International Journal of Language & Communication Disorders

RESEARCH REPORT OPEN ACCESS

Dysarthria Assessment Across Spain: A Survey Study of Tools, Practices, and Needs

Neus Calaf[1,2] | Jiri Mekyska[2,3,4] | Jan Mucha[2,3] | Marcos Faundez-Zanuy[5]

[1]Autonomous University of Barcelona, Bellaterra, Spain | [2]Department of Telecommunications, Brno University of Technology, Brno, Czech Republic | [3]Scicake, Brno, Czech Republic | [4]Central European Institute of Technology (CEITEC), Masaryk University, Brno, Czech Republic | [5]Tecnocampus, Universitat Pompeu Fabra, Mataró, Spain

Correspondence: Neus Calaf (ncalafg@gmail.com)

Received: 31 October 2024 | **Revised:** 15 August 2025 | **Accepted:** 28 August 2025

Funding: This work was supported by Project No. LX22NPO5107 (MEYS): Financed by the European Union-Next Generation EU, project no. TQ13000033 from the Technology Agency of the Czech Republic, Project No. GN23-06074O, from the Czech Science Foundation, and Project no. CZ.02.01.01/00/23_025/0008726 (A Lifetime with Language: The Nature and Ontogeny of Linguistic Communication), co-funded by the European Union.

Keywords: assessment practices | assessment tools | dysarthria | Spanish-speaking population | tool standardisation | tool validation

ABSTRACT

Introduction: Dysarthria, a motor speech disorder that has a significant impact on communication, requires precise assessment for accurate diagnosis and intervention. Although internationally recognised assessment tools exist, many are not culturally or linguistically adapted for Spanish-speaking populations. The objective of this study was to investigate how speech-language pathologists (SLPs) in Spain navigate the lack of appropriate dysarthria assessment tools and identify the additional resources and tools required to enhance evaluation practices.

Method: This cross-sectional study surveyed 73 licensed SLPs in Spain using a 36-question online questionnaire, collecting data on a broad spectrum of topics, such as clinical experience, dysarthria assessment tools, tasks, and bilingual/multilingual practices. Descriptive statistical analysis was used to identify and highlight the key trends.

Results: The findings revealed that participants commonly relied on informal tools for dysarthria assessment, with frequent use of linguistically dependent tasks, such as word repetition, loud reading, and sentence repetition, in addition to orofacial motricity. Participants also reported low use of patient-reported outcome measures (PROMs) and showed confusion regarding the validation status of the tools they used. Additionally, many expressed dissatisfaction with the current tools, highlighting the lack of comprehensive and culturally adapted instruments.

Conclusion: This study underscores the urgent need for validated, standardised, culturally and linguistically adapted tools for dysarthria assessment in Spain. The reliance on informal assessments and the combination of multiple tools highlights gaps in current resources. Future efforts should focus on developing comprehensive, adaptable tools that address the full range of dysarthria symptoms and raise awareness about the importance of tool validation to ensure consistent and effective care for Spain's diverse population.

WHAT THIS PAPER ADDS

What is already known on this subject

- Effective dysarthria assessment requires precise, standardised tools to inform diagnosis and intervention. While different tools are available internationally, they are mostly in English, with a few culturally adapted versions. This study was needed to address the lack of adapted tools for Spanish-speaking clinicians, as this gap may affect diagnostic accuracy in Spain.

https://doi.org/10.1111/1460-6984.70122

What this paper adds to the existing knowledge

- Our study reveals that Spanish SLPs predominantly rely on informal tools to assess dysarthria due to the absence of culturally and linguistically adapted standardised instruments. This study provides detailed insights into the challenges SLPs face in Spain, the tools they currently use, and their perspectives on necessary resources to improve dysarthria assessment practices.

What are the potential or actual clinical implications for this work?

- These findings underscore the need for developing culturally and linguistically validated dysarthria assessment tools for Spanish-speaking SLPs, which would support more consistent and accurate diagnoses, ultimately benefiting patients' clinical outcomes across Spain.

1 | Introduction

Dysarthria, a speech disorder that can severely affect communication, requires precise evaluation to ensure an adequately informed diagnosis and effective intervention. Following the framework of the International Classification of Functioning, Disability and Health (ICF) (World Health Organization 2001), dysarthria assessment tools can be categorised according to the domains they target:

- Body functions and structures (impairment-level measures, e.g., articulatory precision, phonatory quality).
- Activity (functional communication abilities).
- Participation (social and daily life involvement, often assessed through patient-reported outcome measures, PROMs).

Current dysarthria assessments predominantly focus on the impairment level, primarily targeting motor and speech subsystems. A range of internationally recognised tools is available, including the Frenchay Dysarthria Assessment (FDA) (Enderby 1983), Robertson Dysarthria Profile (Robertson 1982), Intelligibility Rating Scale for Motor Speech Disorders (Duffy, 2012), and the Assessment of Intelligibility of Dysarthric Speech (ASSIDS) (Yorkston, Beukelman and Traynor, 1984). More recently developed instruments, such as the Newcastle Dysarthria Assessment Tool (N-DAT) (NSW Adult Speech Pathology EBP Group 2015), the Radboud Dysarthria Assessment (Knuijt et al. 2018), and the Motor Speech Evaluation Template (American Speech-Language-Hearing Association [ASHA], n.d.), have also been introduced. Among these, ASSIDS and the FDA are notably prevalent in clinical practice (Alias et al. 2023). In addition to impairment-focused tools, instruments such as the Dysarthria Therapy Outcome Measure (Enderby et al. 2013) and Dysarthria Impact Profile (DIP) (Walshe et al. 2009) play a critical role in assessing broader personal and social impact of dysarthria by capturing patient-reported outcomes. These tools are primarily available in English. However, to ensure their relevance and validity, these tools must be culturally and linguistically adapted to the populations they serve (International Test Commission 2017).

It is important to distinguish between related but distinct concepts: adaptation, validation, and standardisation. Adaptation refers to the process of modifying a test linguistically, culturally, or contextually to make it appropriate for use in a different population (International Test Commission 2017). Validation, in contrast, involves systematically collecting empirical evidence to support the intended interpretations of test scores for their proposed uses (American Educational Research Association et al. 2014). Standardisation refers to the establishment of normative data through consistent administration across a representative sample (American Educational Research Association et al. 2014).

It should also be noted that while several internationally recognised dysarthria assessment tools are widely used, the extent to which they have undergone comprehensive validation and standardisation varies. Not all instruments cited have accumulated the full body of validity evidence recommended by current international standards (International Test Commission 2017; American Educational Research Association et al. 2014).

In recent years, several dysarthria assessment tools have been adapted and validated for use in languages other than English. Notably, FDA-2 has been adapted and validated in European Portuguese (Cardoso et al. 2017), French (Ghio et al. 2020), and Hebrew (Icht et al. 2022). Furthermore, validations for the DIP have been completed in French (Letanneux et al. 2013) and European Portuguese (Cardoso et al. 2018), expanding the accessibility and applicability of these tools beyond English-speaking populations. This highlights the need for more instruments to be adapted to meet the diverse requirements of global populations. The Test 3F Dysarthria Profile (Test 3F—Dysartrický profil) (Roubíčková 2011) was developed and validated in the Czech language (Košťálová et al. 2013), further illustrating the global effort to create assessment tools in languages other than English.

However, despite these international efforts, Spain faces significant challenges in dysarthria assessment owing to the lack of standardised instruments properly adapted from other languages and contexts (Agudo et al. 2021). For instance, while the *Protocolo de Evaluación del Habla* [Speech evaluation protocol] (González and Toledo 2002) is widely used in Chile (Sanhueza-Garrido et al. 2024), it has not been formally standardised or validated for use in Spain. Additionally, recent studies, such as a database of Parkinsonian speech from Madrid (Mendes-Laureano et al. 2024), have shown the development of unique, non-standardised protocols for assessing dysarthria, further highlighting the lack of consistency in assessment practices. This issue is mirrored at a regional level in Catalonia, where the most recent *Pla de Rehabilitació de Catalunya* [Catalonia Rehabilitation Plan] (Departament de Salut 2022), which gathers assessment tools with the strongest supporting evidence, does not include any tools adapted for the Spanish- or Catalan-speaking population. This lack of culturally and linguistically appropriate tools affects diagnostic accuracy and treatment planning across diverse populations in Spain. This review does not aim to be exhaustive, but to provide a conceptual foundation for examining assessment practices in Spain. We acknowledge that other instruments may exist but were not identified during the review process.

Multiple studies conducted in English-speaking countries, such as Australia, Ireland, the United Kingdom, and the United States, have shown that speech-language pathologists (SLPs) often adopt a customised approach to dysarthria assessment, relying on informal tools rather than standardised assessments (Collis and Bloch 2012; Conway and Walshe 2015; Gurevich and Scamihorn 2017; Miller and Bloch 2017; Rumbach et al. 2019). Similarly, studies of French-speaking SLPs in Belgium, France, Switzerland, Luxembourg, and Maghreb (Pommée et al. 2022) revealed that despite the availability of standardised tools such as the *Batterie d'Évaluation Clinique de la Dysarthrie* [Dysarthria Clinical Assessment Battery] (Auzou and Rolland-Monnoury 2006), the *Évaluation Clinique de la Dysarthrie* [Clinical Assessment of Dysarthria] (Auzou 1998), the French version of the Frenchay Dysarthria Assessment-Second Edition (Ghio et al. 2020), and the *MonPaGe* protocol (Lévêque et al. 2016), many clinicians still adopt a customised approach. They often rely on informal tools rather than standardised assessments, reflecting a broader trend across both English- and French-speaking SLPs.

All of these previous studies have identified a consistent range of tasks commonly employed by SLPs in dysarthria assessment, reflecting the need to evaluate various speech subsystems. Among the most frequently used tasks are word and phrase repetition, which help assess articulation and intelligibility, and loud reading, which evaluates both articulation and prosody (Collis and Bloch 2012; Miller and Bloch 2017). Diadochokinetic tasks involving the rapid repetition of syllables are often applied to assess motor coordination and speech rhythm (Conway and Walshe 2015). Similarly, sustained phonation has been widely used to examine phonatory and respiratory functions (Rumbach et al. 2019). Finally, conversation analysis has emerged as a more informal but frequently utilised method, allowing clinicians to observe functional communication and intelligibility in naturalistic speech contexts (Pommée et al. 2022; Gurevich and Scamihorn 2017). These findings suggest that many SLPs adopt a flexible, task-based approach to dysarthria assessment, adjusting their choice of tasks to meet the specific needs of each patient, even when standardised tools are available. However, this flexibility, while clinically useful, can introduce inconsistency in evaluation practices when not supported by validated frameworks.

Building on these international findings and considering the lack of adapted and validated tools in Spain, our study aims to explore the current practices of SLPs in Spain, focusing on how they navigate the absence of appropriate assessment tools, whether they find the available tools adequate, and what additional resources or tools they need. In doing so, we aim to clarify existing misunderstandings around tool validation and highlight future directions for developing culturally and linguistically appropriate assessments for Spain's multilingual population.

2 | Methods

2.1 | Ethical Approval

The study was approved by the Ethics Committee of Fundació Tecnocampus Mataró-Maresme, affiliated with Pompeu Fabra University, on July 3rd, 2024 (Reference number: 5/2024).

2.2 | Participants

This study included 73 licensed SLPs from Spain, representing a wide range of clinical environments and patient demographics. Eligibility criteria required SLPs to be actively practising and have at least 1 year of experience in dysarthria assessment and treatment. Those not currently working with dysarthria or with less than 1 year of experience were excluded. Inclusion and exclusion criteria were verified through participant self-declaration within the questionnaire. Recruitment was conducted through social media platforms and professional networks.

Informed consent was obtained from all participants, who also received an information sheet detailing the study. All personal data were handled with strict confidentiality, stored on a password-protected computer, and not shared with the third parties. Although slight boredom or fatigue was a potential concern due to the length of the survey, the participants were free to take breaks as needed. The participants did not identify any significant risks.

2.3 | Instrument

Data were collected using an online questionnaire administered through *Google Forms*. This structured questionnaire, containing 36 questions, was designed ad hoc to comprehensively capture the current dysarthria assessment practices of SLPs in Spain. It addressed topics such as demographic and professional background, clinical experience with dysarthria, types of dysarthria encountered, and tools and methods used for assessment. A summary table indicating which questionnaire items were analysed in this manuscript and which were reserved for future analyses is provided in the supplementary material (Table S1). The cross-sectional nature of the survey allowed for the collection of real-world data on reported practices and perceptions.

The survey explored a range of topics related to dysarthria assessment, including the use of specific tools (both formal and informal) and tasks involved in dysarthria evaluations. The selection of assessment tools included in the questionnaire was informed by the International Classification of Functioning, Disability and Health (ICF) framework (World Health Organization 2001), aiming to cover both impairment-level measures and participation-level measures through PROMs.

The questionnaire included multiple-choice questions, Likert-scale items (e.g., for rating frequency or prevalence), dropdown menus, and free-text fields where participants could elaborate on practices or specify additional tools. Measures were selected based on their relevance to dysarthria assessment practices; instruments not specifically developed or validated for dysarthria, such as the Voice Handicap Index (VHI), were excluded to maintain construct relevance.

Additionally, the questionnaire gathered data on the perceived adequacy and validation of these tools, extent of bilingual/multilingual assessments, and use of digital tools in practice. It also sought to identify gaps in existing resources and tools, focusing on the need for culturally adapted and standardised instruments. Practical considerations such as evaluation duration, associated costs, and willingness to adopt digital solutions were also considered. However, this manuscript focuses on key findings related to task selection, tool adequacy, and clinical practice, based on 26 of the questionnaire's 36 items (see Table S1 for an overview of analysed and non-analysed items); the remaining results will be explored in future analyses.

The questionnaire was initially reviewed by three experts, two specialising in adult evaluation and one in pediatric evaluation, to ensure its relevance, clarity, and comprehensiveness. After this expert review, the questionnaire was pilot-tested by another expert to assess its understandability and practical application. Feedback from both stages was used to make necessary revisions, enhance its effectiveness, and ensure the accuracy of the main findings of the study.

2.4 | Procedure

The study spanned 4 months, from July to October 2024, with participant recruitment and data collection occurring simultaneously. Recruitment was conducted via social media using public posts and direct messages to reach SLPs across various regions and clinical settings in Spain. Data collection was closely monitored by tracking the number of responses, sending standardised reminders to participants, and ensuring that all eligible respondents had similar opportunities to complete the survey.

2.5 | Statistical Analysis

Given the exploratory nature of this study and the lack of prior data on dysarthria assessment practices in Spain, we included a broad set of variables to capture the diversity of clinicians' backgrounds, institutional contexts, and clinical routines. This approach allowed for a comprehensive mapping of current practices. While the primary goal was descriptive, the dataset was structured in a way that could support future inferential analysis. Variables and response categories were retained in their original form to preserve transparency and reflect the full range of clinical experiences.

The analysis for this study primarily involved descriptive statistics to summarise the characteristics of the participants, their clinical experience, the tools they use for dysarthria assessment, and their task selection. Counts and percentages were calculated for various variables, such as age, region, years of experience, types of institution in which participants worked, and the types of tools and tasks they selected for dysarthria evaluation. The present manuscript focuses specifically on the analysis of task selection, tool adequacy, and clinical practice-related variables. Other collected data, such as evaluation costs, use of digital tools, and multilingual assessment practices, are reserved for future analyses. Where appropriate, the data were categorised to provide further insight into specific trends, such as the percentage of bilingual or multilingual patients evaluated in different contexts. All analyses were performed in Python, and the results are presented in tables and figures throughout the manuscript, highlighting key trends and findings.

TABLE 1 | Participant demographics.

Variable	Counts	Percentage (%)
Age		
30–39	27	37
22–29	23	32
40–49	14	19
50–59	6	8
60+	3	4
Gender		
Female	68	93
Male	4	5
Prefer not to say	1	1
Region		
Catalonia	20	27
Community of Madrid	14	19
Galicia	13	18
Community of Valencia	8	11
Andalusia	4	5
Castilla-La Mancha	3	4
Region of Murcia	2	3
Canary Islands	2	3
Castile and León	2	3
Balearic Islands	1	1
Extremadura	1	1
Melilla	1	1
Cantabria	1	1
Basque Country	1	1

3 | Results

3.1 | Participant Demographics and Clinical Practice Characteristics

As shown in Table 1, participants were predominantly younger professionals, mostly women, and represented various regions of Spain, with higher concentrations in Catalonia, Madrid, and Galicia (see Table 1). The sample reflects a broad range of clinical contexts and patient populations, which adds depth to our understanding of current practices.

As outlined in Table 2, most participants held a master's degree or equivalent and reported having received specialised training

TABLE 2 | Specialised training and clinical experience.

Variable	Counts	Percentage (%)
SPECIALISED TRAINING		
Academic background		
Master's degree or equivalent	50	68
Bachelor's degree	15	21
Doctorate	7	10
No response	1	1
Specialised training in dysarthria		
Yes	59	81
No	13	18
No response	1	1
Specialised training details		
Only Master's Program	17	23
Master's Program combined with Workshops, Conferences, Specialised Courses, Seminars or other	16	22
Workshops, Conferences, and Specialised Courses or Seminars	13	18
Only Specialised Courses or Seminars	11	15
No Response	11	15
Other Combinations	3	4
Other	2	3
CLINICAL EXPERIENCE		
Institution type		
Two or more combined institution types	25	34
Only Hospital	15	21
Only Sociosanitary centre	13	18
Only Outpatient Clinic	11	15
Only Patient Association	6	8
Other	2	3
Only independent practice	1	1
Years working with dysarthria patients		
1–5	37	51
6–10	13	18
11–15	12	16
16–20	8	11
21–25	2	3
26–30	1	1
Monthly dysarthria patients		
1–5	34	47
6–10	21	29
11–20	14	19
21–30	2	3
More than 30	1	1
No response	1	1

(Continues)

TABLE 2 | (Continued)

Variable	Counts	Percentage (%)
Dysarthria evaluation percentage		
1%–20%	24	36
81%–100%	19	28
21%–40%	12	18
61%–80%	6	9
41%–60%	6	9
No response	6	8
Dysarthria treatment percentage		
81%–100%	27	37
1%–20%	17	23
61%–80%	12	16
21%–40%	9	12
41%–60%	8	11

TABLE 3 | Patient population.

Variable	Counts	Percentage (%)
Patient type		
Acute, subacute and chronic	21	29
Subacute and chronic	16	22
Acute and subacute	10	14
Only chronic	9	12
Only subacute	7	10
Only acute	7	10
Acute and chronic	2	3
No response	1	1
Age groups		
≥46	38	52
≥18	14	19
≥31	12	16
All ages	5	7
≥6	3	4
0–12	1	1

in dysarthria. Clinically, they were relatively early-career professionals, with over half having 1–5 years of experience and primarily managing a small caseload of dysarthria patients per month. Many worked across multiple types of institutions, reflecting the diverse clinical contexts in which dysarthria care is delivered in Spain.

As shown in Table 3, participants predominantly worked with patients across multiple stages of care, most commonly subacute and chronic phases. The patient population was primarily composed of adults over 46 years old, with fewer clinicians treating younger adults or paediatric populations. This distribution reflects the clinical focus of dysarthria care in Spain, where adult and chronic cases are more prevalent.

As shown in Figure 1, the frequency of working with different types of dysarthria varied among the participants. Mixed dysarthria and spastic dysarthria were the most frequently encountered types, with a considerable number of participants working frequently or almost always. Other types, such as hypokinetic, ataxic, and hyperkinetic dysarthria, are also commonly managed, although with a higher proportion of occasional or rare encounters. Unilateral upper motor neuron dysarthria occurred the least frequently.

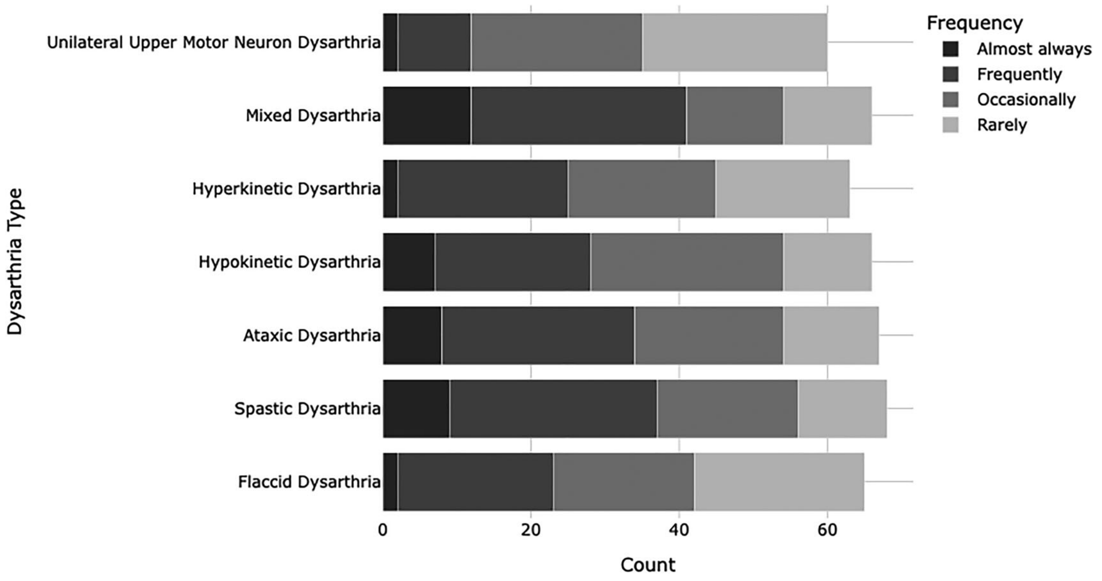

FIGURE 1 | Frequency of treating different types of dysarthria.

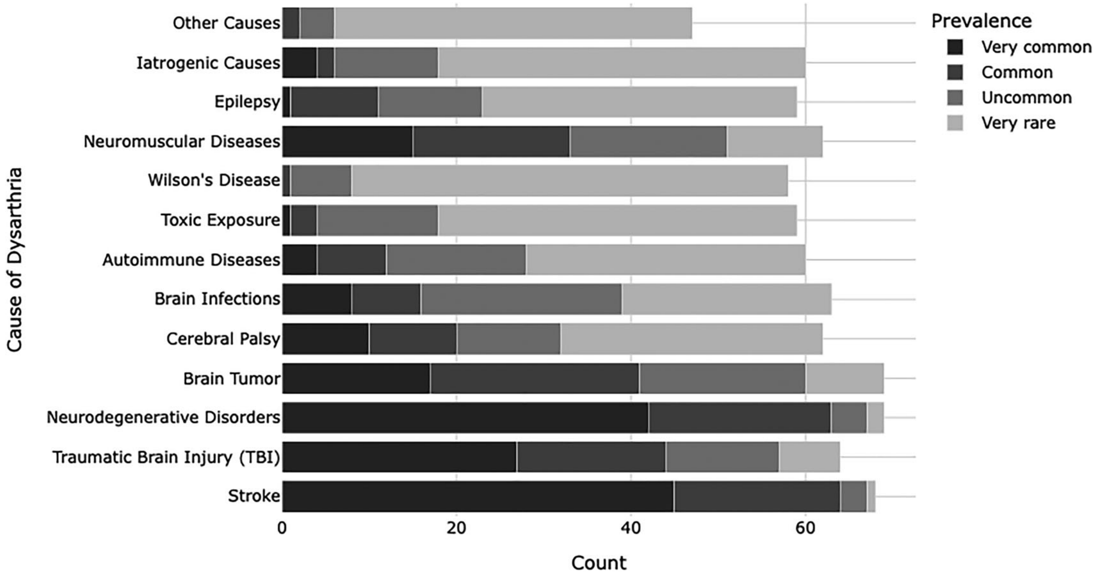

FIGURE 2 | Prevalence of dysarthria causes encountered by professionals.

As shown in Figure 2, the prevalence of various causes of dysarthria varied considerably across the samples. Stroke and neurodegenerative disorders have been reported to be common in a substantial number of participants. In contrast, conditions such as Wilson's disease, toxic exposure, and iatrogenic causes are rarely encountered in clinical practice, with most participants rating these as rare or very rare. Other causes, such as traumatic brain injury, brain tumours, and neuromuscular diseases, showed mixed responses.

3.2 | Assessment Tools and Tasks for Dysarthria

3.2.1 | Tools for Dysarthria Assessment

As shown in Table S2, most participants relied on informal assessments, often in combination with standardised tools such as the Robertson Dysarthria Profile and the Motor Speech Evaluation Template. While informal assessments dominated, clinicians frequently selected multiple tools to complement their evaluations. Among those who did not use informal methods, standardised tools like the Motor Speech Evaluation Template and the Robertson Dysarthria Profile were the most common choices. A small number of participants also reported using less common or locally developed protocols. Template (18%) and the Robertson Dysarthria Profile (14%). A few participants reported using less commonly selected tools, including the Radboud Dysarthria Assessment, the Newcastle Dysarthria Assessment Tool, and locally developed protocols.

3.3 | Tasks in Dysarthria Assessment

As shown in Table 4, most participants reported using a wide range of tasks for dysarthria assessment, with nearly all selecting

TABLE 4 | Tasks used by participants for dysarthria assessment.

Variable	Counts	Percentage (%)
Number of tasks selected for each participant		
Ten tasks selected + "Other"	34	47
Ten tasks selected	30	41
Nine tasks selected	3	4
Eight tasks selected	3	4
Five tasks selected	1	1
Four tasks selected	1	1
One task selected	1	1

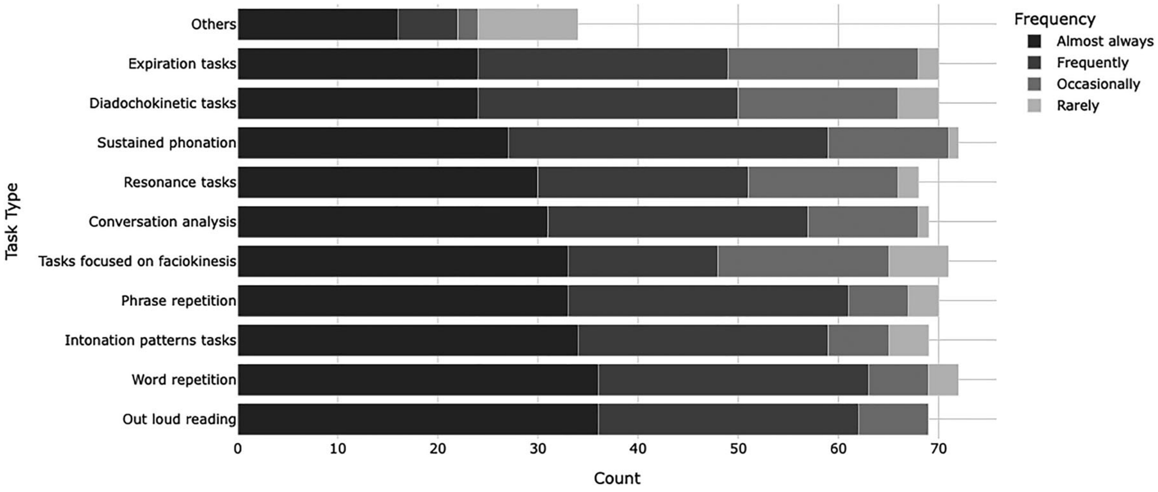

FIGURE 3 | Task frequency in dysarthria assessment.

the full set of ten tasks, sometimes supplemented by additional ones. Only a few clinicians reported using a limited number of tasks, highlighting a general preference for comprehensive assessment approaches.

Figure 3 highlights the frequency of task use in dysarthria evaluations. Word repetition, loud reading, and sentence repetition were the most commonly used tasks, with the majority of participants almost always or frequently using them. Intonation patterns, facial movement tasks, and conversation analysis were also frequently employed but showed more variability, with some participants using them occasionally.

Tasks such as sustained phonation, respiration, and diadochokinetic exercises were used regularly but with notable differences in frequency. Resonance tasks were used less frequently, with more participants reporting occasional use. The least-used tasks were grouped under 'other,' with only a few participants indicating regular use. Overall, certain tasks were consistently favoured, while others were applied more selectively based on the specific assessment context.

As shown in Table S3, a substantial number of participants did not report using any tasks 'almost always.' Among those who did, the number of tasks selected ranged from one to several. For tasks used frequently, a smaller group did not select any; however, some participants opted for multiple tasks in this category. Overall, tasks used occasionally were selected by fewer participants, with most choosing only a limited number of tasks. Rarely used tasks were even less common, with many participants not selecting any at all, suggesting a general preference for tasks that were used more regularly.

3.4 | Patient-Reported Outcome Measures (PROMs)

Regarding the use of patient-reported outcome measures (PROMs) for dysarthria evaluation, a notable proportion of participants did not respond or indicated that they did not use any specific PROMs (see Table 5). Among those who responded, the Dysarthria Impact Profile (Walshe et al. 2009) was the most frequently mentioned tool, followed by the Dysarthria Therapy Outcome Measures (Enderby et al. 2013). Some participants reported using other PROMs, such as informal or customised assessments, the WHODAS (WHO 2015), or the Quality of Life in the Dysarthric Speaker (Martínez-Cifuentes et al. 2021).

3.5 | Status of Validation and Adaptation of Assessment Tools

As shown in Table 6, many participants reported being aware of the validation status of the tools they used, with a significant

TABLE 5 | Patient-reported outcome measures (PROMs) selected by participants.

Variable	Counts	Percentage (%)
PROMs used for dysarthria evaluation (all selections)		
No response/None	28	38
Dysarthria Impact Profile [a]	22	30
Dysarthria Therapy Outcome Measures[b]	14	19
Other (Informal/Customised assessments)	7	10
Other (WHODAS[c])	1	1
Other (Quality of Life in the Dysarthric Speaker[d])	1	1
Living with Dysarthria[e]	1	1

Note: All percentages are calculated on the total number of participants.

[a] Walshe et al. (2009).

[b] Enderby et al. (2013).

[c] WHO (2015).

[d] Martínez-Cifuentes et al. (2021).

[e] Hartelius et al. (2008).

TABLE 6 | Validation status and adaptation of tools used by participants.

Variable	Counts	Percentage (%)
Awareness of the validation status of the tools used.	38	52
Use of tools formally adapted and validated into Spanish.	32	44
Creation of personal translations or adaptations of tools	24	33
Use of tools specifically created for Spanish speakers.	16	22
Use of tools informally adapted to Spanish	15	21
Use of tools without knowledge of their origin or validation status.	12	16
Other	2	3
No response	2	3

Note: All percentages are calculated on the total number of participants.

portion indicating the use of tools that have been formally adapted and validated in Spanish. Some participants mentioned creating their own translations or adaptations of tools, whereas others reported using tools that had been informally adapted to Spanish or specifically designed for Spanish speakers. In addition, a smaller group of participants indicated that they used tools without knowledge of their origin or validation status.

A follow-up question requesting specific details about the tools' validation status revealed that many participants were vague. A significant 92% of participants did not respond. Among the few who did, one participant mentioned using an unpublished, unvalidated translation of the Robertson Dysarthria Profile (Robertson 1982) in Spanish and self-translated other tools.

3.6 | Linguistic Considerations in Dysarthria Assessment

As shown in Table S4, when asked about their ability to assess dysarthria in multiple languages, a substantial portion of participants reported being qualified to assess dysarthria in two or more languages, while others indicated proficiency in only one language. Spanish was the primary language of assessment for most respondents, along with other languages such as Catalan, Galician, and English. Some participants reported qualifications in additional languages, including Italian, Valencian, Basque, and French.

In terms of patient profiles, a significant number of participants reported that bilingual or multilingual patients made up a portion of their caseloads, with varying percentages ranging from very few bilingual patients to the majority of their dysarthria patients being bilingual.

Most clinicians treating bilingual or multilingual patients indicated that they primarily use the patient's dominant language for dysarthria assessment. A smaller group reported evaluating dysarthria in both the dominant and other familiar languages. A few clinicians chose the assessment language based on the availability of validated tools, while one participant mentioned using translators or assistants for language interpretation when necessary.

TABLE 7 | Suitability of the current available tools and areas for improvement.

Variable	Counts	Percentage (%)
Suitability of the currently available tools		
Insufficient	42	58
Enough	15	21
Very insufficient	12	16
Very sufficient	1	1
No response	3	4
Areas for improvement		
Diagnostic accuracy	51	70
Coverage of all types of dysarthria	50	68
Linguistic and cultural adaptation	41	56
Streamlined tools for quick screenings (e.g., in intensive care units)	40	55
Ability to use smart devices (e.g., tablets or smartphones)	37	51
Easy to use	36	49
Enhanced training and resources	24	33
Other	1	1
No response	0	0

Note: All percentages are calculated on the total number of participants.

3.7 | Suitability of the Currently Available Tools and Areas for Improvement

As shown in Table 7, the majority of the participants expressed concerns regarding the suitability of the currently available tools for dysarthria assessment, with most finding them inadequate. A notable portion of the participants also highlighted areas for improvement, with key focus areas including the need for better diagnostic accuracy, more comprehensive coverage of all types of dysarthria, and enhanced linguistic and cultural adaptation. There was also a significant interest in developing streamlined tools for quicker screenings, particularly for use in settings such as intensive care units. Participants further emphasised the importance of tools that are easy to use, compatible with smart devices, and supported by enhanced training and resources.

4 | Discussion

This study adopted a descriptive approach to explore real-world assessment practices and tool usage across diverse Spanish clinical contexts. The inclusion of multiple variables and categories was intentional to reflect the complexity of dysarthria care and to provide a foundation for future inferential studies. While some tables have been moved to supplementary materials to improve readability, the descriptive detail remains available for transparency and replication.

4.1 | Participant Demographics, Clinical Practice, and Implications for Dysarthria Assessment

Since the majority of participants were young professionals between the ages of 22 and 39 years, this age distribution may influence the representativeness of clinicians with longer careers. This tendency could be attributed to the recruitment method, as the call for responses was primarily disseminated through social media, in which younger professionals were more likely to engage. Other studies have also reported similar age profiles: for example, Pommée et al. (2022) reported a median age of 39 among French-speaking clinicians. Most other survey-based studies in the field do not report the chronological age of participants, limiting direct comparisons. Nevertheless, this potential limitation should be considered in future studies.

Regarding regional representation, the majority of respondents were from Catalonia, the Community of Madrid, and Galicia. However, there appears to be an underrepresentation of some regions, such as Andalusia, which likely have a higher number of SLPs than the number of responses we received suggests. This uneven distribution raises questions regarding the geographical coverage of the study and whether certain regions are underrepresented, potentially limiting the generalizability of the findings across Spain.

The educational background of the participants was strong, with most holding a master's degree or higher, and a significant portion having received specialised training in dysarthria. However, more than half of the participants reported having between 1 and 5 years of experience with dysarthric patients, which may indicate a relatively novice cohort in terms of clinical practice. This trend is not unique to our study: other studies have reported similar sample characteristics, with a large proportion of participants having less than 10 years of experience as SLPs or in the management of dysarthria (e.g., Conway and Walshe 2015; Miller and Bloch 2017; Collis and Bloch 2012). This suggests that the professional profile of our respondents is consistent with that of previous research in the field. Additionally, a substantial proportion of participants indicated that only 1%–20% of their workload involved dysarthria evaluations, suggesting that for many clinicians, dysarthria assessment is not the primary focus of their practice.

In terms of clinical settings, a large proportion of participants combined work in two or more types of institutions, reflecting the common practice in Spain, where many speech-language pathologists hold multiple jobs. This tendency toward multi-institutional employment could influence the variability in clinical experience and access to different dysarthria cases, potentially affecting the scope and depth of expertise of the professionals surveyed.

In terms of patient phases, the distribution of acute, subacute, and chronic cases likely reflects the diversity of the clinical settings in which the participants work, as different institutions may specialise in or have more access to patients in particular stages of recovery. Regarding age groups, the lower number of participants working with younger adults or children was likely due to the lower prevalence of dysarthria in these populations. However, future studies should focus on these groups to better understand their specific needs and improve care for younger patients with dysarthria.

The varied experiences of the participants in this study reflect a broad spectrum of clinical practice, which is valuable for the first investigation of dysarthria assessment practices. However, the results highlight the need for more focused research on evaluating different dysarthria types, especially given the lower frequency of certain types, such as hypokinetic, ataxic, hyperkinetic, and unilateral upper motor neuron dysarthria. The participants expressed the need for tools with more comprehensive coverage of all dysarthria types, underscoring the importance of developing assessment instruments that can better support clinicians in managing the full range of dysarthria presentations.

4.2 | Balancing Flexibility and Structure: Combining Formal and Informal Tools in Dysarthria Assessment

Our findings underscore the versatility and frequent use of informal assessments both independently and in combination with formal tools. Most participants selected two or more tools, with informal assessment being the most commonly used. This mirrors broader trends in clinical practice, as seen in studies conducted in other countries, where many SLPs adopted a customised approach instead of relying solely on standardised tools (Collis and Bloch 2012; Conway and Walshe 2015; Gurevich and Scamihorn 2017; Miller and Bloch 2017; Pommée et al. 2022; Rumbach et al. 2019), despite differences in professional experience, institutional settings, or healthcare systems. This flexibility likely reflects both a gap in the current tools and the need for more comprehensive instruments that can address the diverse clinical profiles of dysarthria. At the same time, it may also stem from clinicians' need to tailor assessments to a highly heterogeneous patient population, as well as from limited awareness or access to existing validated tools, especially those developed in other languages or contexts. The combination of formal and informal tools reflects clinicians' efforts to balance flexibility with structures in assessments of dysarthria. While informal assessments allow for personalised evaluation, formal tools provide the consistency and standardisation necessary for reliable diagnosis and treatment planning. The frequent use of multiple tools indicates that no single tool meets all clinical needs, driving clinicians to combine assessments to cover the full spectrum of dysarthria. This further emphasises the need for integrative tools that combine individualised care with clinical rigour.

Participants who did not use informal assessments favoured structured formal tools, such as the Motor Speech Evaluation Template (ASHA, n.d.) and the Robertson Dysarthria Profile (Robertson 1982). This preference highlights the demand for reliable and validated methods, particularly in clinical environments, where consistency is essential. However, the frequent selection of multiple formal tools suggests that no single tool fully captures the complexity of dysarthria, prompting clinicians to use several methods for comprehensive evaluation. This reliance on multiple tools underscores the limitations of current standardised assessments, indicating the need for flexible yet validated approaches.

4.3 | Tailoring Task Selection in Dysarthria Assessment: Variability and Adaptation

Most participants selected a wide range of tasks for dysarthria assessment, and many combined multiple tasks. Remarkably, 88% selected all 10 tasks offered, with some adding others under 'Other.' However, participants did not apply these tasks uniformly; each was marked with varying frequencies of use, indicating that clinicians adapt task choices based on patient needs and the context of the assessment.

In our study, word repetition, loud reading, and sentence repetition were the most commonly employed tasks, with a large proportion of participants using these tasks either almost always or frequently. These tasks likely reflect the phonetic and syntactic demands of the language, underscoring the importance of linguistic adaptation in assessments of dysarthria. Similarly, in the study by Pommée et al. (2022), word repetition and reading tasks were among the most frequently used, with 95% of clinicians using word repetition and 77% employing text reading in their assessments. This consistency across studies highlights the central role of these tasks in evaluating dysarthria in different linguistic contexts.

In addition to these linguistically dependent tasks, our study found notable emphasis on tasks assessing faciokinesis (orofacial motricity), which were used almost always or frequently by a significant number of participants. This aligns with the findings of Pommée et al. (2022), where orofacial motricity tasks were widely applied (85%). Similarly, Rumbach et al. (2019) found that Australian SLPs frequently used informal oromotor examinations (91%) in non-progressive dysarthria assessments. This consistency across studies suggests that assessing orofacial movements, such as lip, jaw, and tongue coordination, is a key component in dysarthria assessment, regardless of the linguistic context.

The variability in task use underscores the fact that dysarthria assessment is not one-size-fits-all. Clinicians employ a wide range of tasks and adapt their frequency to ensure that assessments are responsive to patients' linguistic and clinical needs.

4.4 | Addressing the Gap in Standardised PROMs for Dysarthria: An Urgent Clinical Need

Our findings raise concerns regarding the use of patient-reported outcome measures (PROMs) in dysarthria evaluation. Many participants either did not respond to or indicated that they did not use specific PROMs. Among those who did, the Dysarthria Impact Profile (Walshe et al. 2009) was the most frequently selected, followed by Dysarthria Therapy Outcome Measures (Enderby et al. 2013). A few participants mentioned using informal or customised assessments, WHODAS (WHO 2015), or Quality of Life in the Dysarthric Speaker (Martínez-Cifuentes et al. 2021). Similar issues have been reported in other settings. For instance, Miller and Bloch (2017) observed that although activity and participation were recognised as essential rehabilitation targets, clinicians often relied on informal assessments and overlooked the availability of validated PROMs.

The relatively low use of standardised PROMs is concerning, as these tools are crucial for understanding the impact of dysarthria on patients' daily lives and interactions. This finding aligns with that of Pommée et al. (2022), who found that one-quarter of SLPs do not use PROMs for speech disorder evaluations. In our study, the proportion was even higher, revealing a greater gap in the use of standardised PROMs.

Pommée et al. (2022) also found that the Voice Handicap Index (VHI) (Jacobson et al. 1997), although developed for dysphonia, is commonly used. We did not include the VHI in our questionnaire because it was not designed for dysarthria. Although none of our participants reported using the VHI, some SLPs may still use it to assess voice aspects in patients with dysarthria, suggesting the need for clearer guidance on tool selection.

It is noteworthy that despite the availability of a Spanish adaptation of the Quality of Life in the Dysarthric Speaker for Chilean Spanish speakers (Martínez-Cifuentes et al. 2021), only one participant reported using it. We were unaware of this adaptation during the questionnaire design, but the participants were able to list the tools they used in practice. This limited use suggests barriers to awareness or access to such PROMs, underscoring the need to promote validated, accessible tools for Spanish-speaking clinicians.

These patterns of tool use and the limited uptake of PROMs also suggest that clinical practices, while broadly consistent with previous studies, may vary depending on context. Differences in healthcare systems, access to validated tools, or training may influence how dysarthria is assessed across settings. Although our study followed a descriptive approach, future research could explore whether such factors lead to meaningful differences in practice through comparative or subgroup analyses.

4.5 | Tool Validation Misunderstandings: A Call for Clarity in Dysarthria Assessment

A significant number of participants indicated awareness of the validation status of the tools they used, with 44% of the participants reporting the use of tools formally adapted and validated in Spanish. However, this presents a notable contradiction: of the tools available in Spanish, the Protocolo de Evaluación del Habla (González and Toledo 2002), while created in Spanish, is neither formally standardised nor broadly validated for use in Spain (Sanhueza-Garrido et al. 2024). Similarly, the Quality of Life in the Dysarthric Speaker (Martínez-Cifuentes et al. 2021) was adapted for Chilean Spanish and not for the variety spoken in Spain. Despite the availability of these tools, very few participants reported using them, which underscores the discrepancy between what clinicians perceive as validated and the actual validation status of the tools in use.

This disparity suggests that participants may not have fully distinguished between tools that have been formally validated and those that have been created or informally adapted for Spanish-speaking populations. It is possible that some clinicians believe that they are using validated tools when, in fact, they may only be informally adapted or developed without undergoing a formal validation process. Additionally, a smaller group of participants reported using tools without any knowledge of their validation status, further highlighting the need for clearer guidance on the validation status of Spanish assessment tools.

A follow-up question requesting specific details on the tools' validation status revealed further ambiguity, with 92% of the participants not providing any response. Among the few who did, one participant mentioned using an unpublished, unvalidated translation of the Robertson Dysarthria Profile (Robertson 1982) into Spanish, while others reported self-translating various tools. This reliance on informal or self-created adaptations is concerning, as these practices may introduce uncontrolled variability into assessment procedures. Although this issue has not been empirically studied in the context of dysarthria or speech-language pathology more broadly, international guidelines warn that using non-validated or culturally unadapted tools may compromise diagnostic reliability (International Test Commission 2017; American Educational Research Association et al. 2014). Further research is needed to investigate whether such risks apply specifically to motor speech disorder assessment.

These findings highlight the urgent need for Spanish-speaking clinicians to develop and promote formally validated assessment tools. Additionally, increasing education and awareness of what constitutes formal validation is crucial to ensure that clinicians use reliable and standardised tools. Without such clarity, the risk of inconsistencies in dysarthria assessments remains high, potentially compromising the quality of patient care.

4.6 | Navigating Multilingualism: Challenges in Dysarthria Assessment in Spain

The lack of validated assessment tools in Spanish is already a challenge for patient care, and Spain's linguistic diversity further complicates this. Many SLPs in regions such as Catalonia, Galicia, Basque Country and Valencian Community must assess dysarthria in bilingual or multilingual patients. A considerable proportion of these patients speak multiple languages, yet there are no validated tools available in key regional languages such as Catalan, Galician, Basque or Valencian.

A limitation of this study is that we did not ask about the predominant languages spoken by patients treated by clinicians. Spain is home to a variety of languages, including minority languages and immigrant communities such as Arabic. This leaves a gap in understanding the full linguistic diversity of dysarthria patients and the potential challenges that clinicians face when assessing and treating patients who speak non-official languages. Without this information, it remains unclear whether dysarthria assessment tools in languages such as Arabic are necessary.

Addressing this issue will require not only the development of validated tools in Spanish but also a concerted effort to create and validate tools in all major languages spoken in Spain. Such tools are essential to ensure that clinicians can provide culturally and linguistically appropriate care, particularly given the complex linguistic profiles of many patients with dysarthria. Future research should focus on a better understanding of the linguistic diversity of patient populations, enabling the more targeted development of assessment tools.

4.7 | The Urgent Need for Enhanced Dysarthria Assessment Tools: Clinicians' Perspectives

The vast majority of participants found the available tools for dysarthria assessment insufficient, with only a small portion considering them to be adequate. These findings suggest that many professionals see a need for improvement in current tools, highlighting the gap between clinical needs and available resources. Clinicians may struggle to find tools that balance flexibility for individual patient needs with the consistency and objectivity required for an effective assessment.

This finding is consistent with that of Pommée et al. (2022), who found that SLPs generally rated the available tools for dysarthria assessment as moderately satisfactory. Both studies highlight the ongoing dissatisfaction among clinicians regarding the suitability of the tools at their disposal. While these tools may meet the basic criteria, they fail to provide comprehensive coverage for the diverse and complex presentations of dysarthria in clinical practice.

This dissatisfaction likely stems from the lack of validated tools in specific languages and the absence of comprehensive instruments that address the full range of dysarthria symptoms. Clinicians often compensate for the shortcomings of existing assessments by combining formal and informal tools. However, this practice can introduce inconsistencies across clinical settings and is not a sustainable solution.

These results emphasise the urgent need for more comprehensive dysarthria assessment tools that are validated across multiple languages and are adaptable to the various manifestations of the disorder. Developing such tools would help clinicians provide accurate, reliable, and individualised assessments, ultimately leading to improved patient outcomes.

5 | Conclusions

This study highlights the challenges faced by SLPs in assessing dysarthria in Spain, particularly due to the lack of validated tools adapted to local linguistic and cultural needs. Clinicians rely heavily on informal assessments and combinations of multiple tools, indicating that no single tool fully satisfies their requirements. Despite the availability of some tools in Spanish, their use remains limited, suggesting barriers such as limited access to validated versions, lack of adaptation to the Spanish clinical context, or perceived mismatch between the tools and clinicians' daily practice needs.

Participants emphasised the need for more comprehensive, adaptable tools that can address the full range of dysarthria symptoms and accommodate Spain's multilingual population. To improve clinical practice, future efforts should prioritise developing validated assessment tools that are culturally and linguistically appropriate while also raising awareness of tool validation to ensure consistent, high-quality care.

Acknowledgements

Special thanks to Núria Oriol, Celia Alba, Milena Košťálová, and Javier Bueno for their contributions in reviewing and pilot-testing the questionnaire. This work was supported by Project No. LX22NPO5107 (MEYS): Financed by the European Union-Next Generation EU, project no. TQ13000033 from the Technology Agency of the Czech Republic, Project No. GN23-06074O, from the Czech Science Foundation, and Project no. CZ.02.01.01/00/23_025/0008726 (A Lifetime with Language: The Nature and Ontogeny of Linguistic Communication), co-funded by the European Union.

Conflicts of Interest

J.Mu. and J.Me. are employees of Scicake and were involved in this study. Their participation is part of their professional duties at the company and constitutes a potential conflict of interest. N.C. and M.F.-Z. serve on Scicake's advisory board, which may also be perceived as a conflict. N.C. additionally received paid consulting work from Scicake. All parties were committed to conducting the study with integrity and adhering to ethical guidelines to minimise any potential bias.

Data Availability Statement

The datasets generated and analysed during the current study are available from the corresponding author upon request.

Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

During the preparation of this work, the authors used GPT-4, a generative AI tool developed by OpenAI, to assist in the drafting and refinement of the manuscript. After using this tool, the authors reviewed and edited the content as necessary, taking full responsibility for the publication.

References

Agudo, C., L. Moreno, A. Hernández, et al. 2021. *Protocolo de logopedia en la enfermedad de Parkinson* [Speech Therapy Protocol for Parkinson's

Disease]. Federación Española de Parkinson. Cyan, Proyectos Editoriales, SA. https://www.esparkinson.es/recursos/protocolo-de-logopedia-en-la-enfermedad-de-parkinson.

Alias, N., N. A. M. Zain, S. Rahmat, and N. B. I. Zulkifli. 2023. "Standard Assessments and Outcome Measures for Patients With Dysarthria: A Scoping Review Study." *International Journal of Allied Health Sciences* 7, no. 1: 2887–2894. https://doi.org/10.31436/ijahs.v7i1.751.

American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. 2014. *Standards for Educational and Psychological Testing*. American Educational Research Association. https://www.testingstandards.net.

American Speech-Language-Hearing Association. (n.d.) *Motor Speech Evaluation Template*. ASHA. https://www.asha.org/siteassets/practice-portal/aatmotorspeech.pdf.

Auzou, P. 1998. *Évaluation clinique de la dysarthrie* [Clinical Assessment of Dysarthria]. Orthoédition.

Auzou, P., and V. Rolland-Monnoury. 2006. *BECD: batterie d'évaluation clinique de la dysarthrie* [Dysarthria Clinical Assessment Battery]. Orthoédition.

Cardoso, R., I. Guimarães, H. Santos, et al. 2017. "Frenchay Dysarthria Assessment (FDA-2) in Parkinson's Disease: Cross-Cultural Adaptation and Psychometric Properties of the European Portuguese Version." *Journal of Neurology* 264, no. 1: 21–31. https://doi.org/10.1007/s00415-016-8298-6.

Cardoso, R., I. Guimarães, H. Santos, et al. 2018. "Psychosocial Impact of Parkinson's Disease-Associated Dysarthria: Cross-Cultural Adaptation and Validation of the Dysarthria Impact Profile Into European Portuguese." *Geriatrics & Gerontology International* 18, no. 5: 767–774. https://doi.org/10.1111/ggi.13255.

Collis, J., and S. Bloch. 2012. "Survey of UK Speech and Language Therapists' Assessment and Treatment Practices for People With Progressive Dysarthria." *International Journal of Language & Communication Disorders* 47, no. 6: 725–737. https://doi.org/10.1111/j.1460-6984.2012.00183.x.

Conway, A., and M. Walshe. 2015. "Management of Non-Progressive Dysarthria: Practice Patterns of Speech and Language Therapists in the Republic of Ireland." *International Journal of Language & Communication Disorders* 50, no. 3: 374–388. https://doi.org/10.1111/1460-6984.12143.

Departament de Salut. 2022. *Pla de rehabilitació de Catalunya: Abordatge integral del funcionament i la discapacitat* [Catalonia Rehabilitation Plan: Comprehensive Approach to Functioning and Disability]. Direcció General de Planificació i Recerca en Salut, http://scientiasalut.gencat.cat/handle/11351/9485.

Duffy, J. R. 2012. *Motor Speech Disorders: Substrates, Differential Diagnosis, and Management*. 3rd ed. Elsevier.

Enderby, P., A. John, and B. Petheram. 2013. *Therapy Outcome Measures for Rehabilitation Professionals: Speech and Language Therapy, Physiotherapy, Occupational Therapy*. John Wiley & Sons. https://books.google.com/books?hl=ca&lr=&id=MQmbh6cp6JYC&oi=fnd&pg=PT9.

Enderby, P. M. 1983. *Frenchay Dysarthria Assessment*. College-Hill Press. https://search.library.wisc.edu/catalog/999527466502121.

Ghio, A., L. Giusti, E. Blanc, and S. Pinto. 2020. "French Adaptation of the "Frenchay Dysarthria Assessment 2" Speech Intelligibility Test." *European Annals of Otorhinolaryngology, Head and Neck Diseases* 137, no. 2: 111–116. https://doi.org/10.1016/j.anorl.2019.10.007.

González, R., and L. Toledo. 2002. *Protocolo de evaluación de habla* [Speech Evaluation Protocol]. *Unpublished manuscript*.

Gurevich, N., and S. L. Scamihorn. 2017. "Speech-language Pathologists' use of Intelligibility Measures in Adults With Dysarthria." *American Journal of Speech-Language Pathology* 26, no. 3: 873–892. https://doi.org/10.1044/2017_AJSLP-16-0112.

Hartelius, L., M. Elmberg, R. Holm, A. S. Lövberg, and S. Nikolaidis. 2008. "Living With Dysarthria: Evaluation of a Self-Report Questionnaire." *Folia Phoniatrica Et Logopaedica* 60, no. 1: 11–19. https://doi.org/10.1159/000111799.

Icht, M., O. Bergerzon-Bitton, and B. M. Ben-David. 2022. "Validation and Cross-Linguistic Adaptation of the Frenchay Dysarthria Assessment (FDA-2) Speech Intelligibility Tests: Hebrew Version." *International Journal of Language & Communication Disorders* 57, no. 5: 1023–1049. https://doi.org/10.1111/1460-6984.12737.

International Test Commission. 2017. The ITC Guidelines for Translating and Adapting Tests. 2nd ed. International Test Commission. www.InTestCom.org.

Jacobson, B. H., A. Johnson, C. Grywalski, et al. 1997. "The Voice Handicap Index (VHI). Development and Validation." *American Journal of Speech-Language Pathology* 6, no. 3: 66–70. https://doi.org/10.1044/1058-0360.0603.66.

Knuijt, S., J. G. Kalf, B. G. M. Van Engelen, B. J. M. De Swart, and A. C. H. Geurts. 2018. "The Radboud Dysarthria Assessment: Development and Clinimetric Evaluation." *Folia Phoniatrica Et Logopaedica* 69, no. 4: 143–153. https://doi.org/10.1159/000484556.

Košťálová, M., M. Mračková, R. Mareček, et al. 2013. "*Test 3F Dysartrický profil—normativní hodnoty řeči v češtině* [Test 3F Dysarthria Profile—Normative speech values in Czech]." *Česká a Slovenská Neurologie a Neurochirurgie* 76, no. 109: 5.

Letanneux, A., M. Walshe, F. Viallet, and S. Pinto. 2013. "The Dysarthria Impact Profile: A preliminary French Experience With Parkinson's Disease." *Parkinson's Disease* 2013, no. 1: 403680. https://doi.org/10.1155/2013/403680.

Lévêque, N., M. Laganaro, C. Fougeron, et al. 2016. "MonPaGe: un protocole informatisé d'évaluation de la parole pathologique en langue française [MonPaGe: a Computerized Protocol for the Assessment of Pathological Speech in the French Language]." *Revue Neurologique* 172: A162–A163. https://doi.org/10.1016/j.neurol.2016.01.386.

Martínez-Cifuentes, R., T. Pierart-Vásquez, J. I. Castro-Mellado, et al. 2021. "*Traducción y adaptación del "Quality of Life in the Dysarthric Speaker" (QOL-DYS) para su uso en usuarios chilenos con disartria* [Translation and Adaptation of the "Quality of Life in the Dysarthric Speaker" (QOL-DYS) for Chilean Dysarthric Users]." *Rehabilitación Integral* 16, no. 1: 27–38. https://doi.org/10.51230/ri.v16i1.77.

Mendes-Laureano, J., J. A. Gómez-García, A. Guerrero-López, et al. 2024. "NeuroVoz: A Castilian Spanish corpus of parkinsonian speech." *Scientific Data* 11, no. 1: 141. https://doi.org/10.1038/s41597-024-04186-z.

Miller, N., and S. Bloch. 2017. "A Survey of Speech-Language Therapy Provision for People With Post-Stroke Dysarthria in the UK." *International Journal of Language & Communication Disorders* 52, no. 6: 800–815. https://doi.org/10.1111/1460-6984.12316.

NSW Adult Speech Pathology Acquired Communication Impairment EBP Group. 2015. Newcastle Dysarthria Assessment Tool (N-DAT). Newcastle & Hunter Region. https://nswspeechpathologyebp.com/wp-content/uploads/2015/10/newcastle-ebp-dysarthria-assessment-tool-n-dat-dec-2015.pdf.

Pommée, T., M. Balaguer, J. Mauclair, J. Pinquier, and V. Woisard. 2022. "Assessment of Adult Speech Disorders: Current Situation and Needs in French-Speaking Clinical Practice." *Logopedics Phoniatrics Vocology* 47, no. 2: 92–108. https://doi.org/10.1080/14015439.2020.1870245.

Robertson, S. J. 1982. *Dysarthria Profile*. Winslow Press.

Roubíčková, J. 2011. *Test 3F: Dysartrický profil* [Test 3F: Dysarthria Profile]. Galén.

Rumbach, A. F., E. Finch, and G. Stevenson. 2019. "What Are the Usual Assessment Practices in Adult Non-Progressive Dysarthria Rehabilitation? A Survey of Australian Dysarthria Practice Patterns." *Journal of Communication Disorders* 79: 46–57. https://doi.org/10.1016/j.jcomdis.2019.03.002.

Sanhueza-Garrido, M., V. García-Flores, C. Rojas-Zepeda, and J. Crisosto-Alarcón. 2024. "*Análisis comparativo de los instrumentos de evaluación del habla para personas con disartria en Chile y el mundo* [Comparative Analysis of Speech Evaluation Instruments for People With dysarthria in Chile and the World]." *Salud Ciencia Tecnología* 4: 626.

Walshe, M., R. K. Peach, and N. Miller. 2009. "Dysarthria Impact Profile: Development of a Scale to Measure Psychosocial Effects." *International Journal of Language & Communication Disorders* 44, no. 5: 693–715. https://doi.org/10.56294/saludcyt2024626.

World Health Organization. 2001. International Classification of Functioning, Disability and Health (ICF). World Health Organization. https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health.

World Health Organization. 2015. *Measuring Health and Disability: Manual for WHO Disability Assessment Schedule WHODAS 2.0*. National Rehabilitation Service. https://iris.who.int/handle/10665/170500.

Yorkston, K. M., D. R. Beukelman, and R. L. Traynor. 1984. *Assessment of Intelligibility of Dysarthric Speech*. Austin, TX: PRO-ED.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supplementary Table S1: Summary of Questionnaire Items and Their Inclusion in the Present Analysis. **Supplementary Table S2**: Summary of Tools Used by Participants for Dysarthria Assessment and Common Combinations. **Supplementary Table S3**: Summary of Tasks Used by Participants for Dysarthria Assessment and Common Combinations. **Supplementary Table S4**: Linguistic Considerations in Dysarthria Assessment: Clinicians' Practices and Patient Language Profiles.