Current Practices of Speech-Language Pathologists Serving Culturally and Linguistically Diverse Adults with Communication Disorders in Alberta

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SLP Practices for CALD Clients

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Abstract

Speech-language pathologists (SLPs) provide language-based services which makes working with culturally and linguistically diverse (CALD) clients uniquely challenging. Alberta is becoming increasingly diverse, but little is known about the ways in which Albertan SLPs are currently serving their CALD adult clients. SLPs working with adult clients in Alberta were invited to complete a survey exploring their experiences with CALD service delivery. A mixture of qualitative and quantitative data was gathered. Results indicate that graduate and professional development/continuing education training inadequately prepares SLPs to work with CALD clients. Formal interpreters are rarely used, possibly because they can be difficult to access. Informal interpreters are used more frequently. Participants reported lacking the knowledge, confidence, and resources to effectively serve their CALD clients. More than 70% of participants support increased education and advocacy surrounding CALD service delivery. Future research may expand upon the findings from this study by surveying SLPs across the country.

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Alberta is becoming increasingly diverse, with many different cultural groups migrating to the province. Many of these individuals are culturally and linguistically diverse (CALD), meaning that they speak more than one language or identify with more than one cultural group (Siyambalapitiya & Davidson, 2015). At some points in their lives, CALD adults may require the services of a speech-language pathologist (SLP). Because SLPs provide language-based services, working with clients who speak a language other than English, or who have limited English proficiency, poses unique challenges.

Although there are a number of other terms to describe culturally and linguistically diverse populations that are often used interchangeably, the term “CALD” was chosen for this project. Unlike some other terms, such as English as a Second Language (ESL), CALD does not assume that English is the second language that a person speaks, because many CALD individuals speak multiple languages. The term “CALD” also considers cultural diversity as well as linguistic diversity, making it a broader and more inclusive term.

According to the 2011 Canadian Census, 19.4% of individuals in Alberta reported only speaking a non-official language and an even greater number reported speaking a non-official language in addition to English. Alberta’s population increased by 10.8% between 2006 and 2011 (Statistics Canada, 2011) and will likely continue to increase in the future. Major cultural groups in Alberta include individuals who have immigrated from Asia, the Middle East, Europe, Southeast Asia, and Eastern Asia (Statistics Canada, 2006). The most commonly spoken languages, other than English, are German, Tagalog, Punjabi, Chinese, and Spanish (Statistics

Canada, 2011). With more than one fifth of Alberta's population being CALD, it is important that SLPs have the tools necessary to provide optimal care for these clients.

LITERATURE REVIEW

Service Delivery

Providing services to members of diverse cultural and linguistic groups require specific considerations. A client's use of a minority language can make identification and treatment of communication disorders very difficult for clinicians who do not speak the minority language. Distinguishing between linguistic differences and pathological features of communication can be challenging due to the fact that norms for voice quality, prosody, phonology, morphology, syntax, and semantics vary across languages. What may be considered pathological in one language may be within normal limits in another (ASHA, 2015), and a clinician's unfamiliarity with a client's language could lead to misdiagnosis of communication disorders.

Both the American Speech-Language-Hearing Association (ASHA) and Speech-Language & Audiology Canada (SAC) have provided guidelines for professionals working with CALD clients (ASHA, 1985; Crago & Westernoff, 1997). ASHA's suggestions for optimal care include providing services in the client's first language, using criterion-referenced assessment procedures rather than norm-referenced tools, modifying standardized assessments to meet the client's needs, and collaborating with interpreters to provide services when the clinician is not proficient in the CALD client's language (1985). SAC's guidelines are similar, stating that appropriate assessment should consider all of a client's languages, be culturally and linguistically appropriate, and include descriptive non-standardized assessments and assessment reports (Crago &

Westernoff, 2011). SAC's guidelines for intervention include offering services in a client's native language when appropriate, which may require collaboration with interpreters. In addition, SAC suggests that intervention materials, strategies, procedures, and interpersonal contexts should be culturally adapted (Crago & Westernoff, 2011). Recommendations also exist regarding SLP services to specific cultural groups, including the Asian (Sung, 2014), South Asian (Faroqi-Shah, 2012), Middle Eastern (Al-Amawi, Ferguson, & Hewat, 2009), and Aboriginal communities (Kay-Raining Bird, 2014). Some recommendations include incorporating cultural knowledge into practice (Sung, 2014), exploring levels of acculturation (Faroqi-Shah, 2012), and consulting with community members who may act as cultural informants (Kay-Raining Bird, 2014). All of these recommendations demonstrate the need for special considerations when serving these populations.

Although there are many recommendations for SLPs working with CALD clients, many issues may arise when these recommendations are put into practice. For example, ASHA (1985) recommends modifying standardized assessments for use with CALD clients; however, this invalidates the use of normative information. Furthermore, although it would be ideal for SLPs to provide services in every client's dominant language, this is not realistic due to the limited number of bilingual SLPs (Sung, 2014) and the vast diversity of languages represented in the population. Despite the existence of recommendations and guidelines regarding service delivery for CALD clients, it is unclear the extent to which these recommendations are being put into practice by SLPs working in Alberta.

Interpreters

When SLPs are unable to practice in a client's native language, formal or informal interpreters can provide support by aiding in assessment, administering activities, and transcribing responses in the client's native language (ASHA, 2016). *Formal* interpreters are individuals who have been professionally trained to translate oral communication or manual communication systems from one language to another (ASHA, 2004). *Informal* interpreters are individuals who have knowledge of the client's language, but are not professionally trained in interpretation. Informal interpreters may be bilingual professionals from other disciplines, family members, friends, or others who are proficient in the client's language. Ideally, formal interpreters would be utilized most frequently. Unfortunately, access to trained, professional interpreters is limited (Wafula & Snipes, 2014) and may vary by geographic area and work setting. Informal interpreters may be used to fill in the gaps when formal interpreters are unavailable, which may result in negative clinical consequences (Sung, 2014), such as confidentiality issues, lower patient satisfaction, inaccurate information, and misdiagnosis (Jacobs et al, 2001).

Cultural Competence

Even when interpreters are available, it is important that SLPs themselves be culturally competent. Cultural competence is the ability to work effectively in cross-cultural situations and provide effective services to clients regardless of their cultural and/or linguistic status (ASHA, 2013). An individual's cultural identity may include elements such as race, ethnicity, language, religion, and values, among others (ASHA, 2004). Culture and language can influence the ways clients and clinicians approach clinical interactions. Some materials may not be

appropriate for certain cultural groups. For example, standardized tests may contain stimulus pictures of items that are not found in a client's culture, putting the results of the assessment into question. Furthermore, the clinician-client relationship may be affected by culture and identity in various ways (e.g., a male client feel may feel uncomfortable receiving services from a female clinician). If clinicians are culturally competent, they will be able to better navigate these cultural differences in order to provide effective service to clients of various cultural backgrounds.

Purpose

Although ASHA and SAC have released best-practice guidelines regarding services for CALD clients, little research has examined the extent to which these guidelines are being followed by clinicians in the field. To our knowledge, no research has explored the ways SLPs in Alberta have been serving their CALD clients. The purpose of this study was to examine the challenges SLPs face in serving CALD clients in Alberta, resources SLPs draw upon to assist with service delivery (e.g., use of interpreters), and possible discrepancies in resource availability between urban and rural settings. Topics of interest include working with interpreters, CALD caseload demographics, currently available resources, and geographic limitations. Information gathered from this study may be used in the creation of an online resource package to address areas of need in order to support appropriate service delivery for CALD clients.

METHODS

Survey

An online survey was distributed to SLPs in Alberta through the Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA) newsletter and email distribution lists targeting SLPs serving CALD adults. A two-month period was provided for participants to respond to the survey questions. Informed consent was assumed by the participants clicking on the link to start the survey.

The survey was organized according to the following sections: participant demographics (e.g., languages spoken, work setting, geographic location, years of experience), current caseload, training, and experiences with CALD service delivery. Questions regarding training explored graduate-level, professional development, and self-directed learning about CALD service delivery. Questions regarding experiences working with CALD clients explored current practices, perceived barriers to effective service delivery, and recommendations for improved quality of care. Question formats included short answer, multiple choice, and yes/no questions. A link to the survey is provided in Appendix A.

Survey questions were developed based on key themes from the literature regarding CALD service delivery. A pilot of the survey was completed with a small sample of SLPs prior to being disseminated more widely.

Participants

The desired sample size was set to a minimum of 50 respondents. Since ACSLPA estimates that 150 SLPs in Alberta work with adult clients (2014), it was decided that a 33.3% response rate would provide a representative overview of current practices in the province.

Focus Groups and Interviews

Survey participants were invited to participate in focus groups as an opportunity to expand upon some of the issues introduced in the survey. Focus groups were conducted via face-to-face meetings, telehealth, or video conferencing and included a total of eight SLPs from various regions and practice settings across Alberta. Focus group data will be analyzed as part of a future project.

RESULTS

A total of 31 responses to the survey were recorded. The first five responses were from an earlier version of the survey piloted during the trial period (after which the survey was altered based on feedback from these respondents) and were omitted from data analysis. Therefore, 26 participant responses were included in the final analyses.

Demographics

Work setting. The majority (61.5%) of participants reported working in rehabilitation settings with 34.6% of participants working in multiple settings. See Figure 1 for work settings reported by survey participants. The 'other' category included the university setting and home care.

Figure 1. Work setting reported by survey participants.

Geographic location. Survey respondents were primarily located in the urban centers of Edmonton and Calgary (57.7% from Edmonton, 34.6% from Calgary). Only two participants (7.7%) reported working in rural settings, including Vegreville and Thorhild.

Years of experience. Participants varied in their level of experience and represented a range from less than one year to 35 years of experience. See Figure 2 for participants' reported years of experience working as a SLP.

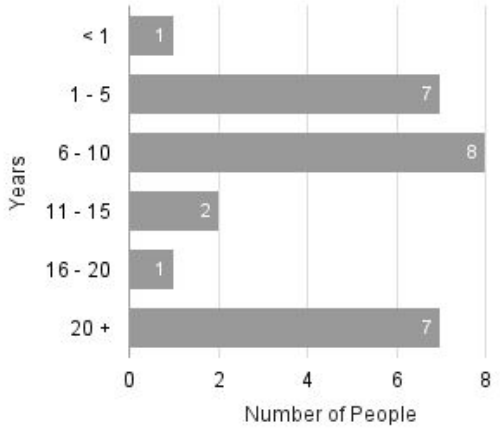

Figure 2. Years of experience working as a speech-language pathologist (SLP)

SLP graduate education. The majority of participants (77%) received their SLP graduate training in Canada, at the University of Alberta in particular (57%). See Figure 3 for participants' SLP graduate education by geographic location.

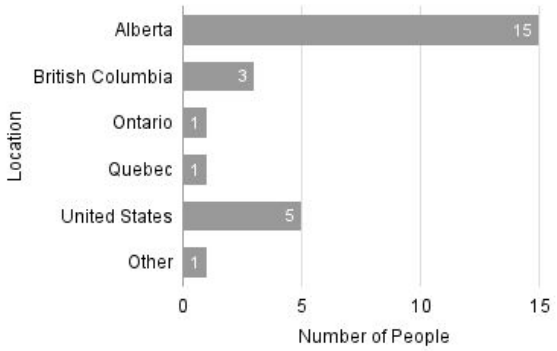

Figure 3. SLP graduate education by geographic location.

Languages spoken. Half of the participants (13) reported speaking a language other than English. Eight participants reported speaking more than one other language. Eleven participants spoke French and two participants spoke Spanish. Participants also reported speaking a number of other languages, such as Dutch, German, Greek, Italian, Malayalam, and

Portuguese. In general, participants rated themselves as beginner to intermediate proficiency in languages other than English. Two participants reported native proficiency. See Appendix B for details. Four participants indicated that they would feel confident practicing in a language other than English (two speakers with native proficiency, one speaker with advanced proficiency, and one speaker with intermediate proficiency).

Background & Training

Graduate training. Seventeen participants (65.4%) had not received training on CALD service delivery during their graduate education (via coursework or clinical practicum experiences); nine participants (34.6 %) reported that they did receive training. Participants who had received training on CALD service delivery during their graduate education were asked to describe this training. Since each participant could report having had multiple training experiences, total numbers of training experiences are greater than nine. Eight participants described their training as consisting of portions of lectures or entire lectures. These lectures were further described as covering topics such as specific populations (e.g., Spanish or French speakers) or general ESL assessment. One participant reported receiving an entire course on CALD service delivery and another participant attended conference presentations on CALD service delivery. Two participants had internship or observation experiences (graduates of McGill University and the University of British Columbia).

Participants who had received training on CALD service delivery during their graduate education were asked to rate their agreement with the statement, “I received adequate training on CALD service delivery during my graduate education.” Two participants (22.2%) either agreed or strongly agreed with the statement. Seven participants (77.7%) either felt

neutral or disagreed with the statement. Those who agreed with the statement reported that their training gave them a good understanding of resources to aid in CALD service delivery. Those who disagreed reported several reasons; some felt the topic deserved more academic focus and should be learned about in practice as well as in school. Others mentioned that more cultural sensitivity training and information on different cultural groups would have been beneficial. Some participants felt that not enough information was provided on norms, treatment outcomes, and the SLP's role. Some also stated that not enough experience was received during internships and that the focus was more on assessment than on treatment.

Professional development/continuing education. Only seven participants (26.9%) reported having received professional development/continuing education training in CALD service delivery for adult clients since graduating from their SLP training program. Five participants described their training as consisting of lectures. These lectures were described as seminars, courses, lectures provided by other disciplines (e.g., social work), and lectures provided at ACSLPA. One participant reported having received accent modification training, and one participant received the Certificate in Francophone Practice for SLPs offered through the University of Alberta.

Participants who had received professional development/continuing education on CALD service delivery were asked to rate their agreement with the statement, "I received adequate training on CALD service delivery during my professional development/continuing education experiences." Two participants (28.6%) either agreed or strongly agreed with this statement. Five participants (71.4%) either disagreed with the statement or felt neutral. Those who agreed or strongly agreed with the statement reported that their training had a heavy pediatrics focus

and focused too much on a single cultural group. Those who disagreed with the statement or felt neutral reported that there were too few professional development/continuing education opportunities and that the training they received did not focus enough on language.

Self-directed learning. Eleven participants (42.3%) reported that they do not engage in self-directed learning about CALD service delivery for adult clients; fifteen participants (57.7%) reported that they do. See Figure 4 for sources of information used in self-directed learning. The "other" category included non-SLP colleagues, Alberta Health Services support personnel, family members of clients, journal articles, and in-services.

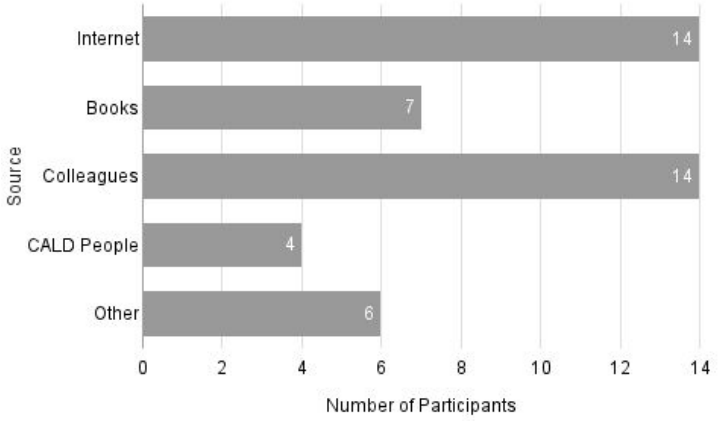

Figure 4. Sources of information used in self-directed learning.

Confidence in CALD service delivery. Participants were asked to rate their agreement with the statement, "I have a good understanding of best practices regarding CALD service delivery." Six participants (23.1%) agreed with the statement; no participants strongly agreed. Ten participants (38.5%) felt neutral about the statement, and ten participants (38.5%) either disagreed (26.9%) or strongly disagreed (11.5%).

Participants were asked to rate their agreement with the statement, "I feel confident in my ability to distinguish between a language difference and a language disorder." Sixteen

participants (61.6%) either agreed or strongly agreed with this statement. Seven participants (26.9%) felt neutral, and three participants (11.5%) disagreed.

Current Caseload

Participants reported that CALD clients comprise between 0% to 50% of their current caseloads (Figure 5). CALD caseloads consist of a variety of different cultural and linguistic groups with the top four being Tagalog (Filipino), Cantonese, Chinese (not otherwise specified), and Punjabi. See Figure 6 for the most common cultural and linguistic groups represented on participants' current caseloads.

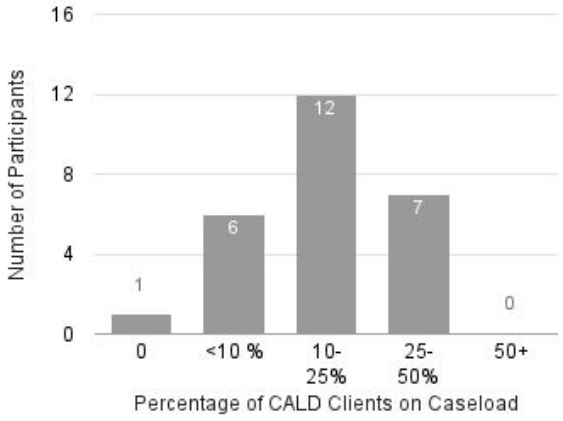

Figure 5. The proportion of CALD clients on current caseloads.

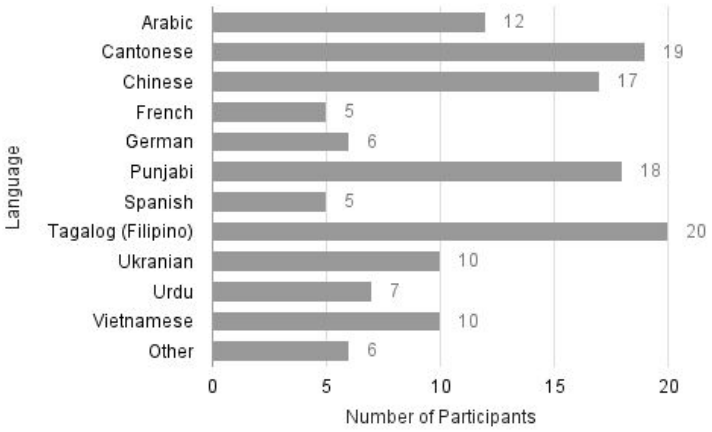

Figure 6. The most common cultural and linguistic groups on current caseloads.

Safety Issues

Eleven participants (44%) have encountered patient safety issues directly related to CALD issues or barriers including: adherence to dietary restrictions, mobility, transfers, and access to basic needs. Many of these safety issues were due to clients' and family members' lack of understanding regarding safety recommendations.

Formal Interpreters

Participants were asked how frequently they work with formal interpreters and selected between five choices (Figure 7). Participants were also asked to rate their agreement with the statements “I have access to formal interpreters whenever I need them” (Figure 8) and “I feel comfortable working with formal interpreters” (Figure 9) on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree).

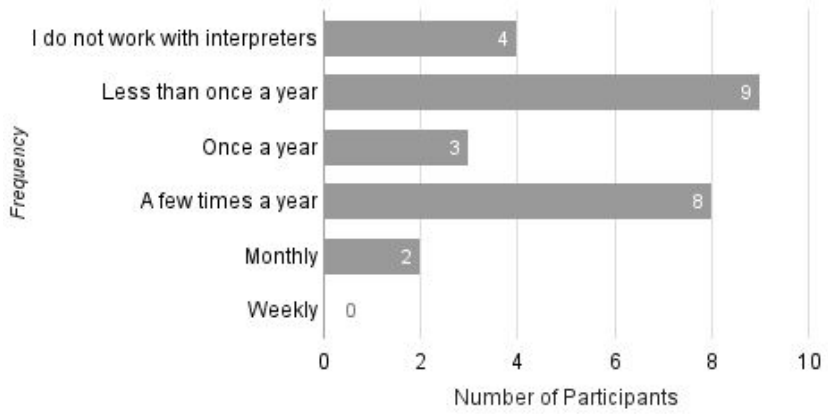

Figure 7. Frequency with which participants work with formal interpreters.

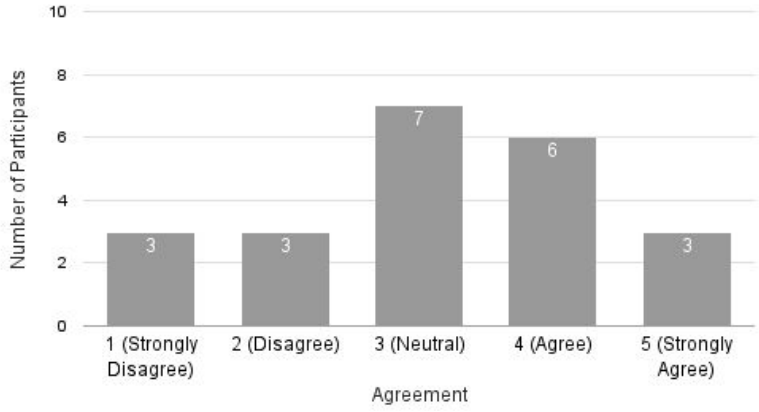

Figure 8. Participant agreement with the statement, “I have access to formal interpreters whenever I need them.”

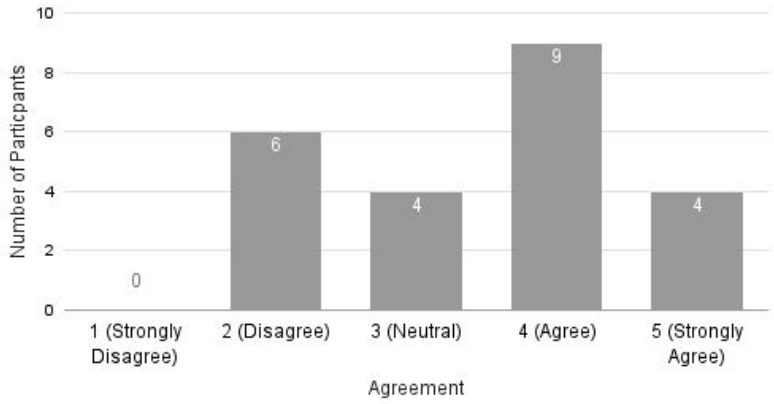

Figure 9. Participant agreement with the statement, "I feel comfortable working with formal interpreters."

Participants were asked what types of information they provide to formal interpreters before beginning assessment. Most participants reported providing an overview of aphasia, the client's communication abilities, and needs. Many SLPs reported providing information on the assessment process and expectations about the importance of translating everything verbatim and to avoid cueing. Two participants reported giving very little information to formal interpreters due to time constraints in a hospital setting and lack of requests for information from formal interpreters. Another participant reported that they provide basic social and medical history.

Participants were also asked to rate their agreement with the statement, "The formal interpreters I have worked with are knowledgeable about the field of speech-language pathology." Most participants were either neutral (31.8%) or disagreed (36.3%) with this statement (Figure 10). When asked about formal interpreters' knowledge of communication disorders caused by stroke/brain injury, no participants reported that interpreters had advanced knowledge.

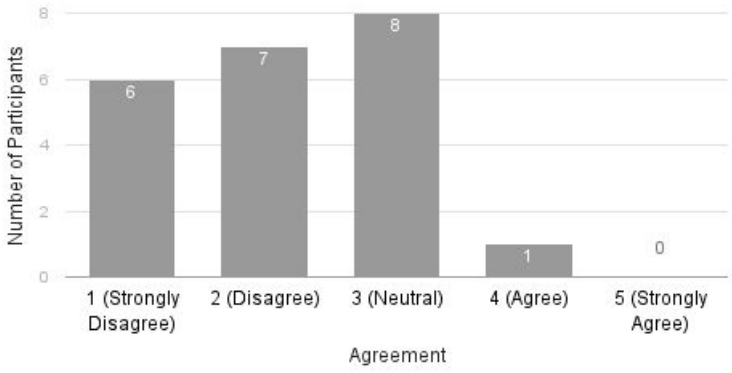

Figure 10. Participant agreement with the statement, "The formal interpreters I have worked with are knowledgeable about the field of speech-language pathology."

Twenty-two participants responded to a question indicating the purposes for which they used formal interpreters. Formal interpreters were most commonly used for "assessment" (100%) and "client education" (86.3%) (Figure 11).

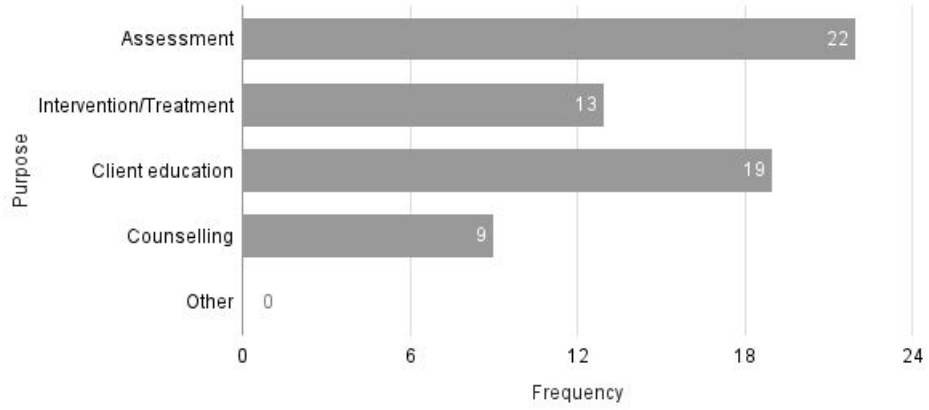

Figure 11. Purposes for which participants have used informal interpreters.

Informal Interpreters

Participants were asked to describe how frequently they work with informal interpreters. See Figure 12 for details. The "monthly" option had the largest number of respondents, with eight participants (30.8%) indicating that they work with informal interpreters on a monthly basis.

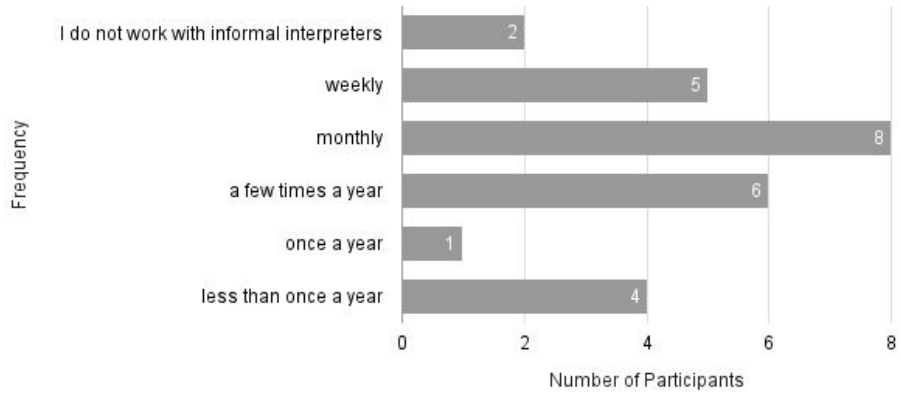

Figure 12. Frequency of informal interpreter use by number of participants

Participants were then asked to rate their agreement with the statement, "I feel comfortable working with informal interpreters." The most common rating was 3 (neutral), followed by 5 (strongly agree) (Figure 13).

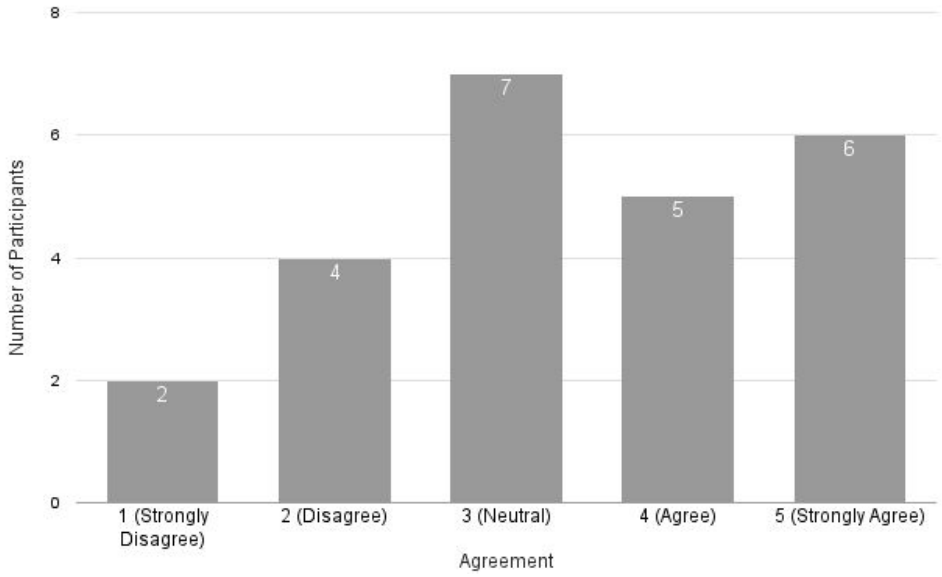

Figure 13. Participants' agreement with the statement, "I feel comfortable working with informal interpreters."

Participants were asked to describe what types of information they provide to informal interpreters prior to client assessment. Many participants reported providing the same

information to informal and formal interpreters (e.g., interpret verbatim and adhere to standardization protocol). One participant noted that they instruct informal interpreters to interpret in a culturally-relevant manner (e.g., changing information to fit the cultural norms of the client). Other participants provide general information about assessment, the goals of assessment tasks, and treatment. Some participants also stated that they find informal interpreters more useful for treatment than assessment, since they can be taught helpful strategies to use with the client. Two participants stated that they do not provide any information to informal interpreters prior to client assessment; one of these participants noted that they felt unsure about confidentiality issues. Another participant stated that they do not use informal interpreters for assessment purposes due to concerns about assessment validity.

A subsequent question asked participants to indicate purposes for which they have used informal interpreters. The largest group of participants indicated that they use informal interpreters for “client education;” following that, “assessment” then “treatment” were the most common purposes (Figure 14). Fewer participants stated that they use informal interpreters for counselling purposes. One participant, who selected “other,” noted that they use informal interpreters for carryover into the home environment.

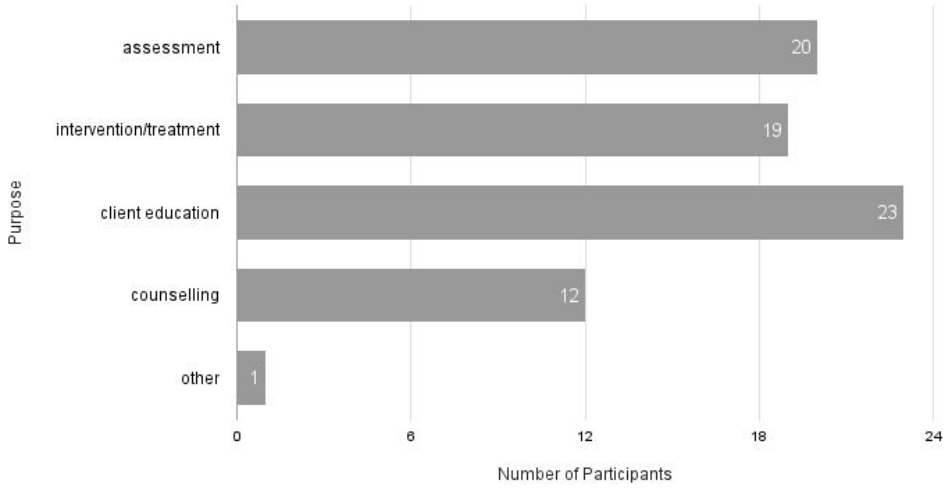

Figure 14. Purposes for which participants have used informal interpreters.

CALD Assessment

Participants were asked to indicate the formal assessments they use with CALD clients. Four tests were provided as choices including the *Aachen Aphasia test*, *Bilingual Aphasia*, *Boston Diagnostic Aphasia Examination (BDAE)*, and the *Multilingual Aphasia Examination*. The *BDAE* was one of the most popular choices (10 participants). Ten participants reported using other tests including the *Western Aphasia Battery (WAB)*, *Functional Assessment of Verbal Reasoning and Executive Strategies (FAVRES)*, *Boston Naming Test (BNT)*, *Scales of Cognitive and Communicative Ability for Neurorehabilitation* (*SCCAN)*, *Canadian Occupational Performance Measure (COPM)*, the *Lee Silverman Voice Treatment (LSVT) assessment*, *Ross Information Processing Assessment (RIPA)*, the *Robertson Dysarthria profile*, and informal language probes (Figure 15).

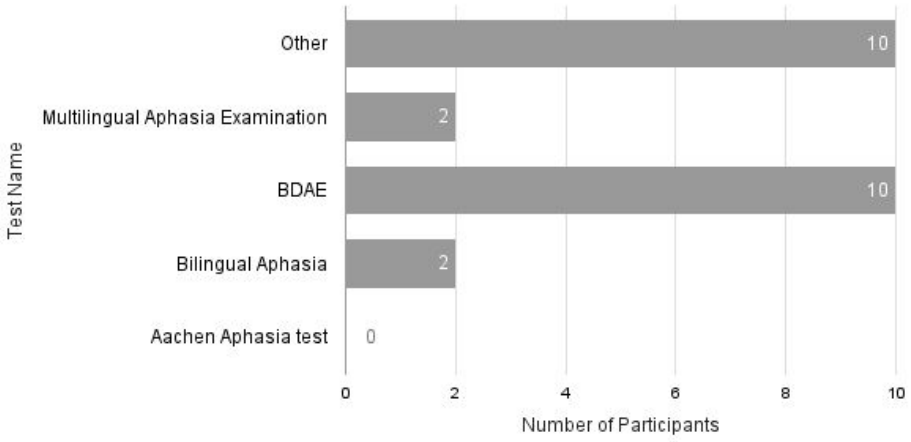

Figure 15. Formal assessments used with CALD clients.

Participants were asked, “Have you ever experienced a conflict arising from differences between your belief system and that of your clients?” Nineteen participants (73.1%) reported having had experienced some conflict while seven participants (26.9%) have not.

Participants were then asked to elaborate on the top three issues with providing services to CALD clients. Common themes included: poor carryover to the home, lack of resources, lack of confidence in assessment, lack of confidence in therapy delivery, interpretation/translation issues, working with different family dynamics, cultural differences, interpreter knowledge, access to interpreters and healthcare providers lacking knowledge (See Table 1 in Appendix D). Next, participants were asked what supports would improve services to their CALD clients. Responses included: having more multilingual resources and discharge resources, more training of SLPs in CALD practices, increasing ease of access to interpreters, multilingual SLPs, interpreter training and finally documentation guidelines (See Table 2 in Appendix D).

Recommendations

Participants were asked to rate their level of agreement with statements regarding recommendations for improved services for adult CALD clients. Agreement was indicated on a 5-point Likert scale from strongly disagree to strongly agree. More than 70% of participants either agreed or strongly agreed with the following statements: SLP graduate education programs should include training on using formal interpreters for service delivery; employers/facilities should provide training on using interpreters for service delivery; formal interpreters should receive additional training related to the field of speech-language pathology; SLPs should advocate for increased services and supports for CALD clients where there is no or limited access. See Appendix C for details on participant responses to agreement statements regarding recommendations.

DISCUSSION

The purpose of this study is to better understand the unique challenges for Albertan SLPs working with CALD clients since little is known about current service delivery for this population. Respondents identified several areas including inadequate training for working with CALD clients, use of formal interpreters, and issues impacting CALD service delivery, such as lack of resources and translation challenges, which will be discussed in further detail.

Training

Results indicate that training on CALD service delivery is relatively uncommon and sub-optimal where it exists. Most participants did not receive training on CALD service delivery

during their graduate education, and those that did tended to find it inadequate. These results are particularly alarming given that only a little more than a quarter of participants received professional development/continuing education training, and less than a third of those participants found this training adequate. These results suggest that SLPs whose graduate training inadequately prepares them to work with CALD clients have little opportunity to receive this training later. This may partially explain why so many participants engage in self-directed learning regarding CALD service delivery; if few formal training opportunities exist, self-directed learning may be the only way for SLPs to become better educated on CALD service delivery. This may also explain why less than a quarter of participants reported having a good understanding of best practices in the area of CALD service delivery.

Interpreters

Survey participants indicated they have used formal and informal interpreters for the same purposes. This is surprising given that both types of interpreters have different skills: formal interpreters are more likely to provide accurate interpretations (which has implications for assessment validity) and informal interpreters may be better suited to help with client-clinician rapport (which has particular implications for counselling and intervention).

Although formal interpreters are professionally trained in interpretation, survey participants did not prefer them to informal interpreters. Contrary to ASHA guidelines, the majority of participants reported working with formal interpreters once a year or less, whereas the majority of participants reported working with informal interpreters once a year or more. This may be partially explained by the fact that the formal interpreters participants have worked with are not knowledgeable about speech-language pathology and communication

disorders. Furthermore, preliminary focus group data suggests that many formal interpreter services are offered over the phone. Participants generally found over-the-phone interpretation unsuitable for their needs. Another explanation is that the nature of informal interpreters (such as being known to the client and improving carryover into the home) makes them more appealing than formal interpreters. In a field like speech-language pathology the ongoing client-clinician relationship is prioritized, it may be more important to have an interpreter who can strengthen that relationship rather than an interpreter who can accurately translate medical terminology.

Participants report similar levels of comfort working with informal and formal interpreters, despite working with informal interpreters more frequently. This provides support to the notion that participants' low rates of formal interpreter use are due to choice rather than necessity.

CALD Service Delivery

Lack of resources was the most common issue among SLPs working with CALD clients. This included time, supplies, discharge options, assessment tools, institutional limitations, and materials. Many SLPs expressed that they engaged in ongoing self-directed learning, so the creation of an online resource package with suggestions for multilingual supplies and materials may benefit many SLPs working with CALD clients if such materials are not available at their institution. Other comments such as time and institutional limitations also highlighted common challenges working with this population. These are harder to address, especially in settings like acute care. Both ASHA and SAC have released best-practice guidelines; however, further

investigation on how best to address these challenges and possible comparisons with other institutions is needed.

The next most common issue surrounding CALD service delivery was interpretation/translation issues. More specifically, SLPs reported that telephone delivery and interpretation using family members because of family dynamics were difficult. Future studies can look at factors that can facilitate the translation process. Also, a few SLPs identified in-person delivery and access to multilingual SLPs as possible supports to provide better care to CALD clients. Although most participants believed that they had access to interpreters at their workplace, when asked to provide the top issues when working with CALD clients, SLPs identified that there was a lack of access to interpreters. Further research may explore this contradictory finding. Perhaps interpreters in general are easily accessible, but access to ones who are well versed in the field of speech-language pathology and communication disorders are not. Another explanation could be access to formal as opposed to informal interpreters or access through a specific medium such as in-person interpretation in contrast to interpretation over the phone.

Limitations

Although we aimed to have more respondents complete the survey, our study is limited by a small sample size. Therefore, the sample of participants who completed the online survey may not be representative of all SLPs in Alberta who work with adult clients. ACSLPA (2014) estimates that 150 SLPs in Alberta work with adult clients. A 33.3% response rate (50 respondents) was determined sufficient to provide a representative overview of current practices in the province. Only 26 clinicians responded to the survey which represents an

estimated 17.3% of SLPs in Alberta working with adult clients. Furthermore, the vast majority of respondents were from the urban settings of Edmonton and Calgary. Preliminary data from the focus groups indicated that rural SLPs may have different experiences working with CALD clients.

The survey format also presented some limitations. Responses to open-ended questions were sometimes difficult to interpret because it was not possible to ask for clarification; however, focus groups were conducted to further explore common themes from the survey responses. The survey questions may need to be modified for clarity. When asking participants if they felt confident in CALD service delivery, the different aspects of service delivery could have been further specified (e.g., assessment, treatment, education). A question like this may have revealed the specific areas in which clinicians may benefit from additional supports. This information could be used for the development of training programs or resource packages.

Also, the survey did not include questions regarding dysphagia, which many clinicians brought up in their answers. Given that many SLPs working with adults will work with clients with dysphagia, including questions regarding dysphagia may provide a better understanding of the challenges and practices of SLPs working with CALD clients.

The survey included a question regarding what type of information clinicians provided to interpreters prior to assessment but did not explore the information provided to interpreters when engaging in other types of activities. Including a similar question for other types of activities would provide a better understanding of how SLPs prepare interpreters working with CALD clients with communication disorders.

Future Directions

Future research may expand upon the findings from this study by surveying SLPs across the country to get a better understanding of the current practices of SLPs serving CALD adult clients. The results of this study may be elaborated upon by examining factors that may facilitate the interpretation process as well as specific issues regarding lack of access. A nationwide survey may shed light on the potential differences in regional practice standards and the availability of resources including access to interpreters. Furthermore, a review of the training offered at different SLP graduate programs across the country may identify possible areas for curriculum improvements given that many SLPs reported not receiving adequate training on CALD service delivery in their graduate programs.

CONCLUSION

This study identified a definite need for improvement in SLP service delivery for CALD adult clients within Alberta. Challenges include many different areas, such as clinician training, interpreter training, and access to appropriate resources. With Canada's increasingly diverse population, appropriate service delivery for CALD clients is an important issue that warrants further investigation.

Appendix A

Current Practices of SLPs Serving Culturally and Linguistically Diverse (CALD) Adults with Communication Disorders in Alberta Survey link:

http://goo.gl/forms/iweoDlxkcZ

Appendix B

Proficiency of languages spoken by participants other than English

Beginner Proficiency		Intermediate Proficiency		Advanced Proficiency		Native-Like Proficiency	
Language	**Participants**	**Language**	**Participants**	**Language**	**Participants**	**Language**	**Participants**
French	3	French	6	American Sign Language	1	French	2
Italian	1	Spanish	1				
German	1	Dutch	1				
Spanish	1	Greek	1				
Malayalam (South Indian)	1	Portuguese	1				

Appendix C

Level of Agreement with Recommendations

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
SLP graduate education programs should include training on using formal interpreters for service delivery	0%	4%	23%	27%	46%
Employers/facilities should provide training on using interpreters for service delivery	0%	0%	27%	31%	42%
Formal interpreters should receive additional training related to the field of speech-language pathology	0%	0%	15%	27%	58%
An interest group addressing CALD issues in the field of SLP in Alberta is necessary	4%	4%	27%	35%	30%
My employer recognizes that CALD clients require more time, and provides reasonable accommodations	15%	12%	31%	19%	23%
My clients (if you are in private practice) would be willing to pay for longer sessions and/or for a formal interpreter in order to accommodate their CALD needs	0%	16%	31%	0%	0%
SLPs should advocate for increased services and supports for CALD clients where there is no or limited access	0%	0%	19%	31%	50%

Appendix D

Top 3 issues impacting provision of services to CALD clients	Subcategories	Counts
Lack of resources		**12**[1]
	Supplies	1
	Time	3
	Discharge options	1
	Assessment tools	1
	Institutional limitations	1
	Materials	2
Interpretation/Translation issues		**10**
	Medium of interpretation (telephone)	1
	Medium through family	1
Access to interpreters		**9**
	Barriers: language, educating families, etc.	1
Lack of confidence in assessment		**5**
	Knowledge	1
	Medium of interpreters	1
Cultural differences		
	Gender norms	2
	Relevance (barriers to communicating/educating clients	3
	SLP knowledge	1
	Cultural relevance	1
Poor carryover		**3**
Confidence in therapy delivery		**3**
Interpreter knowledge		**3**
Family dynamics		**2**

[1] Subcategory totals may not equal overall category totals, as not all participant responses fit into a subcategory

Healthcare providers lacking knowledge		**1**

Table 1. Open-ended (written) questions regarding the top 3 issues SLPs face when working with CALD clients and the counts for each category and subcategory

General supports to provide better care to CALD clients	Subcategories	Counts
Ease of access to interpreters		**8**
	Affordability	1
	Formal interpreters	1
	In-person	3
More training of SLPs		**4**
	Cultural competency	1
More multilingual resources		**4**
	Evidence-based	2
	Cultural brokers	1
Discharge resources		**1**
Multilingual SLPs		**1**
Resources		**1**
	Online resources	1
	Materials	1
	Resources to educate other professionals	1
Interpreter training		**1**
	Medically compromised clients	1
	Communicative disorders	1
Documentation guidelines		**1**

Table 2. Open-ended (written) questions regarding supports for SLPs that can increase the quality of care for CALD clients and the counts for each category and subcategory

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