



Cultural responsiveness in a paediatric hospital setting

People, processes, and practice environment

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To be ethical, safe, and of high quality, speech-language pathology services must be responsive to the needs of culturally and linguistically diverse (CALD) consumers. However, cultural responsiveness is an ongoing challenge in Australian health care. A service evaluation conducted within the speech pathology department of a major Australian paediatric hospital explored the practices, challenges, and needs of speech-language pathologists (SLPs) and allied health assistants when working with CALD consumers. Twenty-nine clinicians across a range of communication and feeding caseloads were interviewed. Issues were identified in three key areas: people, processes, and the practice environment. Clinicians suggested improvements to service delivery spanned the levels of the individual, the profession, the organisation, and the overall health care system. The implications of these findings for SLPs and the broader health care workforce are discussed, and a framework for improving cultural responsiveness is proposed. Future directions for research in this area are also detailed.

Cultural diversity in Australia is evidenced by over one-quarter of Australians born overseas, over 300 languages spoken, and an increasing number of Australians who identify as being of Aboriginal and Torres Strait Islander origin (Australian Bureau of Statistics, 2017). Culturally and linguistically diverse (CALD) consumers can represent up to 50% of speech-language pathology caseloads (Verdon, McLeod & McDonald, 2014), and appropriate services for these families are vital for ethical practice, safety, and quality. While the authors acknowledge person-centred language, “CALD consumers” has been utilised for ease of reading, referring to patients/clients and their families who are “not of the dominant language and cultural background of the broader social context in which they reside” as well as those “with multiple linguistic and

cultural influences” (Verdon, McLeod, & Wong, 2015, p. 75), including Deaf consumers and those from Aboriginal and Torres Strait Islander backgrounds.

Culturally responsive practice has been identified as key to providing accessible and appropriate services for all clients, regardless of their backgrounds. It contextualises cultural differences, challenges prejudice, encourages institutional change to promote inclusion, and supports a dynamic, flexible and relational approach to working across cultures (Gill & Babacan, 2012). It describes individual and systemic responsiveness to health care in diverse communities and requires action at system, organisation, professional, and individual levels (State of Victoria Department of Health, 2009). A systematic review of reviews (Truong, Paradies & Priest, 2014) identified that interventions to improve culturally responsive care in health settings led to better service access, increased service utilisation, consumer implementation of service recommendations, and better outcomes for consumers. Regardless of methodological issues in the included studies, the review concluded that cultural responsiveness is paramount to service evaluation and quality health service delivery.

Despite consumer diversity and the importance of cultural responsiveness, this approach is not always implemented (Gill & Babacan, 2012). Speech-language pathologists (SLPs) often lack the confidence, knowledge, and skills to engage effectively and appropriately with CALD consumers (Guiberson & Atkins, 2012; Riquelme, 2007). Issues such as the shortage of available staff who speak a family’s preferred language, the lack of assessment tools for bilingual communication development, and the lack of training to work with CALD consumers have been identified (e.g., D’Souza, Bird & Deacon, 2012; Kohnert, Kennedy, Glaze, Kan & Carney, 2003; Kostich & Weiss 2007). However, almost all studies relating to speech-language pathology service delivery to CALD consumers have focused on the practice area of communication. Furthermore, previous studies have primarily surveyed American and Canadian SLPs, often in school settings (Roseberry-McKibbin, Brice & O’Hanlon, 2005), with rare involvement of Australian speech pathologists (Williams & McLeod, 2012). Thus, little is known about the current practices and perceived challenges of Australian SLPs working with CALD consumers in paediatric hospital settings. Moreover, literature regarding skills for working across cultures in speech-language pathology has predominantly focused on examining technical aspects of practice, including clinicians’ assessment and intervention practices within the confines of their “clinic rooms” (Caesar

KEYWORDS

CULTURAL RESPONSIVENESS

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)

FEEDING

HOSPITAL

PEDIATRIC

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& Kohler, 2007; Jordaan, 2008). As inter-cultural practice issues extend beyond individual clinicians, it is important to consider how clinical issues are situated within the larger health care and societal settings. This is central to providing accessible, relevant, effective, and ultimately culturally responsive services to CALD consumers (Truong et al., 2014).

The present paper aims to explore current practices and challenges regarding service provision to CALD consumers within the tertiary paediatric health care setting. It presents preliminary findings from the initial stage of a service evaluation conducted at a paediatric hospital in Queensland. Research questions guiding this project include:

1. How do SLPs modify their clinical practice to provide culturally responsive services to CALD consumers?
2. What do SLPs and allied health assistants (AHAs) perceive as challenges to consistently providing quality services to CALD consumers at the levels of the individual clinician, profession, organisation and health system?
3. What do SLPs and AHAs recommend as solutions to these challenges?

Method

Ethical considerations

A waiver of full ethics review was approved by the Children Health Queensland Human Research Ethics Committee. The waiver allowed for the service evaluation to be written up for publication as it met all requirements of Section 5.1.22 and 5.1.23 of the National Statement on Ethical Conduct in Human Research 2007. Prior to publication, written consent was obtained from all participants.

Participants

Participants were recruited from a Queensland paediatric hospital. Inclusion criteria included employment within the hospital's speech pathology department at the time of recruitment, and provision of communication and/or feeding/swallowing services to children aged 0–18 years. Twenty-nine employees within the department were invited verbally or by email to participate in an individual interview with the first author. All participants were provided with a copy of a participation information sheet that specified their participation was voluntary and would in no way impact their employment conditions at the hospital.

Participants included 26 clinical SLPs (i.e., all SLPs employed in the department at the time of recruitment), one clinical education support officer (also an SLP), and two AHAs. All 29 participants were female. Twenty-four percent of participants ($n = 7$) identified as being from a CALD background. Overall, eight languages other than English were spoken by participants, including AUSLAN. Basic proficiency was reported for most languages. The majority of SLP participants (59%, $n=16$) had up to 15 years working experience. Just under a quarter (22%, $n=6$) had up to 5 years experience. Estimates of the percentage of CALD consumers in SLPs' individual caseloads varied between 10% and 60%, with the majority reporting 30–40%.

Survey design and data collection

This project was initiated for service evaluation purposes. A survey design was utilised and included qualitative and quantitative data. Surveys were administered verbally by the first author in an individual interview with each participant.

Close-ended survey questions (multiple choice and rating scales) and open-ended questions on the topic were adapted from D'Souza et al. (2012) and Kohnert et al. (2003). Further questions regarding service delivery were added. The interview schedule (available on request) included the following areas of exploration:

- What policies, literature and best practice guidelines are you aware of and implement in your practice? (Open-ended questions)
- How do you modify your practice when providing services to CALD consumers? (Mix of multiple choice and open-ended questions)
- How challenging do you perceive working with CALD consumers and interpreters? (Likert scales)
- What do you perceive as key barriers that challenge the responsiveness of services provided to CALD patients? (Open-ended questions)
- What solutions do you think are needed to provide culturally responsive services within the department and the whole organisation? (Mix of multiple choice and open-ended questions)

During interviews, the first author recorded quantitative responses on an electronic response form. Given the initial focus on quality improvement rather than research, audio recordings of qualitative responses were not collected. In order to closely reflect the perspectives of participants, comprehensive verbatim note taking of key quotes was conducted during interviews and detailed field notes made (Patton, 2002).

Data analysis

Quantitative data were analysed descriptively. No statistical analysis was undertaken for this quality improvement project. Qualitative data were analysed thematically (Patton, 2002). An initial coding structure was developed inductively through multiple readings and identification of key concepts within the data. The first author then coded all the data section by section, according to the coding structure. Codes were then grouped into themes. For example, "staff knowledge, training and experiences" was grouped with "cultural and linguistic stakeholders" to form the issue area entitled "People". The second author, who is not an employee of the organisation and was not involved in data collection, reviewed the codes and contributed to the development of themes. Departmental directors, given their involvement in the service evaluation and their oversight of clinical practice and service delivery within the department, reviewed codes and themes as they evolved and indicated agreement with all interpretations of the data.

Results

Clinicians reported that they enjoyed working with CALD consumers, but identified the need for individual and organisational improvements. Overall, the majority of the 26 SLPs who responded indicated that intercultural work was challenging. On a 5-point Likert scale, most (42%, $n = 11$) selected a rating of 3 (*challenging to a moderate degree*), 27% ($n = 7$) selected a rating of 4 (*considerable degree*), and 4% ($n = 1$) selected 5 (*great degree*) to reflect their experience. No participants selected a rating of 1 (not at all challenging) (see Figure 1).

Clinician-perceived challenges were represented by three themes: people, processes, and practice environment. These themes, associated sub themes, and participants' recommendations for improving the quality of culturally responsive services aligned with each theme are shown in Table 1.

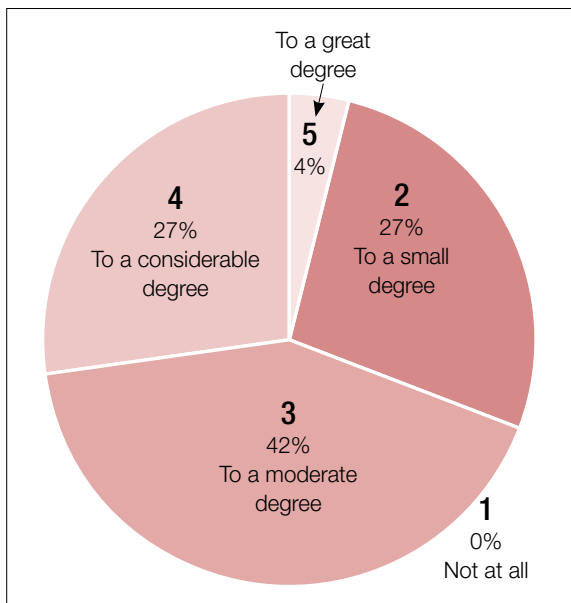


Figure 1. Degree of challenge working with CALD families

People

The theme “People” pertains to challenges that participants identified in relation to interactions with others. Issues included SLPs’ limited knowledge and training regarding working with CALD consumers, challenges working with cultural and linguistic stakeholders such as interpreters and multicultural workers, difficulties advocating for CALD consumers’ needs in multidisciplinary teams, and limited diversity among organisational staff.

Knowledge and training

Forty-six percent (n = 12) of 26 SLPs in the department were either unaware of any literature or clinical guidelines regarding best practice for working with CALD consumers, or could not identify any specific documents. Only 27% (n = 7) of 26 SLPs reported consistently applying CALD-related literature and/or clinical guidelines to their practice, suggesting that 73% were not. Responses indicated a general lack of university-level training across CALD-related topics as well as limited professional development and clinical experiences post-graduation. In particular, of 22 SLPs, only 23% (n = 5) had received tertiary-level training on working with interpreters, 18% (n = 4) in multilingual speech sound assessment and management, and 5% (n = 1) in multicultural feeding/swallowing practice considerations. Furthermore, less than half had attended cultural responsiveness-related professional development (aside from mandatory training), or had caseloads or worked in contexts (such as overseas) in which the culture and language of the consumers were predominantly different from their own. One SLP reflected, “It’s hard to figure out how to do it well, hard to figure out if what you did was the right thing to do” (SLP#5). Another agreed, stating, “It’s just assumed that you can do it” (SLP#1).

Interpreters

Challenges were also identified regarding access to and working with interpreters. While 100% of 26 SLPs reported variability in the degree of challenge depending on the specific interpreter, 69% (n = 18) of these indicated that, on average, working with interpreters was challenging to a moderate, considerable or great degree, with most respondents indicating a moderate degree of challenge (n = 12).

Challenges working with interpreters were twofold: SLPs’ skills to work effectively with interpreters, and the inconsistent quality of interpreters with regards to factors such as the accuracy of the message conveyed (judged by clinicians through the length of interpreted information compared with the original message), professionalism, and knowledge of health care and medical terminology. One participant expressed, “I dread having to work with interpreters because I don’t feel like I can do my job as perfectly as I can” (SLP#7), while another shared “I have had good ones and shocking ones” (SLP#23). Moreover, difficulty regarding access to face-to-face and phone interpreters was reported. Reasons included: (a) uncertainty about the process for requesting an interpreter, (b) a lack of interpreters who speak the correct language and dialect, (c) misalignment between available interpreters and preferences of consumers, (d) families declining interpreters, and (e) a lack of in-house interpreters in the inpatient setting. These frustrations were illustrated by one SLP who reported “difficulties interacting with patients who refuse interpreters who clearly need them” (SLP#23) and supported by others who explained that in some instances when interpreters were not available or were declined by family members, families and other staff members provided interpreting support. For example, two accounts were offered of fathers with better English skills than their spouse, who spoke on behalf of the family. One clinician reflected, “my concern is what goes unreported. What is the woman’s experience?” (SLP#4).

Cultural stakeholders

Access to multicultural consultants/stakeholders was limited. The only type of culture-brokering stakeholder that SLPs were aware of within the organisation was the Indigenous hospital liaison officers. Few SLPs (n=3) mentioned that they had actually worked with such personnel. None had engaged multicultural liaison persons, bicultural workers or refugee support networks while working at the hospital. Similarly, although 44% (n = 11) of 25 SLPs had liaised with external community cultural stakeholders for CALD families, only one reported they did this consistently when needed.

Participants indicated that responding to cultural differences is crucial to the patient–provider relationship and subsequent acceptance of clinical recommendations with one clinician reflecting, “You can see it on parents’ faces that you understand their concerns for the child and their home environment, and when your recommendation sits well with them” (SLP#4). However, cultural differences were not always identified and considered.

If cultural issues were more explicitly addressed during the session, perhaps the discussion would be more open...The biggest issues have come from not understanding therapy techniques and not feeling comfortable enough to say that these techniques don’t suit our family. They tend to disengage. (SLP#16)

Multidisciplinary teams

Some participants discussed the fact that practices varied between professions, which made it difficult for SLPs to advocate for CALD consumers’ needs in multidisciplinary teams. For example, one SLP expressed the opinion that some “members of other disciplines may be adhering to best practice more than others due to differences in clinical experience and own attitudes” (SLP#7). Another explained that staff in other professions “just assume families have

Table 1. Participants' perceived issues and recommendations regarding cultural responsiveness in the workplace

Issues	Recommendations	Examples of other sources supporting participants' recommendations
People		
<ul style="list-style-type: none"> • Variability in staff knowledge and training • Challenges working with cultural and linguistic stakeholders e.g. interpreters and multicultural workers • Limited diversity among staff • Difficulties advocating for CALD consumers' rights in multidisciplinary teams 	<ul style="list-style-type: none"> • Cultural responsiveness training for all staff, e.g. mandatory training, and/or as part of staff onboarding processes • Evaluate the quality of interpreting services, and increased access to interpreters (e.g., recruitment of in-house interpreters) who have experience health care settings • Training programs for clinicians to work more effectively with interpreters and vice versa • Increase recruitment of and collaboration with multicultural consultants • Register of bi/multilingual staff and multicultural consultants • Employ staff in "CALD Champion" roles dedicated to cultural diversity to broker knowledge and drive improvements • Open discussion and increased visibility of CALD-related issues in multidisciplinary teams 	<p>Gill & Babacan (2012), Guiberson & Atkins (2012), Hammer et al. (2004), Kohnert et al. (2003)</p> <p>D'Souza et al. (2012), Guiberson & Atkins (2012)</p> <p>D'Souza et al. (2012), Guiberson & Atkins (2012), Kritikos (2003)</p> <p>Guiberson & Atkins (2012) Henderson & Kendall (2011), Kohnert et al. (2003)</p> <p>Gill & Babacan (2012)</p>
Processes		
<ul style="list-style-type: none"> • Lack of specific workplace policies and procedures • Time limitations and difficulties prioritising CALD issues against complex medical or social issues • Challenges sourcing CALD-related information • Inconsistent clinical documentation and verbal handovers of CALD-related information • Ineffective administrative processes 	<ul style="list-style-type: none"> • Workplace guidelines to integrate cultural responsiveness into clinical practice and service delivery • Practical implementation of CALD-related workplace policies • Evaluate time and budget allocations for CALD consumers in clinical prioritisation schedules, caseload management, and resource distribution • Update patient information systems for sufficient and accurate documentation of CALD consumers' needs • Sound medicolegal procedures e.g. informed consent from consumers with no or low English proficiency • Administrative processes to enhance CALD consumer access and engagement e.g., translated letters vs. English SMS contact 	<p>Gill & Babacan (2012)</p> <p>SPA (2016a)</p> <p>Gill & Babacan (2012)</p> <p>SPA (2016b)</p>
Practice environment		
<ul style="list-style-type: none"> • Lack of culturally and linguistically appropriate clinical resources • Need for increased organisation-wide leadership and initiatives • Questionable cultural appropriateness of physical environments 	<ul style="list-style-type: none"> • Culturally and linguistically appropriate resources for communication and swallowing/feeding management • More written information for CALD consumers • Clinician-lead advocacy for evidence-based cultural responsiveness policy and strategy • Mandatory CALD-related items in health care regulation standards and hospital accreditation • Commitment to cultural responsiveness in recruitment role descriptions • Increase visibility of cultural diversity and responsive practices within organisations • Culturally welcoming physical environments 	<p>D'Souza et al. (2012), McLeod (2014), Riquelme (2007), Williams & McLeod (2012)</p> <p>Gill & Babacan (2012)</p> <p>Gill & Babacan (2012), Verdon, McLeod & Wong (2015)</p> <p>Gill & Babacan (2012)</p> <p>Gill & Babacan (2012)</p> <p>SPA (2016a)</p>

understood” (SLP#20) without checking for comprehension, even in the context of “complex terminology and emotionally charged situations” (SLP#20).

Workforce diversity

Some participants perceived a lack of cultural and linguistic diversity within the workforce. Only 24% (n = 7) participants in this study were from a CALD background themselves. One SLP reported that in her previous job in an overseas hospital “people on the wards could speak different languages” (SLP#20), and suggested that SLPs in the present hospital were often unaware of the cultural and linguistic backgrounds of departmental and organisational staff.

Processes

The theme “Processes” refers to the interaction between professional and organisation-level issues such as workplace policies and procedures, timeframes for practice, sourcing information, clinical documentation, verbal handovers, and administrative processes.

Workplace policies and procedures

SLPs emphasised that workplace policies and procedures influenced their ability to consistently provide culturally responsive services to CALD consumers. Although policies and guidelines that outline requirements for CALD service delivery exist at the organisation and government levels (e.g., The State of Queensland, 2016), 79% (n = 23) of all participants were either unaware of or could not identify specific documents. Only 10% (n = 3) of all participants consistently applied at least one known CALD policy or guideline in their clinical practice. One SLP reflected that there is a “lack of personal accountability to find these documents” (SLP#23). All clinicians indicated that policies and CALD-related literature had not been integrated into any of the department’s clinical procedural documents with one individual reporting, “If I had guidelines or checklists on what to do, I would do it and feel more confident” (SLP#6). Further, a very small number of clinicians (n = 3) mentioned discussing CALD-related service delivery issues in supervision and/or team meetings. The reasoning behind the rarity of such discussions was described by one clinician as, “It’s a bit embarrassing to ask what to do, or if what you’re doing is correct because you don’t want to seem like you’re not being culturally appropriate” (SLP#6).

Time limitations

SLPs also highlighted the need to reflect the extra time needed for effective management of CALD consumers in prioritisation processes. Eighty-five percent (n = 22) of 26 SLPs reported that time limitation is one of the biggest challenges when providing services to CALD consumers and one of the biggest contributors to CALD consumers “not receiv[ing] a complete and full service” (SLP#7).

Time-related issues are reflected in the example of briefing interpreters. Only two SLPs were able to consistently brief interpreters before appointments due to lack of time and inflexibility of appointment bookings in allowing for extra time per allocated clinical “slot”. One SLP advised, “the interpreter is often confused about why you’re prepping them because not everyone does this, and they don’t even know we should be doing this” (SLP#6).

Sourcing information

When it came to sourcing information about culturally responsive practices, participants were asked to select

preferred options from a list of sources. Ninety-two percent (n = 22) of 24 participants selected Google as a source of general multilingual and multicultural practice information, as well as patient-specific language and cultural information. Only 29% (n = 7) selected evidence-based sources such as academic journal articles and best practice guidelines.

Documentation and handover

Multiple issues were identified regarding the inadequacy and/or inconsistency of documentation and verbal handover of patient-specific CALD-related information. “Often you might not even know they are from a CALD background until you see them, unless the name is obvious”, stated SLP#19. Subsequently, information regarding cultural practices has been overlooked in multidisciplinary team discussions when scheduling appointments. One SLP reported an incident where a family has been fasting for Ramadan, but “therapists book[ed] feeding appointments in without thinking this was happening” (SLP#14). Another also indicated that cultural and language information may be missed because clinicians have “assumed that a previous clinician has worked with the client before and has found that info” (SLP#13), and as a result may not clarify with families whether the verbal or written handover information is correct or complete.

Furthermore, patient forms (e.g., registration, privacy, consent, and referral), electronic patient information and booking systems, and electronic medical records do not have detailed fields and options for consistent documentation and/or retrieval of patient-specific cultural and linguistic information. One SLP stated, “I’m unsure about where to find out what languages a person speaks other than trying to find it documented in [electronic patient information systems]” (SLP#10). A number of participants described incidents where interpreters speaking the wrong dialect were booked due to incorrect documentation and/or verbal handover. As language information was sometimes not documented in patient information systems, “admin [officers] make interpreter bookings from the info on [electronic patient information system]...families have come who haven’t had an interpreter booked” (SLP#2).

Administrative processes

Ineffective administrative processes were found to have considerable impact on patient engagement. One SLP perceived that the failure to attend rates for appointments was higher for CALD families than that for the average patient population, “so it’s often not even efficient for us to do lots of extra prep for them” (SLP#5). Another stated that some CALD families “didn’t know how to call up and cancel” (SLP#6). Additionally, SLPs identified that letters inviting patients to call and book an appointment were inappropriate for many CALD families with no or low English proficiency. For example, “we send out long SMS notifications and ‘call to book letters’ to families who can’t read it” (SLP#5). This process presents challenges to equity of access to services as well as inefficiencies for clinicians.

Practice environment

The theme “Practice environment” examines cultural responsiveness at the level of the organisation and health care system. It encompasses the issues of resource availability in the practice setting, the physical environment, and organisation-wide leadership.

Resources

SLPs reported that the amount of written/visual information that CALD consumers take home is less than that of non-CALD consumers. Out of 26 SLPs, 44% (n = 11) had offered professionally translated written information for families with limited English proficiency. Only 16% (n = 4) had offered translated written reports. One SLP reflected, "if they had written info to take away and think about, they could come back and have a better discussion" (SLP#16).

The lack of assessment resources for multilingual and multicultural assessment and intervention was also identified. Two SLPs mentioned uncertainty regarding assessing and reporting on standardised scores from English-based assessments. Only one SLP reported to have frequently used dynamic assessment with existing resources. Others reported a preference to "assess in pure spoken and written English" (SLP#21) because there are "no other resources department-wise that can be easily accessed" (SLP#21). Feeding case histories were SLPs' key tool for assessing CALD populations. However, one SLP questioned whether "new staff starting off in [paediatric] feeding" would be able to provide culturally appropriate services (SLP#23). Culturally sensitive topics related to feeding, such as breastfeeding, were identified as areas of particular uncertainty for SLPs. For example, one SLP discussed the need to check how CALD mothers might feel about being observed when breastfeeding because "some [CALD] families might not feel like they can say no" (SLP#12) to breastfeeding observation.

The lack of resources to support intervention for CALD consumers was highlighted by both AHAs, as well as a number of SLPs. While one AHA reported trying to "make resources that look like the child", they "haven't been asked to do any additional modifications by clinicians" (AHA#1). Similarly, one SLP reported trying to "pick the right skin colour of dolls, and animals that the child is likely to have experience with" (SLP#2). No other modifications to intervention resources were reported by clinicians. With regards to feeding, SLPs reported asking families to bring foods from home. However, "lack of varied food choices for patients" (SLP#20) at the hospital is an issue when families do not bring foods themselves.

Physical environment

When discussing the physical practice environment, one SLP reflected, "The clinical environment...is this confronting? There's nothing here welcoming of them" (SLP#13). Despite documented strategies within the organisation to create culturally appropriate hospital environments for Aboriginal and Torres Strait Islander consumers, SLPs believe the hospital is lacking in this area. Moreover, no such strategy exists to modify environments for other CALD populations. While one AHA reported that on the hospital wards, "one child had words above her bed that were in her language and staff would try to greet her with this" (AHA#1), another believed that "there are still so many places we can put culturally welcoming decorations" to "show more respect for [families'] culture and language" (AHA#2).

Leadership

Participants reported that leadership in the organisation is strong in many areas. However, they perceived a lack of leadership and systemic change related to cultural responsiveness. One participant described the need for organisation- and system-level leadership to effect change: "There's not really a push of Queensland Health for [cultural

responsiveness], not like the push for privacy and hand hygiene" (SLP#23). Another reflected that in order to improve service delivery for CALD consumers, there "needs to be an expectation from management that it's an ongoing conversation" (SLP#1).

Clinicians' recommendations

Within their interviews, participants made recommendations for improving cultural responsiveness across the three levels of people, processes, and practice environment (see Table 1). Recommendations included staff training, further access to and use of interpreters and multicultural workers, improved communication and documentation with respect to cultural responsiveness, revisions to guidelines, policies, standards and position descriptions, revisions to time and budget allocations for services provided to CALD consumers, inclusive administrative procedures, appropriate assessment and therapy resources, increased visibility of cultural diversity, and leadership of cultural responsiveness initiatives within the organisation.

Discussion

Overall, the findings of this study indicate that SLPs and AHAs regularly experience challenges related to people, processes, and the practice environment when working with CALD consumers. Variability in staff knowledge and training, challenges working with cultural and linguistic stakeholders, limited staff diversity and difficulties advocating for CALD consumers' rights in multidisciplinary team were reported in the theme of People. Difficulties with Processes are evident in the lack of workplace policies and procedures to address cultural responsiveness, time limitations, challenges sourcing CALD-related information, variability in clinical documentation and verbal handovers, and ineffective administrative processes. The lack of culturally and linguistically appropriate clinical tools, the questionable cultural appropriateness of physical environments and the reportedly lack of organisation-wide leadership also create a challenging 'practice environment'.

Issues and proposed solutions identified at the levels of people, processes and practice environment have been reported in previous studies. The variability of intercultural knowledge, training, and experiences of SLPs indicated in the data has been documented in numerous studies (Caesar & Kohler, 2007; D'Souza et al., 2012; Guiberson & Atkins, 2012; Hammer, Detwiler, Detwiler, Blood & Qualls, 2004; Kritikos, 2003). As SLPs have ethical and legal obligations to ensure the quality and equity of access to health care services (Speech Pathology Australia, 2016b), the reportedly limited opportunities for cultural responsiveness training is a critical consideration for professional bodies and tertiary institutions. This is important in light of the current data and previous research demonstrating that lack of adequate training to work with CALD populations may be an issue across all health professions (Gill & Babacan, 2012). Participants in the present study and previous researchers have stressed that working with CALD consumers requires explicit teaching of additional skills (Kohnert et al., 2003) in universities and continuing professional development (Caesar & Kohler, 2007; D'Souza et al., 2012; Guiberson & Atkins, 2012; Roseberry-McKibbin et al., 2005). In particular, developing culturally appropriate interviewing skills should be considered, especially for clinicians working in feeding/swallowing (Riquelme, 2007). Consolidation of knowledge and skills may also be improved through

increased international partnerships and improved uptake of inter-cultural student placements and post-graduation volunteering overseas (Crawford et al., 2017), as well as in local CALD and Aboriginal and Torres Strait Islander communities. Similarly, the lack of workforce diversity identified in the present study is relevant to speech-language pathology as well as other professions. Previous research showed that the lack of bilingual SLPs is perceived as one of the key barriers to CALD service provision (D'Souza et al., 2012; Kohnert et al., 2003). This highlights the need to promote speech-language pathology and other health professions as career paths for CALD students (Attrill, Lincoln & McAllister, 2017).

Nevertheless, given the vast diversity of Australia's population, it is unrealistic to expect alignment between the culture and language background of health professionals and that of each consumer (Verdon et al., 2014). As a result, interpreters play a crucial role in ensuring the integrity of communication between CALD consumers and providers. In line with findings from the present study, limited access to and use of appropriate interpreters has been reported in previous studies involving SLPs in the USA (Guiberson & Atkins, 2012; Kostich & Weiss, 2007; Kohnert et al., 2003), SLPs in Australia (Williams & McLeod, 2012) and even by health care consumers in Australia (Henderson & Kendall, 2011). Given government policies to use appropriate interpreters wherever possible (The State of Queensland, 2016), clinicians face ethical dilemmas regarding choices to deliver services without an appropriate interpreter. Furthermore, findings in the present study that 69% of SLPs perceive working with interpreters challenging at least to a moderate degree echoes the reports of Kostich and Weiss (2007) that over 70% of surveyed American SLPs felt not competent or somewhat competent to work with interpreters. The variability of access to and ability to work effectively with linguistic stakeholders thus demonstrate gaps in policy implementation and staff training, posing risks to the safety and quality of services provided to CALD consumers.

The quality of clinical services is further constrained by workplace processes and practice environment. A clinician's work setting has been found to significantly influence their use of recommended practices for CALD consumers (Caesar & Kohler, 2007). The identified lack of time to provide thorough services for CALD consumers mirrors Kritikos' findings that SLPs perceived an insufficiency of time allocated to them to complete bilingual assessments (2003). Although it has been well documented that working with CALD families requires more time (D'Souza et al., 2012; Guiberson & Atkins, 2012; Kostich & Weiss, 2007; Speech Pathology Australia, 2016b), this opens up issues regarding how to prioritise CALD-related issues against other clinically or socially complex issues in busy environments (Gill & Babacan, 2012). While medical and safety concerns should be prioritised, it should not be at the expense of culturally responsive services, nor should culture and language be overlooked in decisions regarding patient safety.

Likewise, the development and acquisition of culturally and linguistically appropriate resources are also reportedly under-prioritised, consistent with existing research regarding insufficient resourcing (D'Souza et al., 2012; Kohnert et al., 2003; McLeod, 2014; Riquelme, 2007; Williams & McLeod, 2012). In addition to communication resources, the present study adds that culturally appropriate foods are especially important, given findings

in Queensland that CALD consumers missed their cultural foods when admitted to hospital (Henderson & Kendall, 2011), which would have considerable impact on the uptake of SLPs' feeding recommendations. Furthermore, the lack of appropriate written handouts may have medico-legal implications for informed consent, and also limits carryover therapy tasks and adherence to recommendations. As such, workplaces should develop, implement and evaluate policy documents that address these service delivery issues (Speech Pathology Australia (2016a), together with culturally responsive procedures embedded into existing documents (Gill & Babacan, 2012).

In addition to procedural and environmental changes, organisational leadership is central to effecting change, shaping organisational culture, collecting data, and implementing evidence-based mechanisms to drive cultural responsive care (Caesar & Kohler, 2007; Gill & Babacan, 2012; Guerrero, Fenwick & Kong, 2017). Many of the present findings in Queensland illustrate similar organisational and systemic issues to a major review of Victorian health services, whereby a "failure to incorporate cultural diversity into all areas of core business" was reported (Gill & Babacan, 2012, p.49). This building evidence of limited cultural responsiveness in health services across Australia highlights the need for leaders to consider strategies at a multiple levels within an organisation. In doing so, the above recommendations cannot be considered in their discrete levels as there is likelihood of flow-on effects from one level to another. For instance, the inclusion of commitment to cultural diversity in recruitment role descriptions at the 'processes' level may drive the employment of staff in "CALD Champion" roles dedicated to cultural diversity at the 'people' level, which in turn promotes increased visibility of cultural diversity at the 'practice environment' level. Considering that the research was conducted in a large hospital setting, perhaps the institutional nature of the practice environment presented complex barriers to the ability of staff to work in a way that Gill and Babacan (2012) describe as flexible, relational, and responsive to cultural diversity. Nevertheless, using the present findings in combination with context specific information, services can devise multi-level plans to increase cultural responsiveness.

Limitations

This project was initially designed as a service evaluation. As such, audio recordings for qualitative data collection did not occur. Despite this, key quotes were transcribed verbatim during interviews along with detailed fieldnotes being recorded. Thus, while the lack of audio-recordings was not ideal, detailed records of participants' responses were obtained and used for analysis and interpretation.

Furthermore, the involvement of the departmental directors in the data analysis processes, while crucial to the service evaluation process, could be seen as problematic. Thorne (2016) encourages the research involvement of staff involved in clinical services, particularly in data analysis phases, in order to provide applied perspectives on data and to incorporate their contextualised knowledge in interpretive insights. This research included departmental directors in the process of checking coding, and also involved an independent researcher in checking the coding and themes and in the write-up phase of the project to ensure trustworthiness. Nonetheless, qualitative analysis would have benefited from the authors grouping concepts separately, and then resolving differences by consensus.

While this research may be relevant for other health and medical professions, the data has been drawn from speech-language pathology only, and transferability of the findings should be carefully considered in relation to localised, context-specific information. Moreover, Australian SLPs work across a wide range of settings and service delivery models. As this service evaluation was conducted as a single-site project, further multi-site research with more rigorous methodology and larger sample sizes is needed to replicate findings in multiple settings across both generalist and specialist SLP caseloads, as well as across entire health care systems in different Australian states and territories. Finally, consumers were not included in the data collection, thus caution should be exercised when drawing conclusions from the findings.

Conclusion and future directions

People, processes, and the practice environment interact and combine to challenge the cultural responsiveness of SLP services within the Australian paediatric tertiary setting. This paper is among few that have explored SLP service delivery for CALD consumers in a larger organisational context, and is the first to address CALD-related issues in the practice area of paediatric feeding and swallowing. While the findings from this paper are exploratory and draw from a service evaluation rather than a formal research project, preliminary insights highlight that skill development alone is not enough to improve the cultural responsiveness of overall service delivery (Truong et al., 2014). As more investigation is needed to enact and appraise evidence-based strategies to CALD service delivery issues in the Australian context, the next stages of this service evaluation will involve the design, implementation and evaluation of cultural responsiveness interventions within the department, with the potential scalability to inform advancements towards a more culturally responsive health workforce. In addition, the authors encourage other services to evaluate their own practices, carry out research, as well as pilot, evaluate, and scale-up strategies such as those suggested in the present project to enhance cultural responsiveness.

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