciences and Disorders*, *36*, 63–76. https://doi.org/10.1044/cicsd_36_S_63

697 Hughes, V., Delva, S., Nkimbeng, M., Spaulding, E., Turkson-Ocran, R-A., Cudjoe, J., Ford, A., Rushton, C.,
698 D'Aoust, R., & Han, H-R. (2020). Not missing the opportunity: Strategies to promote cultural humility
699 among nursing faculty. *Journal of Professional Nursing*, *36*(1), 28-33.
700 https://doi:10.1016/j.profnurs.2019.06.005.

701 Hyter, Y. D., & Salas-Provance, M. B. (2019). *Culturally responsive practices in speech, language, and*
702 *hearing sciences*. Plural Publishing.

703 Khoza-Shangase, K., & Mophosho, M. (2018). Language and culture in speech-language and hearing
704 professions in South Africa: The dangers of a single story. *South African Journal of Communication*
705 *Disorders*, *65*(1), 1–7. https://doi.org/10.4102/sajcd.v65i1.594

Kritikos, E. P. (2003). Speech-language pathologists' beliefs about language assessment of bilingual/bicultural individuals. *American Journal of Speech-Language Pathology*, *12*(1), 73–91. https://doi.org/10.1044/1058-0360(2003/054)

Mdlalo, T., Flack, P. S., & Joubert, R. W. (2019). The cat on a hot tin roof? Critical considerations in multilingual language assessments. *South African Journal of Communication Disorders*, *66*(1), 1–7. https://doi.org/10.4102/sajcd.v66i1.610

McGibbon, E.A. & Etowa, J. B. (2009). *Anti-racist health care practice*. Canadian Scholars' Press Inc.

National Association of School Psychologists. (2019). *Position statement: Prejudice, discrimination, and racism*. https://www.nasponline.org/research-and-policy/policy-priorities/position-statements

National Collaborating Centre for Determinants of Health. (2021). *Let's talk: Community engagement for health equity*. https://nccdh.ca/images/uploads/comments/Lets-Talk-Community-Engagement-EN.pdf

Penn, C., Armstrong, E., Brewer, K., Purves, B., McAllister, M., Hersh, D., Godecke, E., Ciccone, N., & Lewis, A. (2017). Decolonizing speech-language pathology practice in acquired neurogenic disorders. *Perspectives of the ASHA Special Interest Groups*, *2*(2), 91–99. https://doi.org/10.1044/persp2.sig2.91

Privette, C. (2019, October 12). *Implicit bias in clinical practice*. The Arizona Speech-Language-Hearing Association. https://www.arsha.org/implicit-bias-in-clinical-practice/

Riquelme, L. F. (2007). The role of cultural competence in providing services to persons with dysphagia. *Topics in Geriatric Rehabilitation*, *23*(3), 228–239. https://doi.org/10.1097/01.TGR.0000284767.38172.af

Sawrikar, P., & Katz, I. (2008). Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia. *AFCR Issues*, *3*.

Statistics Canada. (2019). *Census profile: 2016 census* [data set]. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/Page.cfm?Lang=E&Geo1=PR&Code1=48&Geo2=&Code2=&Data=Count&SearchText=Alberta&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=48

Stewart, S. R., & Gonzalez, L. S. (2002). Serving a diverse population: the role of speech-language pathology professional preparation programs. *Journal of Allied Health*, *31*(4), 204–216.

Stubbe, D. E. (2020, January 24). *Practicing cultural competence and cultural humility in the care of diverse patients*. Focus. https://focus.psychiatryonline.org/doi/10.1176/appi.focus.20190041

Sufrin, J. (2019, November 5). *3 things to know: Cultural humility* [Blog post]. Hogg Foundation for Mental Health. https://hogg.utexas.edu/3-things-to-know-cultural-humility

Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand. (2012). *Code of conduct for nurses*. https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx?hkey=9fc06ae7-a853-4d10-b5fe-992cd44ba3de

Tucker, C. M., Marsiske, M., Rice, K. G., Jones, J. D., & Herman, K. C. (2011). Patient-centered culturally sensitive health care: Model testing and refinement. *Health Psychol*, *30*(3), 242-–250. https://doi.org/10.1037/a0022967

Verdon, S., McLeod, S., & Wong, S. (2015a). Reconceptualizing practice with multilingual children with speech sound disorders: People, practicalities and policy. *International Journal of Language and Communication Disorders*, *50*(1), 48–62. https://doi.org/10.1111/1460-6984.12112

Verdon, S., McLeod, S., & Wong, S. (2015b). Supporting culturally and linguistically diverse children with speech, language and communication needs: Overarching principles, individual approaches. *Journal of Communication Disorders*, *58*, 74–90. https://doi.org/10.1016/j.jcomdis.2015.10.002

Verdon Pedemont, S. (2021, March 17). *The principles of culturally responsive practice*. https://svp-slp.com/2021/03/17/the-principles-of-culturally-responsive-practice/

Waters, A., & Asbill, L. (2013, August). *Reflections on cultural humility*. American Psychological Association. https://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility

Wilbur, K., Snyder, C., Essary, A. C., Reddy, S., Will, K. K., & Mary Saxon. (2020). Developing workforce diversity in the health professions: A social justice perspective. *Health Professions Education*, *6*(2), 222–229. https://doi.org/10.1016/j.hpe.2020.01.002

Williams, C. J., & McLeod, S. (2012). Speech-language pathologists' assessment and intervention practices with multilingual children. *International Journal of Speech-Language Pathology*, *14*(3), 292–305. https://doi.org/10.3109/17549507.2011.636071

World Health Organization. (2018, February 22). *Health inequities and their causes*. https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes

World Health Organization. (2021). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

World Health Organization. (2022). *Health equity*. https://www.who.int/health-topics/health-equity#tab=tab_1

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research*, *26*(4). https://doi:10.1016/j.apnr.2013.06.008.

Glossary of Terms:

Anti-racism	Actively working against racism; making a commitment to resisting unjust laws, policies, procedures, and attitudes; examining systemic power structures that create and maintain racism; exploring and implementing mechanisms to counteract racism.
Assimilation	The process of denying and erasing the language, culture, customs, and material possessions of a group of people, forcing them to adopt the systems of the dominant group of the society in which they reside.
Biopsychosocial model	An interdisciplinary model that examines the interconnections between biological, psychological, and social factors on the health and well-being of individuals
Client	A recipient of speech, language, or audiology services, and may be an individual, family, group, community, or population. Individual clients may also be referred to as patients.
Cisgender	Denoting or relating to a person whose sense of personal identity and gender corresponds with their birth sex.
Culture	Integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.
Culturally and linguistically diverse	Individuals who are not of the dominant language and cultural background of the society in which they reside, and/or those who have multiple cultural and linguistic influences.
Cultural competence	The process in which clinicians continuously strive to achieve the ability and availability to effectively work within the cultural context of their client(s).
Cultural harm	Any action which diminishes, demeans, or disempowers the cultural identity and well-being of an individual.
Cultural humility	A process of self-reflection to understand personal and systemic biases, to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.
Cultural safety	The provision of quality care for individuals of ethnicities outside of the dominant culture/mainstream culture; and care provided within the cultural norms of the client, so that all people feel respected and safe when they interact with the health care system. Culturally safe health services are free of racism and discrimination and occur when clients are supported to draw strengths from their identity, culture, and community.
Discrimination	Denying members of a particular social group access to comparable and equitable goods, resources, and services.

Dominant culture	The group of people in society who hold the most power and are often (but not always) in the majority.
Eurocentric	Being centered on belief systems, languages, cultures, and ways of thinking that have their historical origins in Europe.
Equity	The absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation).
Equity seeking	Communities that face significant collective challenges in participating in society. This marginalization can be created by attitudinal, historic, social, and environmental barriers based on age, ethnicity, disability, economic status, gender, nationality, race, sexual orientation, transgender status, etc.
Experiential knowledge	Knowledge gained through differential history and experience with oppression in society and the ability of a group to articulate this experience in ways unique to that group.
Inequity	Systemic differences in health status of different population groups, which have significant social and economic costs both to individuals and societies.
Power	The capacity or ability to direct or influence the behavior of others or the course of events.
Racialization	The process by which socially constructed racial categories are assigned and applied in ways that mark non-white individuals as different and unequal and that lead to social, economic, and political impacts.
Racism	Prejudice, discrimination, or antagonism directed against a person or people on the basis of their membership in a particular racial or ethnic group, typically one that is a minority or marginalized, based on beliefs about one's own racial superiority, or the belief that race reflects inherent differences in attributes and capabilities.
Social determinant of health	The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.
Stereotype	An exaggerated belief, image or distorted truth about a person or group; allows for little or no individual differences or social variation.
Underrepresented racial, ethnic, and linguistic minority (URELM):	A group or community that makes up a smaller percentage than a larger subgroup with a population. In Alberta, this larger population subgroup is comprised of people who identify with the dominant culture, i.e., white, English speaking, middle class, cisgender, and Christian. This definition also encompasses groups or individuals whose representation within the SLP and Audiology professions is less than their proportion in the public.

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Schedule 1: Experiencing Discrimination or Racism in the Workplace

Black, Indigenous, and other people of color can face racism, discrimination, and bias in the workplace, which can be directed from clients, colleagues, and managers. Examples of racism and discrimination in the workplace include:

- Refusals from clients to be treated by providers of a certain race, religion, color or who have accented English,
- The questioning of backgrounds, credentials, or qualifications of racialized clinicians,
- Requesting or implementing supervision for racialized providers without evidence to support the need for supervision,
- Overt use of racist or discriminatory language, and
- Institutional policies such as barring the wearing of religious symbols in the workplace or requiring that staff use only standard English for all workplace interactions.

ACSLPA acknowledges that instances such as these can have a variety of harmful effects. Apart from being demoralizing and demeaning, experiencing racism or discrimination in the workplace can also lead to feelings of isolation, particularly if the employee is left to ignore or accommodate without the support of their employer. Having to accommodate discriminatory requests also creates complex legal and ethical issues for both the employee and employer.

In Alberta, the Alberta Human Rights (AHR) Act prohibits discrimination in employment based on a number of protected grounds, which include race, colour, ancestry, place of origin, and religious beliefs. Under the AHR Act, employers are expected to create inclusive workplaces that respect the dignity of every individual. This includes taking responsibility for:

- Removing discriminatory barriers that prevent individuals from getting a job or promotion,
- Accommodating employees who have special needs, and
- Ensuring that the work environment is free from discrimination.

Employees have the right to be accommodated based on their needs related to their protected grounds.

If you are experiencing harassment, discrimination, or racism in the workplace, ACSLPA recommends taking the following steps:

1. Keep detailed records of the discriminatory action(s) or behaviour(s). This should include the names of any witnesses.
2. Seek positive social support from family, friends, or a mental health professional. Dealing with racism or discrimination in the workplace can be stressful, frustrating, and emotionally traumatic, and making the decision to report can compound the emotional burdens faced.
   Some employers offer an employee assistance program, which provides short term, confidential counselling services for employees with difficulties that affect their work performance.
3. Discuss your experience with someone you trust (e.g., a colleague, supervisor, human resources personnel) in your organization to find out what further steps can be taken.
4. Report the action(s) to your employer according to their policy and procedure. Most larger organizations (e.g., Alberta Health Services, or school boards) have internal policies for dealing with complaints that can inform employees on how to report complaints and what the follow up procedure entails.
5. If you are dissatisfied with your employer's handling of your complaint, you can file a complaint with the Alberta Human Rights Commission, who will work with the parties to resolve the complaint.

6. Contact ACSLPA for practice advice. If you are self-employed or the actions are coming from an individual or individuals who are not under the authority of your workplace policies (e.g., a client or member of the public), ACSLPA can offer advice regarding any clinical actions that can be taken by the regulated member in these situations (e.g., extricating self from provider role).

Important Links for Further Information:

1. Alberta Human Rights Commission - Human Rights in the Workplace: https://www.albertahumanrights.ab.ca/employment/Pages/employment.aspx

2. Alberta Anti-Racism Advisory Council: https://www.alberta.ca/anti-racism-advisory-council.aspx

3. Alberta Hate Crimes Committee: https://sites.google.com/albertahatecrimes.org/ahcc/home?authuser=0

References

Alberta Human Rights Commission. (2018, April). *Protected areas and grounds under the Alberta Human Rights Act*. https://www.albertahumanrights.ab.ca/Documents/ProtAreasGrounds.pdf

Anti-Racism Advocacy Group for Speech-Language Pathology and Audiology. (2020). *Report on the impacts of systemic racism in the speech-language pathology and audiology professions in Quebec*. https://drive.google.com/file/d/1-8SWTjbAff7cfJEhS35a2QrmCpqYVIGl/view?fbclid=IwAR342g04LJ4uTRTymvEPXB3kNDKi0YWYY5XreiNPPKWOG7lgRNqUWd5dk0s

Paul-Emile, K., Smith, A. K., Lo, B., & Fernandez, A. (2016). Dealing with racist patients. *New England Journal of Medicine*, *374*(8), 708–711. https://doi.org/10.1056/nejmp150881

Rasmussen, B. M., & Garran, A. M. (2016). In the line of duty: Racism in health care. *Social Work (United States)*, *61*(2), 175–177. https://doi.org/10.1093/sw/sww006

Schedule 2: Culturally Safe and Effective Clinical Supervision of Culturally and Linguistically Diverse SLP and Audiology Support Personnel and Students

Introduction

Culturally and linguistically diverse (CLD) students and support personnel (SP) are those who are not of the dominant language and cultural background of the society in which they reside, and/or those who have multiple cultural and linguistic influences. Clinical educators and supervisors of support personnel have a responsibility to create safe and inclusive clinical learning and supervisory environments for these students and SP. These are environments where:

- Cultural and language barriers are minimized,
- The CLD student or SP is actively involved in intercultural learning opportunities,
- There is reciprocal learning during intercultural learning opportunities,
- There is minimization of ethnic stereotyping of clients, and
- There is critical reflection on prejudice and dominant culture norms in clinical practice.

A culturally responsive clinical educator or supervisor is one who acknowledges the experience of, shows interest in, demonstrates knowledge of, and expresses appreciation for the client's culture and places the client's clinical problem in a cultural context. This educator or supervisor can discuss and provide guidance on multicultural issues with students or SPs, in addition to addressing any cultural concerns, and exploring and validating the student's or SP's cultural perceptions. When intercultural learning opportunities arise, these educators and supervisors are able to reinforce the CLD student's or SP's cultural knowledge, avoid assimilative approaches, and enhance their confidence and professional identity.

Culturally Safe Supervision Strategies

Implementation of Safe Reporting Systems

CLD students or SPs may be exposed to discrimination and racism from educators, other staff, and clients. As such, they should have opportunities to express any concerns about racism and discrimination. Clear help systems should be put into place, where steps can be practically and visibly taken to address any racism or discrimination experienced.

Increase Clinical Educator or Supervisor Cultural Awareness

Clinical educators and supervisors should critically reflect on and assess their:

- Comfort and competence in working with CLD students and SP,
- Awareness of cross-cultural differences in learning behaviors and expression of professional skills like communication,
- Limitations concerning knowledge of the CLD student's or SP's culture and their willingness to learn about it from the student,
- Use of dominant culture norms as the standard with which to evaluate students or SP and promotion of CLD student or SP assimilation to dominant culture norms,
- Perceptions of student or SP expression of culturally bound learning and professional skills as a deficiency,
- Willingness to engage in reciprocal learning with CLD students and SP when intercultural learning opportunities arise,
- Awareness that the responsibility for creating safe and inclusive learning and supervisory environments lies with them, and

- Skill in allowing students or SP to retain their cultural beliefs while developing clinical proficiency during clinical learning.

Engagement in Cultural Discussions During Clinical Education

Cultural discussions are discussions that clinical educators and students or supervisors and SP can engage in around the differences and similarities between their cultural perspectives, as well as that of the client, and how these may impact clinical work. While more culturally aware students or SP may feel more comfortable with initiating these discussions, it is the responsibility of the clinical educator or supervisor to initiate these discussions. Cultural discussions should:

- Be joint discussions between clinical educators and students or supervisor and SP,
- Include reflections of personal biases, dominant culture norms, power differentials, and racism and discrimination in the historical and contemporary contexts,
- Encompass value conflicts that may arise when the student's or SP's cultural values differ from dominant culture norms, or that of the client's,
- Accommodate different worldviews, and
- Not assign inferiority status to student's, SP's, or client's culture.

Culturally Safe Assessment and Feedback

Learning behaviors are culturally bound and as such, CLD students' expression of learning behaviors may differ from those of the dominant culture, which are considered the 'norm' in education settings, including clinical learning environments. Culturally safe clinical education strategies can be implemented for CLD students, including:

- Providing regular assessment and feedback,
- Acknowledging differences in learning and teaching styles (e.g., some students may have well developed rote learning strategies, and therefore may have difficulties learning 'on the fly,' asking questions, giving peer or supervisor feedback, or undertaking reflective learning),
- Discussing and agreeing on expectations and roles at the onset of clinical placement (including feedback process, explicit supervisory expectations, evaluation methods, consequences of poor performance etc.),
- Providing sufficient orientation into the wider health or education systems that the clinical placement takes place in, as some students may be unfamiliar with the structures, routines, and policies of mainstream healthcare,
- Acknowledging that interpersonal communication norms differ cross-culturally (e.g., showing emotions, interacting in groups, being assertive, definitions of personal space). Student should not be judged on ability to conform to dominant culture interpersonal communication norms,
- Providing support for CLD students to integrate and adapt to the clinical contexts, including explicit explanations of behaviours that CLD students find confusing or challenging (cultural norms may seem arbitrary if not explained),
- Facilitating the negotiation of cultural barriers, i.e., structure teaching to incorporate CLD students' cultural beliefs, and
- Allowing students to preserve their cultural identity during clinical learning and development of their professional identity and encouraging students to function biculturally.

The Multicultural Supervision Tool can be used to elicit feedback from CLD students on the quality of multicultural supervision.

Clinical Education

Goals of Clinical Supervision

Clinical supervision plays a critical role in helping SLP, Audiology and Supportive Personnel students translate theories into clinical practice; by guiding the learning process, setting outcomes, providing time for individual and shared reflection, evaluating progress, allocating resources, providing a link between other staff members and students, and creating safe learning environments. The individualized clinical education relationship is crucial to effective clinical learning and is a significant factor in student satisfaction during clinical placements.

Clinical educators also play an important role in helping students to develop their professional identity, (i.e., the attitudes, values, knowledge, beliefs, and skills shared with others within a professional group).

Current Clinical Education Pedagogy

Although post-secondary education is often thought of as neutral and objective, it is becoming more recognized that the learning needs of CLD students have not been systematically considered in the post-secondary education context. CLD students are those who are not of the dominant language and cultural background of the society in which they reside, and/or those who have multiple cultural and linguistic influences. The lack of scientific and pedagogical diversity, combined with the lack of diversity in teaching staff, including clinical educators, can create barriers to success in clinical education for CLD students. It also creates an atmosphere where CLD students are expected to assimilate to dominant culture norms to be successful.

Traditionally, SLP and Audiology training has had little to no focus on issues of systemic marginalization for equity-seeking groups, and so the bias, discrimination, racism, and oppression that CLD students may face goes unacknowledged.

The Culturally and Linguistically Diverse Student Perspective

CLD students operate from deeply embedded and culturally defined systems of values, beliefs, and meanings about the world. As such they may have additional needs within the supervisory relationship, including the need for:

- Acknowledgement of their lived experience,
- Acknowledgement of their learning styles,
- Acknowledgement of their everyday realities, including the additional stressors that racialized students face outside of their academic life,
- Acknowledgement of the value of their experience to the professional community,
- Provision of adjustments and adaptations to assist them to achieve their potential,
- Clear definitions of the expectations of them and of their educators, and
- Provision of support in facing feelings of isolation, alienation, and uncertainty in dealing with being underrepresented in the professional environment.

Although CLD students may have experienced acculturation (i.e., the behavioral and internal changes in individuals as they experience firsthand contact with a new culture) to the dominant culture to some degree, cultural conflicts may still arise in clinical education. Cross-cultural conflicts may arise due to differences in:

- Definitions of health,
- Views of appropriate interpersonal relationships with clinical educators (e.g., some students may come from cultures where respect and good manners are demonstrated by taking a passive and silent attitude, but this may be judged as a lack of assertiveness by clinical educators),
- Values and views about appropriate communication patterns and interpersonal relationships with clients, and
- Training goals and expectations (e.g., students from systems that value interdependence may have difficulties adjusting to dominant cultural norms which value individualism and independence).

The degree of difficulty encountered during clinical education and the strength of the student-educator bond are both associated with the degree of dissimilarity between the student's culture and the dominant culture. Research has shown that when these cross-cultural boundaries exist, clinical educators and CLD students tend to view the students' background as a need, rather than a strength.

However, CLD students, given their own cultural constructs, sociocultural understandings, and having to exist biculturally within their own culture and the dominant culture of the society in which they reside, are able to apply their cultural knowledge and awareness into their clinical practice, and can be an effective resource for CLD clients. CLD students may also have an increased interest in multicultural issues in clinical practice, given the relevance to their own backgrounds.

Barriers to Safe and Effective Supervision of CLD Students

Lack of Clinical Educator, Staff, and Peer Diversity

The lack of cultural and linguistic diversity in staff and peers during clinical placements can have the following impacts on CLD students:

- Evaluation processes which may be consciously or unconsciously biased, whereby:
  - Competencies of CLD students are undervalued, and
  - Educators may judge certain skills as lacking if they deviate from dominant culture norms (e.g., professional skills like communication, assertiveness).
- Lack of appropriate mentorship opportunities,
- Supervisory relationships may be different to that afforded to white students, and
- Feelings of alienation and isolation during clinical placements.

Unwelcoming Learning Environments

CLD students may encounter unwelcoming learning environments on clinical placements which may include any or all the following:

- Lack of organizational awareness and understanding of issues faced by CLD students,
- Unfavourable clinical educator and staff attitudes (e.g., aggressive, avoidant, judgmental, hostile, unwelcoming reception to placement),
- Unfavourable client attitudes (which can be influenced by staff attitudes),
- Unfavourable peer attitudes,
- Overt racism and discrimination (e.g., offensive comments, rejection, harassment, microaggression, bullying),

- Negative stereotyping, and
- CLD students not being recognized and trusted as motivated learners, resulting in CLD students having limited learning opportunities, (i.e., not being assigned more complex tasks or clients, being limited to observation only, or being more frequently challenged and questioned than their white peers).

An unwelcoming environment can impact CLD students on clinical placements in the following ways:

- Increased risk of lower performance during clinical placement,
- Difficulties integrating into clinical learning environment,
- Feelings of being overwhelmed, confronted, disoriented, frustrated, intimidated, alienated, and isolated,
- Internalization of prejudice experienced into feelings of incompetence,
- More severe mental health concerns including burnout, depression, and anxiety, and
- Lack of a safe space in which to report or resolve concerns.

These impacts may be compounded by language barriers.

Educator Attitudes and Awareness

Clinical educators who lack cultural sensitivity, i.e., the ability to understand and embrace diversity and cultural expressions outside of the dominant culture norm in which they operate, present a significant barrier in clinical education for CLD students. While a cross-cultural supervisory relationship is not dysfunctional in itself, clinical educators who lack cultural competence skills, who experience diversity-based anxiety, and whose racial identities are not yet developed can create dysfunction and impact the CLD student in the following ways:

- Application of a 'deficiency' status to CLD students whose culturally bound expression of professional skills (e.g., communication) differs from dominant culture norms, requiring some degree of assimilation to the dominant culture norms of learning. Students in return may resist assimilation for fear of being forced to give up their cultural identities.
- Educators who do not believe issues related to prejudice, racism, and oppression are relevant to the clinical learning environment are not able to engage with these issues during clinical teaching, which affects student learning and engagement with these topics.
- CLD students may be hesitant or fearful of addressing cultural differences or perspectives due to the power dynamic of the clinical educator-student relationship. This hinders the development of the student and can result in the student feeling dissatisfied or disengaged.
- Clinical educators may feel uncomfortable giving feedback to CLD students. This may be because they fear being perceived as racist. Educators may also experience difficulties communicating with CLD students and providing instructional responses that are not patronizing, assimilationist, or demeaning for students. This impacts the quality of clinical teaching and student satisfaction with supervision.
- Clinical educators who lack cultural sensitivity may discuss cultural competence learning activities in a way that further stigmatizes CLD students and creates an unsafe learning climate. This occurs when intercultural learning activities are presented in ways which:
    - Reinforce negative stereotypes,
    - Reinforce dominant culture norms, whereby cultural differences that vary from the 'norm' are problematized or pathologized,
    - Confirm prejudices against equity-seeking groups instead of adding t intercultural awareness,
    - Do not incorporate the cultural awareness and knowledge of the CLD student, and
    - 'Others' the CLD student through the 'othering' of CLD clients

As a result, CLD students may feel a burden to provide correct information or may develop a perception of their clinical educator not being well informed, and lose confidence in the supervisory relationship and learning process.

Approaches to Clinical Education

Yoder (2001) described five patterns of teaching CLD students characterized by educator attitudes and behaviors.

Generic Pattern

- Believe that all students have the same opportunities to learn because they have physical access to learning,
- Cannot recognize that CLD students have different needs due to experience in different cultures,
- Expect that all students behave in the same way,
- Do not view cultural diversity as an important factor influencing the learning process, and
- Are not aware of issues facing CLD students both within and outside of the learning environment.

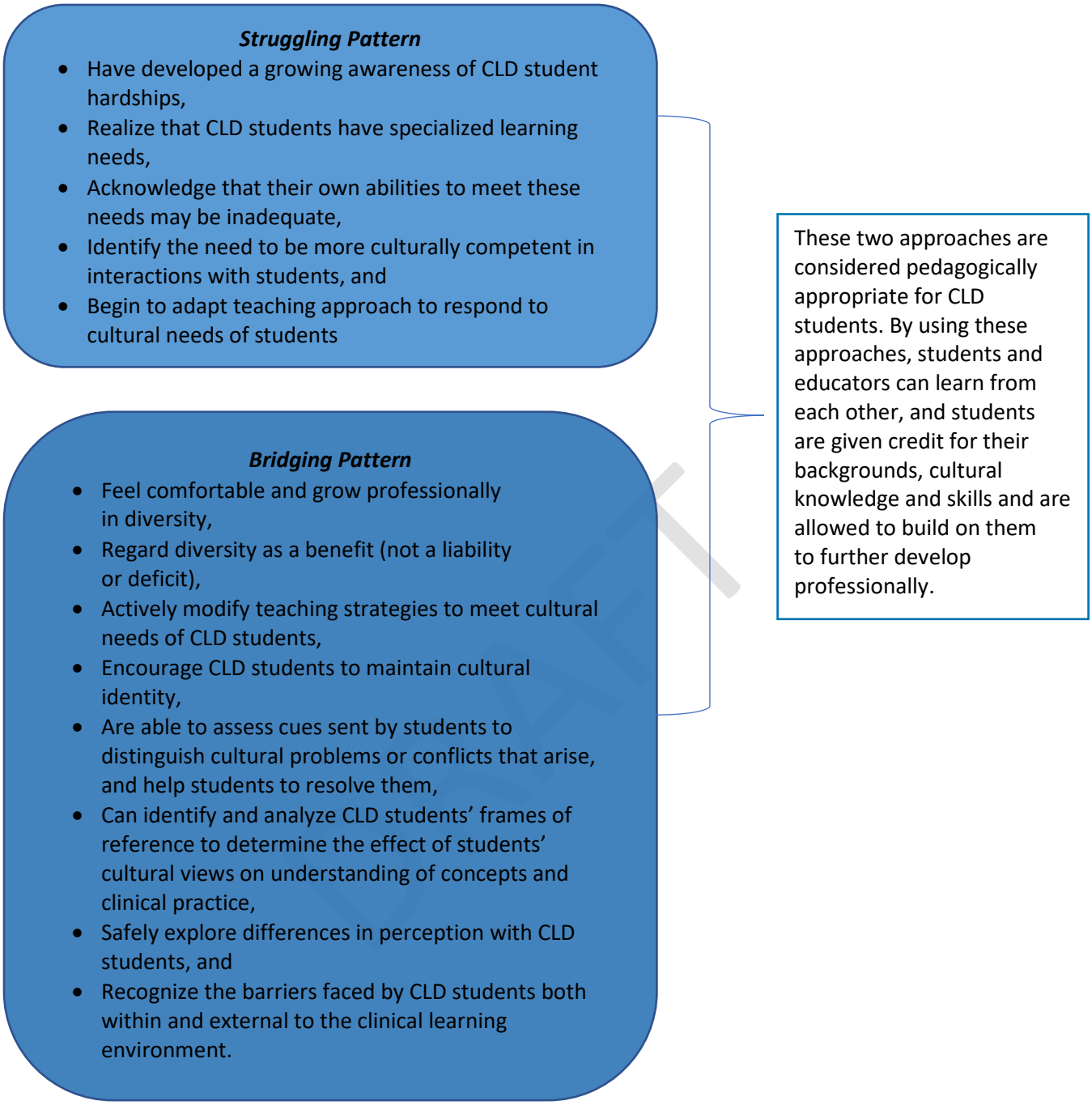
Culturally Non-Tolerant Pattern

- Are unwilling to tolerate cultural differences, and
- At times, display frustration and hostility towards cultural differences.

Mainstreaming Pattern

- Have some awareness of the different needs of CLD students, and
- Rationalize these needs as deficiencies to be remediated to be brought to level of mainstream peers

These three approaches provide little accommodation for CLD students, even when there is some awareness of their needs, and often result in negative consequences for these students. These deficits-based approaches view difficulties as arising solely from the student, place the onus of remediation on the student, and overlook the role of the clinical educator in facilitating learning. They give rise to assimilative practices, which aim to enculturate CLD students into the values, beliefs, and practices of the dominant culture.



Summary

The supervision and learning needs of CLD students has not been systematically or traditionally considered in the clinical education of SLP or Audiology students. There are, however, a number of barriers to culturally safe and effective clinical supervision. SLP or Audiology clinical educators should use pedagogically appropriate supervision techniques to ensure that CLD students have satisfactory and effective learning opportunities during clinical intern and externships.

References

Abu-Arab, A., & Parry, A. (2015). Supervising culturally and linguistically diverse (CALD) nursing students: A challenge for clinical educators. *Nurse Education in Practice*, *15*(4), e1–e9. https://doi.org/10.1016/j.nepr.2015.02.006

Anti-Racism Advocacy Group for Speech-Language Pathology and Audiology. (2020). *Report on the impacts of systemic racism in the speech-language pathology and audiology professions in Quebec*. https://drive.google.com/file/d/1-8SWTjbAff7cfJEhS35a2QrmCpqYVIGl/view?fbclid=IwAR342g04LJ4uTRTymvEPXB3kNDKi0YWYY5XreiNPPKWOG7lgRNqUWd5dk0s

ClinEdAus (2021). *Supporting students' cultural and linguistic diversity.* https://www.clinedaus.org.au/topics-category/supporting-students-cultural-and-linguistic-188#Supportingstudentscultural

Howells, S., Barton, G., & Westerveld, M. (2016). Exploring the development of cultural awareness amongst post-graduate speech-language pathology students. *International Journal of Speech-Language Pathology*, *18*(3), 259–271. https://doi.org/10.3109/17549507.2016.1154982

Korhonen, H., Tuomikoski, A-M., Oikarainen, A., Kaariainen, M., Elo, S., Kyngas, H., Liikanen, E., & Mikkonen, K. (2019). Culturally and linguistically diverse students' experiences of the clinical learning environment and mentoring: A qualitative study. *Nurse Education in Practice, 41*. https://doi.org/10.1016/j.nepr.2019.102637

Leyerzapf, H., & Abma, T. (2017). Cultural minority students' experiences with intercultural competency in medical education. *Medical Education*, *51*(5), 521–530. https://doi.org/10.1111/medu.13302

Mikkonen, K., Elo, S., Kulvila, H-M., Tuomikoski, A-M., & Kaariainen, M. (2016). Culturally and linguistically diverse healthcare students' experiences of learning in a clinical environment: A systematic review of qualitative studies. *International Journal of Nursing Studies, 54*, 173–187. https://doi.org/10.1016/j.ijnurstu.2015.06.004

Mori, Y., Inman, A. G., & Caskie, G. I. L. (2009). Supervising international students: Relationship between acculturation, supervisor multicultural competence, cultural discussions, and supervision satisfaction. *Training and Education in Professional Psychology*, *3*(1), 10–18. https://doi.org/10.1037/a0013072

Nilsson, J. E., & Anderson, M. Z. (2004). Supervising international students: The role of acculturation, role ambiguity, and multicultural discussions. *Professional Psychology: Research and Practice*, *35*(3), 306–312. https://doi.org/10.1037/0735-7028.35.3.306

O'Reilly, S. L., & Milner, J. (2015). Supporting culturally and linguistically diverse students during clinical placement: Strategies from both sides of the table Approaches to teaching and learning. *BMC Medical Education*, *15*(1), 1–12. https://doi.org/10.1186/s12909-015-0458-3

Thomas, K. M., Willis, L. A., & Davis, J. (2007). Mentoring minority graduate students: issues and strategies for institutions, faculty, and students. *Equal Opportunities International*, *26*(3), 178–192. https://doi.org/10.1108/02610150710735471

Yoder, M. K. (2001). The bridging approach: Effective strategies for teaching ethnically diverse nursing students. *Journal of Transcultural Nursing, 12*(4), 319–325.