

# 8<sup>th</sup> Draft

## Revised IALP EDUCATION GUIDELINES (Jan 26, 2009) IALP Guidelines for Initial Education in Speech Language Pathology

### Preamble

In 1995, the IALP Board approved the Guidelines for the Initial Education in Logopedics. The guidelines were published in *Folia Phoniatica et Logopedica* in 1995. They have been used extensively to support and inform those interested in the development of new education courses/programs and the revision of existing course curricula/programs around the world.

Since the original adoption, many cultural, political and educational changes have taken place globally. Several countries are developing an awareness of the need to provide services to persons with disabilities. Others are finding it necessary to expand their education programs to meet the needs of expanding client base. It was necessary to review the educational guidelines for the current appropriateness.

Members of the Education Committee (Logopedics) met at the 2007 IALP Congress in Copenhagen, Denmark and agreed to contribute to the review of the education guidelines and revise as necessary. The following is the revised version.

### Part A: Preface

#### 1. Background

- 1.1. At its meeting in Hanover, Germany in August 1992, the Education Committee (Logopedics) of the International Association of Logopedics and Phoniatics (IALP) agreed to take steps towards preparing international guidelines for the initial education of speech language pathologists<sup>1</sup>.
- 1.2. A first draft of guidelines was prepared and discussed by the Education Committee (Logopedics), three national professional bodies and other associations and individuals. A second draft was presented at a conference organized by the Education Committee (Logopedics) at the University of Newcastle upon Tyne, UK, in 1993; it was discussed in detail by 28 people from 16 different countries. A third draft incorporated comments made by these participants, and was endorsed by the Education Committee (Logopedics) for circulation (January-February 1994) and further consultation world-wide. A fourth draft was discussed at a symposium at the 1995 IALP Congress in Cairo, and a final draft was approved by the Board of IALP on August 10, 1995 for dissemination as a definitive statement.
- 1.3. The aims of providing guidelines is to harmonise the initial education of speech language pathologists, to develop and maintain appropriately high standards of education, and to, in due course, facilitate the international movement of

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<sup>1</sup> Speech language pathologists are referred as speech language therapists, logopedists and orthophonists in some countries. Similarly, the profession is termed speech language pathology, logopedics and orthophony, respectively. For this reason such terms may be used interchangeably in this document.

personnel and knowledge. It is hoped through the *dissemination* of these guidelines (recommendations) to all educational programmes in logopedics that competent and innovative practitioners will be able:

- (a) To offer and/or to improve quality service to people with communication and/or swallowing disorders in countries where initial educational programs are already established;
  - (b) To improve the service to people with communication and/or swallowing disorders in countries where educational programs are developing;
  - (c) To establish new programmes for the initial professional education of speech language pathologists, where such programmes do not currently exist.
- 1.4. Surveys of the education of Logopedics world-wide indicated that:
- (a) a variety of approaches to the initial education of speech language pathologists currently exists;
  - (b) in some countries education in Logopedics is undertaken simultaneously with education in a second profession, i.e. audiology/hearing therapy, education, psychology, generalist rehabilitation.

The statement of premises and the Illustrative Framework below provide a general statement of principles to be taken into consideration in the education of speech language pathologists, with allowance for the practices of different cultures and countries. Where it is the practice to combine education in logopedics with that for another profession, these guidelines relate specifically and strongly to the logopedics component of the education. This is to ensure that this discipline should be sufficient to stand on its own and to be comparable with such programmes where it is taught as an independent field.

## **2. Statement of Premises**

The profession is an identifiable independent profession in its own right, and is not one whose practitioners are seen as educational/ medical/ social assistants

- 2.1. Practitioners follow a code of ethics, which specifies, level of training and responsibilities, recognition of the boundaries of their work and skills and the need to consult with and refer clients on to other professionals as appropriate.
- 2.2. The education of speech language pathologists is aimed at preparing professionals for a broad and general scope of work with people of all ages who may have communication and/or swallowing disorders.
- 2.3. The education of speech language pathologists will include an appreciation of cultural and linguistic factors that influence the development of speech and language and the delivery of appropriate clinical services.

- 2.4. The education of professional practitioners will include advance of knowledge about the nature of communication disorders, the appropriate diagnosis and intervention for the provision of culturally appropriate services.
- 2.5. The education of professionals will include an appreciation of evidence based practice and the use of research to support clinical approaches
- 2.6. Speech language pathologists should be given opportunities to develop their skills under supervision for their first year of experience in the profession.
- 2.7. Opportunities should be provided for speech language pathologists to continue their professional development through continuing education, specialization and studying for advanced degrees which foster research in communication disorders.

## **PART B: ILLUSTRATIVE FRAMEWORK**

### **1. Principles**

- 1.1. The program should make its students aware of the complexity of human communication and its disorders as well as normal/disordered swallowing. A fundamental principle of education is the recognition of complexity in the field of human communication, and its development, and within the field of communication impairments and disabilities.
- 1.2. The study of communication disabilities should be based on a foundation of the study of normal communication and its development through early mother-child interactions.
- 1.3. The program should integrate the teaching of theory with the teaching of the practical applications of theory, and include a substantial element of clinical practicum to achieve clinical competence as generic therapists.
- 1.4. The program should include an awareness of social, linguistic and cultural differences both within and across countries, and a respect for differences both amongst individuals and amongst societies. Students should be made aware of the growing multilingual issues within specific communities. They should be informed about the possible role of the speech language pathologist to establish inter-professional networks in their communities.

### **2. Content**

- 2.1. The study of Logopedics is highly dependent (or reliant) on supporting disciplines of psychology and linguistics, behavioral sciences and biomedical sciences. The programme should cover the main context of supporting disciplines. Such coverage should provide the students with an overview of the relevance of the main contexts of each discipline, and detailed study of such theories and

approaches as are directly relevant to the understanding of human communication and its disorders. (The relevance of each discipline to the study of speech language pathology should be made clear to the students. The study of each of these disciplines should include a practical component or guided fieldwork.)

### **Supporting Disciplines**

(a) Linguistics

Linguistics, language acquisition, sociolinguistics, multilingualism, phonetics, acoustics are relevant to linguistic sciences. The study should include the production and classification of speech sounds, phonology, syntax, semantics, lexicons, discourse and pragmatics, with practical work in data collection, transcription, measurement and analysis (including qualitative analysis of oral as well as written language. It should also include discourse analysis, especially in relation to disordered speech and language). The content of the above mentioned domains of study should be relative to the country's language.

(b) Behavioural Sciences

Studies in the Behavioural Sciences should include cognitive psychology, social psychology, developmental psychology (across the life span), neuropsychology, education/pedagogy and studies of personality and individual differences, with guided fieldwork particularly in relation to understanding psychological assessment.

(c) Biomedical Sciences

Studies in Biomedical Sciences should include biological bases of language, speech and swallowing (gross and neuroanatomy and physiology); clinical medical sciences as applied in neurology, otorhinolaryngology, paediatrics, geriatric medicine, psychiatry (across the age-span), audiology, orthodontics and the study of craniofacial anomalies and their repair, and of deglutition. Opportunities for observing clinical sessions (especially multidisciplinary) in these related disciplines should be included. The teaching should preferably be provided by qualified specialists in each field, who are sensitive to the specific relevances of their field to the needs of logopedics.

(d) Ethical issues in connection with research and practice.

The programme should use professionally and scientifically qualified teachers. Teachers providing clinical supervision need to hold professional certificate in speech-language pathology required in the local country. Students should have knowledge of relevant ethical guidelines of research and practice. They should be familiar with laws, statutes and regulations concerning to professionals in private and public social and health care organizations. Throughout the entire programme, students need to follow these ethical principles in theoretical and practical studies. Students should be aware when attending the practical studies; they need to follow the local laws concerning the health care professionals.

- 2.2 In addition to the above supporting sciences, the programme should cover the principal discipline of logopedics. This will include the study of:
- (a) the varieties of normal and abnormal communication, their characteristics and possible causal factors/aetiologies and interpretations of their nature from biological, cognitive and socio-cultural perspectives;
  - (b) theories of the assisted establishment/recovery of language function;
  - (c) culturally and linguistically appropriate methods and resources for assessment and diagnosis;
  - (d) methods of evaluating the effectiveness of diagnostic and intervention;
  - (e) the consequences of communication disorders for the families and social contacts of individuals, and methods of counseling;
  - (f) the social and organizational settings in which speech language pathologists work, with respect to health, education, the work of allied professionals, legal and ethical issues, use of resources and professional responsibility.
  - (g) The teaching of logopedics should be provided by qualified speech language pathologists, who maintain active involvement with clinical work and have clinical research experience in specific areas of logopedics, including AAC methods.
- 2.2.1 The study of logopedics must include practical work carried out under the supervision of qualified and experienced speech language pathologists, and monitored by the logopedic educational programme. This should be aimed at enabling the student to acquire generalist skills and systematic methods of working with clients. It should foster the personal development of the student and interactive communication skills. It is necessary that the supervisors should have current knowledge of the profession and be trained in supervision.
- 2.2.2 The practicum should show how the studies identified under 2.2. (a) to (h) above are applied and how. It is, therefore recommended that it is undertaken in association with the teaching of the theory components outlined in 2.2., in order to facilitate the integration of theory and practice.
- 2.2.3 Practicum should begin with observation of skilled practitioners and continue with direct interactive experience for each student in a variety of settings and with a variety of types of clients and with a variety of responsibilities, from screening to diagnosis, from planning to applying intervention programmes.

2.2.4 In respect of variety of cases (see 2.2. (a) above) direct experience in clinical practicum should include work with *at least* the following types of disorders:

- (a) Developmental and acquired speech and language disorders - oral or written (including, in children, disorders of a phonological nature and, in children and adults, disorders which predominantly or also involve other levels of language organization);
- (b) Voice disorders
- (c) Fluency disorder
- (d) Swallowing disorders
- (e) Reading and writing disorders

2.2.5 In addition the programme should provide some practical experience for the student of cases with communication or oral disorders secondary to at least some of the following:

- (a) hearing impairment and disability;
- (b) cognitive impairment disability;
- (c) language learning impairment disability and dysgraphia;
- (d) behavioral and emotional disabilities (e.g., autism, attention deficit);
- (e) psychiatric disabilities (e.g., schizophrenia, psychosis, the dementias);
- (f) structural abnormalities, congenital (e.g., cleft palate) and acquired (e.g., laryngectomy); cerebral palsy and other neuro-motor disabilities;
- (g) symptoms secondary to social deprivation;
- (h) multiple and complex impairments and disabilities (e.g., combinations of any of the above);
- (i) swallowing and feeding impairments and disabilities. See 2.2.4. above.

To supplement (but not substitute for) the direct practical experience with some of the above, videotaped recordings (preferably interactive) may be used in order to make students aware of work with the other categories of disabilities if direct access to such client groups is not possible. Topics of evidence based practice are a new paradigm for speech therapists in East European countries.

- 2.2.6. There should be a practical examination of the student's clinical work at or near the end of the programme, in which the student's ability to apply theory to practice is assessed. It is also recommended that there should be frequent in-course assessment of students during the programme, so as to allow for remedial help or redirection. At the same time, clinical guidelines for supervisors should be provided by a group (committee) of advanced speech language pathology members in each country. Many East European countries like Bulgaria, Poland and Macedonia are in the process of developing guidelines for supervisors.

### **3. Structure**

- 2.3. In respect of (c) above, it should be noted that these guidelines refer only to the education of speech language pathologists (or their equivalent in other terminologies) as defined in Appendix 1 of this document. The IALP recognizes that some countries (particularly those which are seriously under-resourced) may choose to train people whose work includes helping the communication-disordered through alternative or additional routes than by setting up logopedics programmes of the type illustrated here. The guidelines have been devised with the intention of describing patterns of good practice in the education of professionals identified as speech language pathologists, which many programmes at present follow, and which other programmes may wish to bear in mind in seeking to work towards an international framework.
- 2.4. The IALP Education Committee recognizes that a variety of social, cultural and educational influences need to be taken into consideration in planning programmes in different countries, and that this may be particularly important where new programmes are initiated for the first time in the country. These guidelines relate only to the initial education of speech language pathologists, rather than to their continuing professional development following qualification.

The guidelines are not intended to substitute for the accreditation requirements set by national professional bodies concerned with Logopedics. For the countries without specific accreditation and evaluation of Logopedics requirements, the present guidelines can serve as a reference for the establishment of national standard.

Following the tremendous changes which have taken place globally during the last decades, it is appropriate to describe different educational routes because the profession developed at different levels in different parts of the world.

### **3.1 For countries where the service to people with communication disorders is already well established.**

In order to achieve the requisite competencies related to the profession of speech language pathologist the educational programme giving access to the profession must be undertaken at university or equivalent academic level. If possible doctoral degree and other forms of specialization should be offered in accordance with the possibilities and traditions of the organising university or academic institute or specialized scientific committee.

The educational programme should be in balance with the 'generic competencies' related to academic equivalent degree and in accordance with the 'discipline related competencies' described as an integration of knowledge, understanding, discipline specific skills and abilities and organised into three competence areas:

- (a) Clinical practice: prevention, assessment, diagnostics, training and therapy related to clients and their community.
- (b) Organisation : working in and for an organization
- (c) Professionalization: development of the profession and the discipline.

It is recommended that terms such as 'generic', 'discipline related competencies', 'Master', 'Bachelor level' etc., be adopted and defined. See appendix 2.

### **3.2 For countries where the service to people with communication disorders is developing.**

Two educational routes giving access to the profession are considered acceptable:

- (a) A first degree ('generic competencies' at BA or equivalent degree level) preferably distributed over 4 years and covering all necessary 'domain specific competencies' related to good practice of the profession.
- (b) A post graduate degree or equivalent in logopedics, following a first degree course in logopedics of at least 3 years. It is recommended that the post graduate degree should be distributed over at least 2 years.

### **3.3 For countries where the professional education of speech language pathologists does not currently exist and where the service to people with communication disorders is not yet established.**

The aims of this section is to facilitate the initiation of appropriate professional education in logopedics in countries which have chosen to set up programmes for the education of practitioners in a logopedics service. It is recognised that some countries may choose to develop other patterns of service which include help for the communication-disordered,

and that different means of training workers might be used as a supplement to, or instead of, education in logopedics.

The prime motivations for such education should arise indigenously, with external advisers, where sought, acting as facilitators rather than directors.

A crucial first stage should be to identify major cultural issues and to evaluate needs, including a review of existing services, within the prevailing local context. In particular the local education system should be taken into consideration when devising a new programme.

External facilitators should be sensitive to aspects of indigenous culture and circumstances, and some points for consideration are given below:

- (a) sustainability, financing and the intermeshing of the logopedic service with other existing health and educational services;
- (b) materials such as textbooks must be evaluated for appropriateness for the culture and circumstances, particularly in respect of the pictorial illustrations included;
- (c) the stated aim of rehabilitation in many countries is to work towards the client's achievement of independence; this may conflict with cultural values in some countries where mutual dependence is considered more acceptable;
- (d) equipment and technical resources need to be appropriate to the circumstances, and availability of technical support staff is essential;
- (e) where other professional services are unavailable, workers with the communication-disordered are likely to extend the boundaries of their professional remit beyond that which is conventionally acceptable in better resourced countries, and, therefore, workers and organisers need to be made aware of the points at which such tolerances may endanger the welfare of the communication-disordered;
- (f) in countries where a speech language pathologist service does not exist, local clinical practicum for students may be impossible, and the appropriateness of placing these students in well-resourced countries for their clinical experience needs to be carefully considered; alternatively it may be suggested that experienced professionals are brought to build this practicum;
- (g) a greater emphasis in initial training may need to be given to the management role of communication workers, and their role in training the skills of others;
- (h) there may be linguistic variations and a range of coexisting languages which will have implications for the educational program;

- (i) the balance of the program content may need to be adjusted to facilitate the meeting of local needs;
- (j) students should be made aware of the limitations of using materials and resources which have been developed by other countries (or in other regions of the same country) for different cultural and linguistic needs;
- (k) steps should also be taken to initiate the development of an appropriate status for the profession and career progression of its practitioners.

#### **4. Research**

Academics on the programmes should be active in research in speech language pathology and/or its supporting disciplines, so as to stimulate students' interest in research, and to keep academics and students up-to-date with current developments in these fields, e.g., single case study of behavioural analysis in clinical assessment.

All programmes should include a research project amongst the students' experiences, so as to foster a research-oriented approach (evidence based) to clinical work, and assist the student in the critical examination of research in the field.

#### **5. Program evaluation**

Programmes should periodically undertake their own self- evaluations. In countries with experiences in accreditation of professional programmes (professional body of speech language pathologists or independent organisations) IALP may approve such a body for use as its agent in satisfying itself that the guidelines have been adequately met by identified programmes, and thereby permitting statements to be made to that effect.

#### **6. Continuing Education and Scientific Study**

Speech language pathologists should continue to maintain their competence through updating their knowledge and skills. They should contribute to the development of the discipline and of the profession by undertaking and publishing research. Experienced speech language pathologists have a responsibility to assist and tutor students of their profession and supervise their clinical practice. It is recommended that assistance should be offered to younger therapists who are newly qualified.

### **Definition and Roles of the Logopedist**

The definition and roles of the logopedist have developed and expanded during the 20<sup>th</sup> century. Scientific and technical developments, along with changes in law and funding relating to the provision of health and education services, will influence the definition and roles of the logopedist, so that it will continue to evolve.

#### **1. Definition**

The central concern of the profession of logopedics is that people with communication and swallowing disabilities (dysphagia) receive the best possible service to alleviate their disabilities, and improve their quality of life. To achieve these goals, the logopedist's involvement is in the prevention, assessment, intervention, management and scientific study of disorders of human communication, and of swallowing. In this context, human communication comprises all those processes and functions associated with the production of speech, and with the comprehension and production of oral and written language, as well as forms of non-vocal communication. Swallowing in logopedics refers to safe transit of food and drinks through the oro-pharynx to ensure optimal oral nutrition.

#### **2. Roles and Functions of the Logopedist**

Logopedists require both scientific knowledge and clinical competence in order to achieve optimal levels of client care. The logopedist has the following roles:

##### **Prevention**

- The prevention of the occurrence or the development of communication disorders:
- a) education of the public and other professionals about the nature of communication and the prevention of communication disorders;
  - b) early identification of communication disorders and factors directly associated with communication disorders
  - c) collaboration with other professionals as relevant to the role of the logopedist in the prevention of communication disorders.

##### **Assessment**

Assessment is a continuing process, and in (most cases) many instances will involve collaboration with other disciplines. A diagnosis is reached through objective testing, observation, and consultations with the client/family members, and other professionals as appropriate (necessary). This leads to a hypothesis about the nature and duration of targeted intervention.

##### **Intervention**

The logopedist carries out intervention for communication disorders and dysphagia to assist clients to achieve the best possible function, and to reduce or eliminate the impact of the primary impairment. Intervention represents a joint undertaking between the logopedist and the client/family and subsumes client management, including the selection of goals and therapy procedures. Intervention goals are based on assessment and client/family priorities and may

include early intervention, rehabilitation, counselling, consultation, and participation in management through teamwork. An essential part of intervention is the evaluation by the logopedist of its efficacy.

### **Professional Conduct**

Logopedists must maintain professional responsibility for the welfare of their clients at all times. They must observe the code of ethics of their national professional body and/or as prescribed by their employer, and/or their national/state government.

### **Continuing Education and Scientific Study**

It is an ethical responsibility of the logopedist to participate in continuing education and scientific study to update their knowledge and skills, and to maintain their competence to practice. Where possible, logopedists should contribute to the development of the discipline and of the profession by undertaking and publishing research and therapy reports. Experienced logopedists have a responsibility to assist and tutor students of their profession and supervise their clinical practice.

## Competencies Defined

### 1. What are Competencies?

- (a) Competencies underpin the achieving of Occupational Standards set by the accreditation body.
- (b) Competency based assessment looks at the outcomes of clinical training (have been called Outcome Statements).
- (c) Competencies involve taking a holistic approach - concerned with integrated functioning of student, not isolated skills or attributes.
- (d) Competency is not so concerned with WHAT the students know but with HOW they use it (this doesn't mean that the WHAT is not important).

### 2. Competency based assessment

- (a) Competency-based clinical evaluation report

The level of competence that the student is expected to achieve by the end of the academic year is in bold print on the report form relevant to the year of study. Each competency is rated according to whether the competency is not evident, emerging or present.

The expected level of competence may not be achieved by the end of a first semester placement but would be expected to be emerging. Students are expected to be competent in most/all areas by the end of the final year.

The student should be marked according to his/her ability assumed of the year completed by the student, not as a comparison to a clinician. For example: A second year (Stage II) student should not be expected to be fully competent in areas such as:

- determining diagnosis and prognosis without support
- planning and carrying out intervention without support
- evaluating therapy intervention without support

A third year (Stage III) student should not be expected to be fully competent in areas such as:

- consulting and coordinating with other professionals
- caseload management of a whole service

A final year (Stage IV) student should not be expected to be fully competent in areas such as:

- working with complex caseloads that involve rare aetiologies, multiple impairments, dysphagia and neonatal feeding, as well as those cases involving multiple factors that may combine such issues as culture, alternative service delivery models, etc;
  - working with clients in medico-legal claims.
- (b) Competencies organized around case management
- Assessment of the Client
  - Description and Diagnosis of the Client
  - Planning Management
  - Implementing Management
  - Service Delivery Issues
  - Personal Qualities

**Possible Rating Scale**

*Not evident:* The student has not demonstrated this skill during his/her placement

*Emerging:* The student has demonstrated some ability in this skill and is aware of his/her need to develop it

*Competent:* The student has demonstrated consistent ability in this area.