

- ▶ **Reflections on a Northern Ontario Placement Initiative**
- ▶ **Réflexions sur une initiative de stage dans le Nord de l'Ontario**

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KEY WORDS

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Abstract

This paper discusses a novel initiative in clinical education developed at the School of Communication Sciences and Disorders at the University of Western Ontario. The project is a coordinated effort between clinical education faculty at the university and hospital and school representatives in Moose Factory, Attawapiskat and Kashechewan. It describes a supervised clinical experience for students in the Speech-Language Pathology program that integrates clinical education needs with the provision of services in a culturally diverse, remote, and under-served population. Project background, program development, and logistical planning required for this kind of clinical fieldwork experience are reviewed. Elements of the clinical training provided to the students are outlined. Learning based on these experiences, including the need for culturally sensitive assessment and treatment protocols are discussed. Challenges of service provision to First Nations communities are examined. Future directions including considerations for sustainability are proposed.

Abrégé

Le présent article discute d'une initiative nouvelle en formation clinique conçue par l'École des sciences et des troubles de la communication à l'Université Western Ontario. Cette initiative est le fruit d'efforts concertés entre les chargés de formation clinique à l'université ainsi que des représentants du milieu hospitalier et scolaire de Moose Factory, d'Attawapiskat et de Kashechewan. Il décrit une expérience clinique supervisée destinées aux étudiants en orthophonie qui intègre les besoins de la formation clinique et la prestation de services auprès d'une population hétérogène sur le plan culturel, éloignée et mal desservie. L'article passe en revue le contexte de l'initiative, ses étapes d'élaboration et la planification logistique nécessaires pour ce genre d'expérience clinique sur le terrain. Il souligne les éléments de la formation clinique offerte aux étudiants, aborde les leçons tirées d'une telle expérience, y compris la nécessité d'avoir des évaluations et des protocoles thérapeutiques adaptés à la culture, et examine les défis liés à la prestation de services à des communautés des Premières Nations. Enfin, il propose des orientations, y compris des éléments à prendre en considération, pour assurer la viabilité d'une telle formation.

INTRODUCTION

Since 2008, clinical faculty and Speech Language Pathology students from the School of Communication Sciences and Disorders at the University of Western Ontario have participated in a week-long clinical education opportunity in three remote First Nations communities along the James Bay Coast in Northern Ontario (Moose Factory, Attawapiskat, and Kashechewan).

One of the clinical training objectives of the School of Communication Sciences and Disorders (CSD) at the University of Western Ontario (UWO) has been to ensure that students participate in unique and enhanced clinical education experiences that reflect the needs within the province. The speech and language needs of First Nations communities in Northern Ontario have been well documented (Brown, 2005) and these communities were therefore selected for this project.

Contact with the Weeneebayko General Hospital in Moose Factory led to the identification of key hospital and school partners in all communities. All three were interested in collaborating to offer a clinical placement for students as a means of obtaining speech-language pathology services.

Moose Factory, Attawapiskat, and Kashechewan are Cree communities that lie along the western coast of James Bay. Attawapiskat, Kashchewan and most of Moose Factory are reserve lands, each with populations less than 3,000. Moose Factory is an island in the Moose River accessible by boat in summer months, ice roads in winter months, and by helicopter during winter 'freeze-up' and spring 'break-up'. Transportation between the other two communities is by air only, except in winter when some transport by winter ice road is possible. The closest non-reserve communities are Timmins (pop. 45,000) and Cochrane (pop. 5,500). Timmins is accessible by air from Moosonee (one hour). Cochrane requires an additional commute of about 200 kms. If more advanced medical and educational services were required, patients flew to North Bay, Thunder Bay, or Kingston. Medical consultants also traveled to the communities from these larger centres. Schooling in both Attawapiskat and Kashechewan was further compromised by community evacuations due to flooding, resulting in loss of teaching days. Loss of school facilities due to contamination and fire damage, and the slow replacement of these facilities along with repeated evacuations have resulted in students losing entire academic years.

The remoteness of these communities resulted in both logistical and financial barriers to this clinical placement. These small communities had limited accommodations and services for visiting groups. As

well, flight schedules to reach these communities were infrequent and very costly. Initially, the Faculty of Health Sciences at the University of Western Ontario provided financial support sufficient to cover travel expenses to Moose Factory. Subsequent placements were funded through the School of CSD's Clinical Education Fund, provided by the Province of Ontario to support innovative and expanded clinical education opportunities for students. The Weeneebayko General Hospital was generous in the provision of the remaining flights to and from Attawapiskat and Kashechewan and in the provision of student housing in Moose Factory. In Kashechewan, where no housing options were available for visitors, nursing and school staff shared their homes with both students and faculty. All other expenses were borne by the students who provided \$300.00-\$500.00 of personal funds to support this venture.

OBJECTIVES

With the primary objective of creating high quality and innovative clinical placements for our Speech-Language Pathology (S-LP) students, this initiative intended:

- To use these clinical opportunities to provide S-LP services in areas that were in clear need of these services;
- To ensure that the clinical training of future generations of S-LP service providers fostered a sense of social consciousness and responsibility, as well as an awareness of, and an ability to work effectively within the diverse and multicultural context that exists in Canada;
- To provide students with an opportunity to build on their training, encouraging them to question the validity and applicability of their assessment and treatment approaches when faced with populations that are not adequately serviced using traditional methods, and
- To build and strengthen collaborations with these communities, in order to ensure sustainability of the placement and service provision.

PROGRAM DEVELOPMENT

Contact was made with the Weeneebayko General Hospital. The hospital offered support for a program to be developed and facilitated contact with the Learning Support Teachers (LSTs) in Kashechewan and Attawapiskat. LSTs are teachers who work with children who have identified special learning needs. These key informants, as well as other S-LPs who previously provided

services in these areas, guided the development of the speech-language pathology services to be offered.

CLINICAL PLANNING

A selection process was developed to identify the students most suited for participation. All second year S-LP students were provided with the opportunity to apply for this clinical placement. This formal application process allowed us to select students based on:

- First nation status;
- Demonstrated interest in working in rural and remote or low-resourced areas;
- Demonstrated research interests in this area of service;
- Clinical placement evaluations that identified strong professional and ethical conduct, exceptional interpersonal communication skills, rapid integration of feedback, independent problem solving, critical thinking skills, and
- Strong academic record.

Students were asked to carefully consider their ability to manage the challenges that this experience imposed with respect to motion sickness, cold weather, dietary limitations, and other risks associated with remote travel.

Clinical teaching and preparation began a year in advance of the placement. During 50 hours of instruction, students were required to investigate Cree culture, to explore the history and challenges faced by the three communities selected, and to learn from the experiences of other S-LPs who previously provided contractual services to these and other remote communities. These consultants provided information regarding assessment protocols used, challenges to assessment and intervention, cultural and social information regarding the communities, information on children identified for follow-up services, logistical challenges, and resources available. Other published resources were reviewed to provide further background information (Ball, 2002; Ball, 2007; Ball & Bernhardt, 2008; Ball & Elliot, 2005; Ball & Lewis, 2005; Ball & Simpkins, 2004; Gerlach, 2000; Langan, Sockalingam, Caissie, Corsten, 2007; Smylie, 2000; Smylie, 2001).

Under the guidance of the clinical supervisors, the S-LP students developed the services and resources requested by the communities, and the programming materials to be shared with the school and hospital staff. These teaching clinics resulted in in-depth discussions about the value and applicability of traditional assessment approaches and served to facilitate the development of alternatives that better informed programming

recommendations. Supervisors organized and planned the caseload management and created templates for documentation, for consent and release of information, and for gathering information before and after the placement.

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The LSTs were the primary co-ordinators at these sites. The number of referrals they received ranged from 24-36 children. They assisted in every aspect of the service delivery by:

- Obtaining required consent forms;
- Seeking referrals from the teachers;
- Selecting and prioritizing appropriate students for referral and making referral information available when possible, prior to our arrival;
- Arranging teacher and parent meetings;
- Scheduling sessions, arranging rooms, accompanying each student to and from the session, and
- Providing feedback and discussing future possibilities.

WEENEEBAYKO GENERAL HOSPITAL, MOOSE FACTORY

This 35 bed, acute care hospital used approximately half of the beds for long-term care. Typically, during our placement, 14 -18 beds were occupied and 9 -14 referrals were received for speech, communication, and swallowing services. The physiotherapist was the primary contact for this placement. She facilitated introductions to other key participants. Over the three placements, the following assistance was provided by the physiotherapist, the occupational therapist, and the registered dietician:

- Co-ordination of the referrals with the nursing unit and the on-call physician;
- Organization of the hospital staff in-services, patient rounds, and grand rounds presentations;
- Participation in inter-disciplinary assessment and treatment sessions, and
- Participation in debriefing meetings to provide feedback and discuss future possibilities.

PROGRAM DESCRIPTION

At each school site, LSTs were provided with referral forms and assisted classroom teachers in selecting clients

for referral. The LSTs then prioritized clients and gathered any other relevant information.

Following a 45 minute session, student clinicians were required to develop at least two recommendations suitable for implementation by classroom teachers and/or LSTs. Resources to support these recommendations were selected from a previously developed resource binder. Student clinicians did their best to meet with teachers regarding specific clients. Each family was provided with the opportunity to attend their child's session. Specific family programming was provided. If required, additional resources were mailed upon the team's return to the University of Western Ontario.

Initially, attempts were made to provide general speech and language information to teachers and families in a group forum but this was not found to be successful during the 2008 visit. Parents and teachers reported that they would prefer individual meetings. We abandoned

the group format (with consent from school officials) and directed our efforts to more individualized teacher and parent offerings.

For the hospital portion of the placement, patient information was available prior to our arrival and student clinicians had an opportunity for advance preparation. Chart reviews were completed in the evening prior to the assessment day. Students were responsible for assessing and documenting information about each patient referred. Recommendations were discussed and/or demonstrated to attending nurse(s) and other allied health professionals. Students also attended patient rounds to present their findings to the larger clinical team. In all three placements, students were invited to present on the topic of dysphagia management at Grand Rounds.

Details summarizing the clinical services provided at each site for each year are provided in Table 1.

Table 1

Clinical service provision over three years.					
YEAR	ASSESSMENT/ INTERVENTION	PARENT MEETINGS/ IN-SERVICES	TEACHER MEETINGS/ IN-SERVICES	JOINT BED-SIDE CONSULTS with Nursing, OT, PT, RD	STAFF TRAINING Pt. Rds., Grand Rds., In-services
2008 5 S-LP students	Moose Factory 11	N/A	N/A	10	9
	Attawapiskat 16	7	2	N/A	N/A
	Kashechewan 30	N/A	2	N/A	N/A
2009 4 S-LP students	Moose Factory 11	N/A	N/A	11	5
	Attawapiskat 16	9	9	N/A	N/A
	Kashechewan 30	N/A	3	N/A	N/A
2010 4 S-LP students	Moose Factory 11	N/A	N/A	11	3
	Attawapiskat 16	7	4	N/A	N/A
	Kashechewan 30	N/A	N/A	N/A	N/A

Notes: N/A=Not Applicable
 OT=Occupational Therapist
 PT=Physical Therapist
 RD=Registered Dietician
 Pt.=Patient
 Rds.=Rounds

The information from the 4th (February 2011) placement is currently being compiled and not included in this Table.

DISCUSSION

As we reflect on this project, the following emerge as issues for consideration.

Understanding the Role of Communication and Communication Development within these Communities

As SLPs, our assessment and intervention plans are based on a shared notion of the role that communication plays in social and educational development. This role and its importance are based on cultural values. These values, for these specific communities, were unknown to us. Over the course of the placements, it became clear to us, as evidenced by the referrals we received from our community partners, that communication development and communication abilities were valued life skills. However, we suspected that each of our communities defined communication and promoted communication development differently. For example, it seemed that, unlike the preschoolers with whom we worked in Southern Ontario, young children in these northern communities were rewarded more for becoming good listeners, observers and 'doers' than talkers. Identifying these kinds of differences and generating normative data that accurately reflect these developmental differences will be crucial in our ability to develop valid assessment and treatment protocols. Further complicating this issue is the fact that differences exist between communities, regardless of their geographical proximity or shared linguistic environment.

In mainstream S-LP practice, we operate on the premise that parents are the key to early communication development. Much time and many resources are invested in parent training and education. We acknowledge that all parents play an important role in fostering their children's communication development. However, we need specific information on what this role is and how it is expressed in the families we serve in these northern communities.

Speech and Language Assessment of School-Age Children

English assessment protocols administered by English-speaking S-LPs were used to assess children in the communities visited. We did not have access to Cree speech and language assessment protocols, Cree-speaking S-LP students, or Cree translators. No resources were found specific to speech and language development in Cree children and bilingual English/ Cree children.

Most students entered the school system speaking both English and Cree with varying levels of proficiency. We noted that phonological development was affected by the length and type of exposure as well as the practical use of both languages. For example, we suspected that a

child who had exposure to both Cree and English since birth would enter school with a different pattern of sound and phonological development than a child who was first exposed to English at 5 years of age.

In preparation for articulation evaluation and treatment, available Cree phonology information was reviewed in order to compare and contrast it to English phonology. This allowed us to identify phoneme differences and sound production differences between the English and Cree languages and to adjust articulation protocols accordingly, more accurately identifying articulation delay, disorder and difference. Student clinicians administered either the Goldman Fristoe Test of Articulation (GFTA) or the Structured Photographic Articulation Test – D II (SPAT-D II) in English. These were administered with the knowledge that the Cree language does not have the same phonetic repertoire as English. S-LP students were expected to apply this information when examining a child's errors to delineate between articulation difference and articulation delay. Student clinicians also considered the fact that these children were functioning within an English-speaking school system and would need to acquire these 'new' sounds for spoken and written English proficiency.

When we assessed the English expressive language skills of these children using the Clinical Evaluation of Language Formulation – Primary 2 (CELF-P2), the Clinical Evaluation of Language Formulation – 4 (CELF-4), and informal language sampling, we noted regular omissions of the personal and possessive pronouns he/ she/ his/ her. In discussion with Cree speaking teachers, we learned that there are no male and female pronouns in Cree. Thus, a child's lack of use might have represented a language difference rather than a language delay. This insight indicated that differences in language formulation and conceptualization must be considered in language assessment and intervention.

Differences in language formulation and language conceptualization were also evident in our receptive language assessment attempts (CELF-P2, CELF-4). Many children did not make the distinction between ideas such as beside, between, in front of, and behind in object manipulation tasks, as typically assessed in traditional English receptive language protocols. Cree speaking teachers reported that referencing of spatial prepositions is significantly different than what our test protocols assessed. In Cree, of greater importance is whether an object/person is with or not with another object/person.

On-going Challenges

Each year, we were challenged to modify our processes and procedures, and each year, we confronted basic

fundamental struggles related to our specific project. Regardless of site of service, no local staff was available to accompany us or to participate in our assessment and treatment sessions. We were able to ask teachers and hospital staff specific questions, however, there were no resources for integrative and collaborative sessions.

As described above, we provided a teacher/ parent checklist that served as our referral form. This was completed collaboratively at the schools prior to our arrival. It was a challenge to develop a referral form that provided specific detail that allowed us to prioritize our focus in the short time that we had with each child. Since the schools had very limited contact with speech-language pathology services, it was difficult for them to select those students for whom we could make the greatest difference. Training for classroom teachers in the use of the referral form was limited to the guidance of the LSTs. However, the LSTs had only limited consultation with us regarding this process.

Initially, we anticipated that it would be possible to gather a short language sample from each child. However, we quickly realized that this was not an easy task given the limited time spent per session. We were rarely successful in engaging children expressively or receptively during the time available. We suspected that both our tasks (toys, games and books) and our interactional styles were different than what these children typically experienced with adults within their own communities. Our inability to engage these children and elicit robust language samples, forced us to rely on receptive picture pointing tasks, receptive object manipulation tasks, and expressive fill-in-the-blank strategies. These tasks limited what we were able to observe and measure.

It is important to note that the service providers in this project are student clinicians who often require longer periods of time to complete assessment protocols and formulate recommendations and suggestions in the most typical of circumstances. The on-line problem solving and critical thinking skills that this placement requires are challenging for even the most seasoned clinicians.

Following completion of our assessments, the student clinicians were guided in their selection of two or three recommendations based on their immediate relevance to a child and specific challenges as identified by the LST and teacher. This was a very challenging process because we were developing these recommendations based on very limited clinical information, limited understanding of English/Cree speech and language learning, and limited understanding of the cultural context. The impact of this inadequate knowledge base affected both the relevance of the targets we selected and the resources and materials we developed, gathered, and provided to both the schools

and the hospitals. This also affected the quality of the training we were able to provide to teaching and hospital staff. Only one to two hours were available to provide demonstrations of techniques and to clarify treatment recommendations to LSTs and support personnel, such as Education Assistants and Personal Support Workers. In addition, we were only able to meet with available classroom teachers or nurses for 15-20 minutes. This very brief training time compromised the successful implementation of the programming recommendations and their integration into the classroom or bedside setting. There was also minimal opportunity to provide further consultation, to answer questions, or to clarify recommendations. These remote communities were not yet equipped with reliable access to video conferencing, which limited our follow-up to occasional phone calls and emails.

We acknowledge the value of collaborating with community leaders and service providers when developing any service delivery approach. Early in the project, we met with community partners in an effort to discuss and modify our project. Although we appreciated the strong commitment we received from both hospital and school leaders, which allowed this project to move forward, regular contact with community leaders was difficult to establish and maintain.

The remoteness of the three communities caused further logistical challenges to service provision. Access to the communities was time-consuming, costly, and not always reliable. Weather conditions further complicated access. It was difficult to accommodate even small groups of visitors in these small communities.

Despite these challenges, our students gained insight into issues that encompass much more than speech-language pathology. The placement allowed them to develop an awareness of the complexities of bilingual and multicultural service provision. This allowed them to critically appraise the efficacy and validity of current assessment and treatment protocols and to develop an appreciation of the challenges and importance of developing culturally valid and sensitive indicators. The students were encouraged to consider the impact that history has had on the communities and on the relationships that have developed as a result. Our hope is that this experience fostered a sense of responsibility in our students and challenged them to take an active role in developing resources and services that are sensitive to these communities.

Feedback from the community partners was gathered from debriefing meetings and post project surveys. Feedback was overwhelmingly positive. School and hospital personnel expressed that they appreciated the

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enthusiasm, willingness, professionalism, and flexibility of the students. They appreciated the collaboration and requested that more time be dedicated to each placement site and that greater community involvement be encouraged.

Student feedback was gathered via pre and post placement questionnaires and face-to-face feedback meetings. When asked before preparing and participating in the placement about their concerns, students identified a lack of knowledge and understanding of Cree language and culture, and were uncomfortable with the uncertainty of not knowing, in advance, who they would be seeing. Upon reflection after the placement, students identified several areas of growth. They commented on their growth as professionals, on the need for strong on-line problem solving skills, and on the importance of having respect for cultural differences.

CONCLUSION AND FUTURE DIRECTIONS

We continue to offer a one-week, mixed adult/paediatric placement for our S-LP students for as long as funding allows (confirmed for the period 2008-2012). We continue to explore avenues for more successful collaboration with potential community partners such as CASLPA, Aboriginal Head Start, Healthy Babies, Healthy Children, James Bay Hospital (Attawapiskat), and the community nursing station in Kashechewan. Additionally, we plan to engage in further conversation with Elders and community members to ensure that the program develops in a manner that is respectful. We await improved video conferencing and tele-health capabilities to allow for the provision of follow-up support from London to clients assessed in their home communities, their families, and teachers. In April 2010, our placement expanded to include one clinical faculty member from audiology and one audiology student. This additional service was highly valued by the community and we anticipate that it will continue and expand.

With each passing placement, adjustments are made to the materials we use and to our expectations of what we might accomplish. Each trip identifies more gaps in our knowledge base, and as we prepare for our next placement, it is clear to us that we will continue to struggle to provide appropriate and relevant services in the communities we are visiting. Despite the learning that has taken place over all of these placements and the intensive preparations, we lack fundamental information to assist us in ensuring that the services we provide are valid and culturally relevant. It is encouraging that we can now take advantage of multiple learning opportunities that are emerging as a result of a more recent focus on and interest in service provision in First Nations communities.

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