Addressing health inequalities: the role of speech and language therapy

GUIDANCE

JULY 2021

RCSLT

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Who is this resource for?

This resource is for individual speech and language therapists (SLTs), speech and language therapy teams and services, researchers and/or educators to use in speech and language therapy curriculums. It is relevant for those working in the NHS, independent practice, research, higher education institutions (HEIs) and all other non-NHS settings.

This resource aims to develop understanding across the profession of health inequalities and how to take action to ensure equality and equity, and that the profession is meeting the needs of the populations we serve.

Please see our glossary for definitions of key terms that are used throughout this guidance.

This guidance can also be viewed online at rcslt.org/health-inequalities.

What are health inequalities?

> "Health inequalities are avoidable, unfair systematic differences in health between different groups of people."
>
> (The King's Fund, 2020)

> "Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health."
>
> (Marmot, 2010, p15)

What does it mean?

The link between the social conditions in which a person lives and health inequalities has been understood and documented often; the 2010 report 'Fair Society Healthy Lives' by Sir Michael Marmot (2010) is clear that progress towards a fairer society is marked by the magnitude of health inequalities in the population.

The follow-up report (Health Equity in England: The Marmot Review 10 Years On, 2020), laid bare the widening gap in health inequalities in England, with life expectancy reducing in deprived areas outside London for women and in some regions for men. The World Health Organisation defines the social determinants of health as "the non-medical factors that influence health outcomes."

The term covers many different health inequalities that can arise because of the circumstances and factors that affect peoples' lives. Some groups of people who share certain characteristics may be more vulnerable to health inequalities than others, because they are under-served by the healthcare system ('under-served groups'). Such factors can be characterised in terms of the following broad areas:

- socio-economic factors, eg income
- geography, eg region or whether urban or rural
- specific characteristics including those protected in law, such as sex, ethnicity or disability
- socially disadvantaged groups, eg people experiencing homelessness.

(The King's Fund, 2020)

As Napier et al (2014) state: "The systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide" (Napier et al, 2014, p 1608).

These factors are unlikely to impact on a person one at a time, it is far more likely that the impact will be felt by many of these factors interacting, both in parallel and in sequence over time. As an SLT how much do you know about how these factors affect all your service users?

Health inequalities, under-served groups and the equality, diversity and inclusion (EDI) agenda

Those experiencing health inequality are often from particular under-served groups. The equality, diversity and inclusion agenda should strive to serve such groups to mitigate health inequality.

Increasingly, research is evidencing the differential outcomes experienced by under-served groups:

- Black and ethnic minority patients experience differential (often poorer) outcomes in healthcare, and people from ethnic minority groups are more likely to report being in poorer health than white counterparts (The King's Fund, 2021)
- People who are LGBTQ+ are more likely to experience health inequalities, caused by societal norms that prioritise heterosexuality as well as outright discrimination and stigma (Zeeman et al, 2018)
- Those who are homeless are vulnerable to health inequalities, arising from intertwined adverse social and economic conditions (Stafford and Wood, 2017)

- People with learning disabilities face health inequalities and are at particular risk of premature death (LeDeR, 2020)
- Those living in socio-economically disadvantaged areas may be more likely than those living in affluent areas to experience multiple health problems in adulthood (multi-morbidity) though the causal factors require examination (Olutende, Mse, Wanzala and Wamukoya, 2021)
- Looked after children, who predominantly interact with social workers, may have their health needs overlooked, contributing to health inequalities (Bywaters, 2009)
- There are inequalities in the health of people who belong to traveller communities, more so than almost any other group in the UK (van Cleemput, 2010)

What leads to health inequalities?

Institutional biases

Different types of institutional biases exist, for example systemic racism, homophobia, transphobia, classism or ableism.

Typically, these biases arise from the design of our healthcare systems and the paradigms in which they operate under, which may foster and perpetuate discriminatory beliefs and values (Hui, Latif, Hinsliff-Smith Chen, 2020). Thus, a system and workforce develop which are unable to deliver equitable care (Bailey et al, 2017).

'Systemic' or 'institutional' racism refers to "how ideas of white superiority are captured in everyday thinking at a systems level: taking in the big picture of how society operates, rather than looking at one-on-one interactions." (O'Dowd, 2020).

In healthcare systems, institutional racism may contribute to health inequality for Black and minority ethnic populations – this is inextricably linked with the anti-racism agenda.

Examples of system-wide issues that may perpetuate health inequalities are:

- Our health care systems being underpinned predominantly by one model of illness and disability (ie 'western' medicine, medical models of disability) which render service users operating outside of this vulnerable to disempowerment and leads to inequitable care.
  - See examples of religious beliefs relevant to understanding and experiencing health and healthcare in Swihard, Yarrarapu and Martin (2021).
  - See specific perspectives from under-served groups on approaches to speech and language therapy in Roulstone et al (2015, p 143-145).
- Historically poor representation of people from ethnic minority backgrounds, women, who are LGBTQ+ or with disabilities in clinical research, potentially leading to

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recommendations that are not appropriate for different populations, which can result in inadequate clinical guidance (see eg Smart and Harrison, 2017).

- Biased educational materials and curricula meaning clinicians are not taught how to deliver appropriate care to those from marginalised groups (see example of speech and language from Pillay and Kathard, 2015), or the development of assessment materials lacking sensitivity and representation of marginalised groups therefore creating barriers to engagement.
- Failure to adequately fund a workforce and services required to meet the needs of diverse populations such as overcoming language and cultural barriers, for example not allocating funding for interpreters or development of diverse resources (Piacentini, O'Donnell, Phipps, Jackson and Stack, 2018).
- Ethnicity and gender disparities in position, prestige and pay among healthcare staff have been described in research, affecting, for example, hiring practices and career progression of ethnic minority staff (Milner, Baker, Jeraj and Butt, 2020).

Implicit bias

A clinician's implicit bias may also contribute to health inequalities. Implicit bias is the making of "associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender." (FitzGerald and Hurst, 2017).

Research has shown that healthcare professionals may possess implicit biases which can influence health outcomes. A systematic review concluded that healthcare professionals exhibit implicit bias at the same degree to the mainstream population. These biases may influence clinical decision making, and the level of care offered to service users (FitzGerald and Hurst, 2017).

Studies have documented examples of healthcare professionals with biases toward under-served groups such as:

- Traveller communities (Frances, 2013)
- People of colour (Hall et al, 2015)
- LGBTQ+ people (Sabin, Riskind and Nosek, 2015)
- Disabled people (VanPuymbrouck, Friedman and Feldner, 2020)

As an SLT, are you cautious about making direct assumptions or judgements of service users who both share or do not share your own culture, race, ethnicity or religion?

Going unresolved, a clinician's implicit bias may therefore create inequality in healthcare. Changing this is unreservedly imperative and is an element of becoming anti-racist, anti-homo/transphobic or anti-ableist, and an ally to those from other under-served groups.

The SLT role in health inequalities

This guidance looks firstly at the broader role of speech and language therapists and then more specifically at the typical factors that impact on a service users' experience, and how an SLT might contribute to reducing or mitigating any health inequalities that arise. There are also some interesting observations on the impact of allied health professionals (including SLTs) on health inequalities in a recent rapid review (Ford et al, 2021).

What is the SLT role?

The NHS Constitution requires all staff to contribute towards providing fair and equitable services for all and help to reduce inequalities.

The COVID-19 pandemic has highlighted existing health inequalities (see, for example, Katikireddi et al, 2021). As we move through the pandemic, we are noting an increasing focus on population health and health prevention. This is an opportunity to highlight the role of speech and language therapy in contributing to better population health and reducing health inequalities.

See this King's Fund article for a definition and discussion of population health.

Members can log in to see our public health guidance for further information on the SLT role.

The broader role of SLTs

A crucial part of the speech and language therapist's role is understanding not just the 'norms' of development and communication breakdown in English, but also the norms of development and communication breakdown in other languages and cultures – as well as thorough understanding of the implications of food modification for those with dysphagia.

An SLT must be able to provide personalised and equitable care to all service users who require it, thus understanding each individual's preferred language, culture, religion, family setup, attitudes toward their health status, beliefs on approaches to play, language or rehabilitation is imperative. Having well-planned, accessible, equitable, and appropriate care pathways, resources, assessment materials and workforce are all essential to mitigating health inequalities.

Therefore, SLTs must develop 'cultural humility' and commit to working reflexively across their careers. SLTs will need to constantly adapt their practices to best meet the communities that they work with.

- Cultural humility can be defined as: "A lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities." (Yeager and Bauer-Wu, 2013, p 251).

Specific roles of SLTs

Access to services

- SLTs should consider the impact of services being accessible and especially to potentially under-served groups, for example, do they have the confidence and skills to navigate their local healthcare system; can they travel to them or are there language barriers?
- SLTs are able to help a service user with health literacy, overcoming language barriers and using interpreters where necessary (see RCSLT's Inclusive Communication guidance and information on Communication Access UK) This can support services to meet the requirements of the Accessible Communication Standard and supporting reasonable adjustments for people with communication impairments.
- SLTs need to assess whether digital poverty is impacting on access to services delivered via telehealth (see RCSLT's telehealth guidance section on digital inclusion).

Health status

- SLTs can understand any co-occurring health needs and be aware of health needs of particular under-served groups in planning appropriate care.
- SLTs can take account of the prevalence and incidence of clinical conditions in the population in general, and if there is any known research about specific under-served groups.

Quality and experience of care, for example, levels of service user satisfaction

- SLTs can ensure they understand the service user's experience and social factors that affect them. This can form a part of your initial assessment (see RCSLT guidance on assessment) and could include seeking views from service users in the planning of services, see RCSLT guidance on children's services for example).

- SLTs can personalise care for individuals from different cultures, ethnicities, family setup, languages and socio-economic situations and intellectual ability from their own.
- SLTs can consider the cross-cultural differences in which families access speech and language therapy services and attend regular appointments, ie, older siblings or elder family members attending with children.
- SLTs recognise that adherence to expert dietary guidelines will vary due to food beliefs and practices which will impact on dysphagia management.
    - At a personal level the service users' preference, taste, psychological state is considered.
    - At an interpersonal level, the patterns of the household, food preparation and habits of significant others are investigated.
    - At a community level the food availability and prices which could influence the accessibility of modified food and food choices are also taken into account.

Behavioural risks to health

- SLTs can support service users to understand health risks and choices through reasonable adjustments to their communication needs.
- SLTs support early years development in their awareness of diverse cultural and social communication environments.
- SLTs can support general health promotion campaigns eg referral to a smoking cessation service for a parent who smokes when discussing their child's glue ear, through the rapport they develop with service users and their carers eg Make Every Contact Count.

Wider determinants of health

- SLTs can take account of impacts of deprivation and socio-economic inequalities in managing their caseload eg arranging appointments in the community, where the majority of their funding is targeted.
- SLTs can signpost to appropriate services, both in healthcare and non-healthcare eg debt advice.
- SLTs can understand co-occurring intellectual disabilities and the structural barriers people with learning disabilities face in accessing health services, including diagnostic overshadowing and institutional ableism.

- SLTs can consider appropriate 'did not attend' policies to take account of ability to attend or language barriers or in planning interventions appropriately taking account of potential service user factors, eg homelessness.
- SLTs can facilitate success in education/employment as protective factors for health by assessing and treating communication disorders.

SLT and service role in collecting and analysing data

- An additional role of the SLT is evaluating and monitoring your caseload to ensure you are aware of the needs of everyone you are serving through your practice. The key to this is collecting data about your service users robustly and routinely.
  - This should include basic information about the service users, eg demographic information such as age, gender, ethnicity and diagnoses (see Equality Act 2010) and outcome measures
- Data can then be analysed in conjunction with information you have about the local population, and prevalence/incidence of clinical conditions to see if 'theory' matches 'reality'. Collecting data is valuable, but using data is what is powerful.
- The government's 'Early Years Health Development Review Report: The Best Start for Life, A vision for the 1001 Critical Days (2021)' cites that "good quality datasets are essential to identifying and eliminating the greatest inequalities. Reviewing what data is collected and ensuring it is collected in a way that is both efficient and punctual and that it is correctly recorded will make a substantial difference." (p 101). Read the full government report.
- SLTs can engage with learning from premature deaths and specific current data gathering approaches eg, reporting any death of a child (4 years plus) or person with a learning disability for a review through the Learning Disabilities Mortality Review (LeDeR) programme (LeDeR, 2021) (see the LeDer website)
- Collecting data can sometimes be a sensitive factor for some patients, especially with regard to ethnicity, gender and sexual orientation. The NHS has developed a Sexual Orientation Monitoring Information Standard which you may wish to refer to.
- Members can log in to rcslt.org to view related guidance on:
  - Outcome measurement
  - Assessing the needs of your local population

Inclusive speech and language therapy

Institutional and implicit bias can result in a lack of equitable and appropriate speech and language therapy thus contributing to health inequalities. SLTs should be providing fair, culturally and linguistically appropriate and inclusive services to all.

To support the profession to do so, the RCSLT and members have produced:

- A **self-audit tool** to support you and your service to ensure you are meeting the needs of your diverse populations.

- A series of **case studies** illustrating good practice in delivering quality care to service users' who may be particularly vulnerable to health inequalities (ie those from typically under-served groups)
- A **programme of learning** for our profession-wide event anti-racism in speech and language therapy, including:
    - Naomi Ignatius's video series: Anti-racism in speech and language therapy: What is it like on the ground?
    - Sunita Shah and Dr Sean Pert's video on bilingualism and cultural diversity
    - Jo Fillingham's video on examining the NHS context
    - Towards cultural competency in dysphagia practice

Health inequalities self-audit tool

About the tool

A crucial part of the speech and language therapist's role is understanding not just the 'norms' of development and communication breakdown in English, but also the norms of development and communication breakdown in other languages and cultures – as well as thorough understanding of the implications of food modification for those with dysphagia.

An SLT must be able to provide personalised and equitable care to all service users who require it, thus understanding each individual's preferred language, culture, religion, family setup, attitudes toward their health status, beliefs on approaches to play, language or rehabilitation is imperative. Having well-planned, accessible, equitable, and appropriate care pathways, resources, assessment materials and workforce are all essential to mitigating health inequalities.

In addition, SLTs must avoid the risk of stereotyping or assuming that all service users from particular communities hold the same beliefs or share the same experiences. SLTs should also demonstrate inclusivity and allyship to those from under-served communities, which should be reflected in their approach and resources.

There will always be changes in how language, religion and/or culture impacts on communities and the individuals who live within them. This may be as a result of generational changes or other impacts. Therefore, SLTs must develop 'cultural humility' and commit to working reflexively across their careers. SLTs will need to constantly adapt their practices to best meet the communities that they work with.

Cultural humility can be defined as: "A lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities." (Yeager and Bauer-Wu, 2013, p 251).

As individuals ourselves, we all have different needs (eg which languages we wish to communicate in), values, and beliefs which we hope will be explored and respected. In providing personalised care, we should apply these principles to those we work with.

When working with our diverse caseloads, it is therefore essential that we move to a more flexible approach, applying the research we have where this exists. We have to be aware that much of our research may exclude some of the more vulnerable in our society – including monolingual English-speaking communities living in areas of deprivation, those who are from Black and minority ethnic backgrounds, those who may speak no English or have English as an additional language, or those who are LGBTQ+ or have disabilities. Thus, we also have a role in contributing to the evidence-base in these areas.

How you can use this tool

We would encourage you to use this tool in the context of your team environment as well as in clinical excellence networks (CENs) to consider in the light of the particular clinical conditions.

This tool can be used by SLTs in the NHS and in non-NHS settings, including research and the higher education sector, and we would encourage you to adapt it to your own settings.

You can work through the prompt questions here or visit our website to download an editable version of the tool, which provides space to note your reflections, and actions for next steps.

We are looking for feedback about how your team or CEN has done this to build a picture of best practice. Please contact berenice.napier@rcslt.org and katie.chadd@rcslt.org to share your thoughts.

You might also the King's Fund AHP health inequalities framework helpful. It provides ideas on how to view and consider health inequalities and suggests breaking each area down into how you can improve your awareness of health inequalities, what action you can take and how you can be an advocate.

Part one: Understanding your community

Context

The only way to really evaluate if your service is providing inclusive and equitable care is to understand the community you're working with in the first place – both on a local level, and in terms of the clinical population.

How do you know if you're seeing who you should expect to be seeing in your service? It is the very first and fundamental step in exploring whether your service is inclusive and equal.

Use the prompts below to examine what you know about the community you do and don't serve.

Understanding your local population

- Do you know the general makeup of your local population (eg age, gender, ethnicity, religion, language spoken)? Take a look at the data provided by Public Health England for your area Public Health profiles, the Northern Ireland Census, the Scotland Census, StatsWales or the Office of National Statistics for UK wide data on a range of variables.
- Do you know the general socio-economic landscape of your local population (eg percentage of children on free school meals, index of multiple deprivation in England?
- Do you know about any particular health inequalities raised in your area (eg local reports such as joint strategic needs assessments)?

- Do you know the prevalence of specific under-served groups in your locality who may face particular challenges accessing healthcare, eg refugees or asylum seeking families, or those who are homeless?

Understanding your caseload

- Do you know the demographic and socioeconomic breakdown of your caseload?
- Do you systematically collect service user data including characteristics such as ethnicity, religion, languages spoken?
- Do you systematically evaluate your service user data to examine whether the expected demographics are reflected in your caseloads?
- Do you collect data about appointment/service take-up and map this to your demographic information?

Awareness of prevalence and incidence

- Do you know the general incidence and prevalence of the clinical conditions you come across in your caseload? (see 'statistics' sections in RCSLT guidance, eg aphasia)
- Do you know if there are any specific statistics regarding incidence and prevalence of clinical conditions among populations with specific characteristics (eg prevalence among a given gender, ethnicity, socioeconomic background)?
- Do you systematically evaluate your patient data to examine whether the expected prevalence and incidence of clinical conditions (broadly and among specific populations) are reflected in your caseloads?

Part two: Access and equity

Context

We know there are some clear blocks for some people accessing services which need to be addressed but examining some of the subtler reasons why they may not be accessible is also important. It's also important to understand who is accessing what kind of service to scrutinise whether there are any inequalities. The following questions will help to guide your thinking about how accessible and equitable your service is.

Ensuring accessibility

- Do you know the waiting list figures for assessment and therapy for your general caseload, and specifically for those from typically under-served groups?
- Do you know the accessibility (in terms of proximity and usage) of general and specialist services to your local community, and specifically for those from under-served groups?

- Do you offer options to those on your caseload for where they are seen (where possible/relevant), to ensure you are able to meet the needs of everyone?
- Do you provide communications (including appointment notifications and clinical reports) in accessible formats (eg different languages, braille, spoken rather than written etc) to ensure those from under-served groups fully understand their needs and their care?

Ensuring equity

- Do you systematically compare service user data of those accessing specialist provision with those accessing generalist provision across that community that you serve, to identify whether there is unwarranted variation (specifically in relation to under-served groups)?
- Do you know how to request and work with interpreters, when required?
    - See RCSLT guidance for further information.
- Do you reflect on any planned advice/intervention to ensure there are no assumed prerequisites on resources to be provided by a family (eg a fixed address, money to purchase telephone credit, data for telehealth appointments, living space to carry out intervention)?

Part three: Your service provision

Context

Thinking about what you know about the health inequalities or under-served groups in your local population, how can you apply that in your provision of a service?

The following questions may be used as prompts to evaluate the degree to which your service is reaching all communities.

Appropriateness of service provision

- Do you have access to interpreters to enable you to provide effective support in both the home language of the patient and English?
- Do you have access to interpreters with all the languages you require?
- Do you ensure people are aware of their right to request an interpreter?
- Do you know how to gather information about the service user and family holistically including finding out about religious or cultural beliefs, parental/family arrangement, family practices and attitudes and how this may relate to their understanding of your service (eg cultural norms related to play, or religious beliefs about illness and intervention, view on disabilities or mental health)?

- Do you discuss and consider all elements of a service user's identity when planning assessment, goals and intervention (eg that may support participation in religion, faith and spirituality, LGBTQ+ community activities etc)?
- Do you have access to other services or resources to enable you to provide appropriate support that is sensitive to holistic needs (eg religious counsellors)?
- If relevant, do you have access to eg thickener products or meal plans that are sensitive to various dietary requirements and relevant for authentic dishes from a range of countries?
- Do you have appropriate assessment tools or techniques to reliably and validly assess the needs of under-served groups (eg fully evidence-based, linguistically and culturally translated and standardised tests?)
- Do you have appropriate therapy approaches or techniques to support the needs of under-served groups who are represented on your caseload?
- Do you have access to a range of materials and resources that are appropriate to different needs (eg culturally appropriate, representing Black or minority ethnic people, LGBTQ+ families etc) to support your assessment or intervention?
- Do you know what to do/where to go/who to ask if you do not have appropriate assessment of therapy materials to support the needs of diverse caseloads (eg line manager, head of service)?
- Are the materials, promotional materials and information on display in your environment that show diversity (eg minority ethnic, Black, same-sex couples, trans people, people with physical differences or disabilities)?

Enabling service user involvement

- Do you ask your service users about their pronouns, names or honorifics, and implement this?
- Do you engage service users appropriately in goal setting, planning meaningful intervention and evaluating outcomes in an inclusive manner?
- Do you encourage and provide opportunities for children/their families to share experiences to support ‘oral tradition’ common among cultures and embed this in provision/planning, where appropriate?
- Are these explained to families/carers with space for feedback and adjustments to suit their needs?
- Do you regularly provide opportunities for your service users and their communities to get involved in audits, service evaluations and improvement projects or research?

- Do you regularly provide opportunities for your service users and their communities to support universities or services with teaching, applicant interviews and conversation partner schemes?
- Ensure you seek feedback from diversely represented community members.

Outreach to communities

- Do you/your service outreach to local communities? (eg via an advocate or local religious institutions ie mosque, synagogue, charities)
- Do you have a member of staff in your service who could serve as a cultural interpreter for outreach activities?
- Do you work with the community to help identify barriers to accessing your service?
- Do you collect feedback from your service users about their experiences of healthcare, ensuring avenues to do so are fully accessible and in a range of languages?

Part four: SLT workforce

Context

As health professionals you are encouraged to reflect regularly on your practice and own values, skills and knowledge.

Take the time to broaden your own understanding of health inequalities by looking at some of the references at the end of this guidance and the King's Fund AHP Health Inequalities framework. You might also find the RCSLT anti-racism reading list useful.

Use the following questions to reflect as individuals or as teams.

Professional development and allyship

- Do you seek/are provided appropriate and regular training from your organisation that supports you to address the needs of the community you work in?
- Do you ask your colleagues what their pronouns are and implement this?
- Do you engage with different networks representing the needs of under-served groups? (eg National Trans and Gender Diverse Voice and Communication CEN, UK SLT Pride Network, bilingualism CENs)

- Do you share your learning with colleagues and encourage staff to be allies to under-served groups?
- Do you demonstrate your allyship visibly to service users (eg pride lanyards, Black Lives Matter badges)?
- Does your service provide equality and diversity training for staff?
- Does your service engage staff and students on placement in conversations and provide opportunities to ask questions or feedback about equality, diversity and inclusion in a safe space?
- Is there a clear process for reporting concerns in your workplace and specific support around issues of equality, diversity and inclusion?
- Do you discourage staff and service users from using racially inappropriate terms/language or other discriminatory behaviours if it occurs (including helping people to understand how this impacts others)?

Recruitment

- Do you encourage Black, Asian and minority ethnic people, LGBTQ+, including trans and non-binary, people and people with a disability to apply for posts by specifically inviting people from these communities?
- Does your service employ bilingual assistants?
- Does your service evaluate the diversity of staff teams?

Case studies

This collection of case studies showcases good practice in meeting the needs of under-served groups and delivering quality care to service users who may be particularly vulnerable to health inequalities.

The case studies show how SLTs can support a service user/their families' engagement with speech and language therapy and other health services and include examples of culturally sensitive care, use of trauma-informed approaches, service-level changes and the role of SLTs in wider health promotion.

Speech and language therapists should always take an evidence-based approach to practice (HCPC, 2014) and should always triangulate the findings from research, with clinical expertise and service user preferences.

The case studies illustrate successful examples of speech and language therapy practice, but it should be noted that **each service user is an individual and it should not be considered that the care exemplified in case study is suitable for all people** who meet the descriptions given.

Read our case studies and download a template to share your own by visiting the RCSLT website.

Related guidance

Members should refer to the following pieces of RCSLT guidance:

- Clinical guidance pages (particular attention should be paid to the statistics, or incidence and prevalence sections)
- Working with interpreters
- Assessing needs of local population
- Bilingualism
- Outcome measurement
- Measuring outcomes outside individualised care

Glossary

Ableism
Ableism is discrimination in favour of non-disabled people (Scope, 2021). See Scope for further discussion of both ableism and disablism.

Classism
"Classism is differential treatment based on social class or perceived social class. Classism is the systematic oppression of subordinated class groups to advantage and strengthen the dominant class groups." (Classism, 2021)

Cultural humility
"A lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities." (Yeager and Bauer-Wu, 2013)

Implicit bias
"Implicit biases involve associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender." (FitzGerald and Hurst, 2017)

Institutional bias
Bias induced or embedded within a system or institution (ie not individual), operating at a systems level. Can include institutional or systemic racism, homophobia, transphobia, classism, ableism.

Transphobia
"The fear or dislike of someone based on the fact they are trans, including denying their gender identity or refusing to accept it. Transphobia may be targeted at people who are, or who are perceived to be, trans." (Stonewall, 2021b)

Under-served groups
In the context of healthcare and health research, an under-served group describes a population or community with shared characteristics that have historically been disadvantaged in receiving adequate health care or quality/volume of research, to an equal standard of the 'mainstream' population. Characteristics of under-served groups may be (National Institute of Health Research, 2020):

- "Lower inclusion in research than one would expect from population estimates.
- High healthcare burden that is not matched by the volume of research designed for the group.
- Important differences in how a group responds to or engages with healthcare interventions compared to other groups, with research neglecting to address these factors."

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For information on research and evidence relating to the broader topics of anti-racism, diversity and inclusion please visit the RCSLT website.

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 Acknowledgements

With thanks to the following RCSLT members who have provided feedback during development of this information.

- Ilyeh Nahdi
- Aydan Suphi
- Sean Pert
- Nabiah Sohail
- Sahar Nashir
- Sarah Spencer
- Sally Morgan
- Lindsey Thiel
- Dharinee Hansjee
- Julie Marshall
- Dave McDonald
- Katherine Pritchard
- Toria Kilsby
- Rachael Middle
- Alex Wormall
- Alpana Marwaha
- Rachael Middle
- Anna Raby
- Sophie Woodford
- Matthew Horton
- Kerry Corley
- Pat Mobley

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