GUIDELINES FOR THE INITIAL EDUCATION OF COMMUNICATION AND SWALLOWING PROFESSIONALS

Revised by the IALP Education Committee for Speech and Language Pathology and Audiology

(February 2022)

Preamble

The main aim of this document is to guide educational institutions of higher education to establish or develop further educational professional programs in the area of communication and swallowing sciences and disorders. Furthermore, it intends to provide a model of the global educational standards in the initial education of communication and swallowing professionals. (For the history of the development of the guidelines look at Appendix A)

The nomenclature for this profession and its practitioners differs by country. Terms currently in use include speech-language pathologist, speech and language therapist, speech pathologist, speech therapist, orthophoniste, fonoaudiologist, logopedist, logoped, logopäde, logopédiste, logotherapeftis, logopedista, logopeda, and terapeuta da fala. The discipline of Communication Sciences & Disorders includes the professions of communication/swallowing and audiology. For purposes of this document, we will use the term Communication Sciences and Disorders (CSD) to refer to practitioners of the profession of communication/swallowing. A separate document is in development for the profession of audiology.

Part A: BACKGROUND

1. Purpose

It should be noted that these guidelines refer only to the education of communication/ swallowing professionals (or their equivalent in other terminologies). The IALP recognizes that some countries (particularly those with under-resourced CSD programmes or systems of care) may choose to educate people whose work includes enhancing communication and swallowing function through alternative or additional routes other than by setting up CSD programmes of the type detailed here. The guidelines have been devised with the intention of describing patterns of good practice in the education of professionals identified as communication/swallowing professionals which many programmes at present follow, and which other programmes may wish to bear in mind in seeking to work towards an international framework.

The IALP Education Committee recognizes that a variety of social, cultural and

educational influences need to be considered in planning programmes in different countries, and that this may be particularly important where new programmes are initiated for the first time in a country (See Section 3: Differing Structures in Global Education).

In addition, educational programs in CSD should be committed to and accountable for advancing diversity, equity, inclusion, social justice, and sustainability in all its forms. They should embrace individual uniqueness, foster a culture of inclusion that supports both broad and specific diversity initiatives, leverage the educational and institutional benefits of diversity in society and nature, and engage all individuals to help them thrive. Educational programs should value inclusion as a core strength and an essential element.

These guidelines relate only to the initial education of communication/swallowing professionals, rather than continuing professional development following qualification or certification.

The guidelines are not intended to substitute for the accreditation requirements set by national professional and/ or government bodies related to CSD programmes of study. The purpose of the guidelines is to emphasize the main principles, identify academic content, and relevant professional fundamentals for the programme structure. For countries without specific accreditation and evaluation of CSD requirements, the present guidelines can serve as a reference for the establishment of national standards.

The aim of providing guidelines is to anchor the initial education of communication/ swallowing professionals, to develop and maintain common, appropriately high, but regionally accommodated and achievable standards of education, and to, in due course, facilitate the international movement of personnel and knowledge. It is hoped through the dissemination of these guidelines (recommendations) to all educational programmes in CSD that competent and innovative practitioners will be able to:

1.1 Offer and/or improve the quality of services to enhance communication and/or feeding and swallowing functioning for people in countries where initial educational programmes are already established.

1.2 To guide and/or improve the quality of services to enhance communication and/or feeding and swallowing functioning for people in countries where initial educational programmes are developing.

1.3 Establish new programmes for the initial professional education of communication/swallowing professionals, where such programmes do not currently exist, and where their development is considered appropriate and feasible.

1.4 Be globally, as well as locally conscious and pro-actively engaged in terms of providing and/or promoting the principles, content, and teaching considerations for education in CSD, including counselling, public health, community education, and prevention.

2. Principles of the guidelines

2.1 The statement below provides a general statement of principles to be taken into consideration in the education of communication/swallowing professionals, with consideration of the practices of various and diverse cultures and countries. Where it is the practice to combine education in CSD with that of other professions, these guidelines relate specifically to the CSD component of such educational preparation. This is to ensure that the discipline of CSD can sufficiently stand on its own and is comparable with programmes where CSD is taught as an independent field.

2.2 Surveys of the education of CSD world-wide indicated that:

2.2.1 A variety of approaches to the initial education of communication/swallowing professionals currently exists.

2.2.2 In some countries, education in CSD is undertaken simultaneously with education in a second profession, i.e. audiology/hearing therapy, education, special needs or inclusive studies, psychology, generalist rehabilitation and linguistics.

2.3 The CSD profession is an identifiable autonomous profession and is not one whose practitioners are seen as educational/ medical/ social/ rehabilitation assistants but should closely collaborate with or supervise such assistants.

2.4 Within a profession, the practitioners possess special knowledge and skills in a widely recognised body of learning derived from the evidence-based including research, education, clinical experience, and education at a high level. They follow a code of ethics, which specifies level of education, recognition of the boundaries of their practice and skills, and the need to consult with and refer to individuals in other professions as appropriate.

2.5 Practitioners and students must be prepared for and engage in interprofessional collaboration.

2.6 The competency based education and assessment of communication/ swallowing professionals is aimed at preparing professionals for a broad and general scope of

work to support people of all ages who may require communication and/or swallowing services, with their families and communities, and for advocacy on behalf of persons who require these services.

2.7 Practitioners may use approaches that vary in methodology (direct, indirect, or simulations), content, and delivery (including training and supporting others, e.g., family members, caregivers, assistants, members of the public, and wider workforce). Approaches may be in person or through telepractice.

2.8 The education of communication/swallowing professionals will include an appreciation of cultural and linguistic, social, political and other factors that influence the development of speech and language, the assessment and diagnosis of atypical communication/swallowing, and their associated diseases and conditions (such as stroke, developmental delay or traumatic brain injury), as well as the delivery of appropriate professional services. Assessment and intervention services should be culturally, linguistically, and personally appropriate and guided by the evidence base.

2.9 The education of practitioners will include advanced knowledge about the nature and variability of communication and swallowing, both typical and atypical.

2.10 The education of practitioners will include an appreciation of evidence-based knowledge, skills, principles and practice (EBP) and the use of research-based approaches (RBP) to support their work. It should be noted that topics in evidence-based practice are a new paradigm for communication/swallowing professionals in some countries.

2.11 Communication/swallowing professionals should be provided with opportunities to develop their skills under relevant supervision and/or professional guidance from their first year of experience in the profession.

2.12 Opportunities should be provided for communication/swallowing professionals to continue their professional development through continuing education, specialisation, and pursuing further formal education which foster research in communication and swallowing disorders, its treatment, and its impact.

2.13 Each country needs to determine the most culturally appropriate mechanisms for educating communication/swallowing professionals and advancing the profession of CSD.

PART B: FRAMEWORK

1. Principles of the Framework

The program should integrate the teaching of theory with the practical applications of theory and include a substantial element of clinical practicum[1] to achieve clinical competence[2] as practitioners.

1.1. The program should make its students aware of the complexity of typical and atypical human communication in all its forms as well as typical or atypical hearing or feeding and swallowing. A fundamental principle of education is the recognition of complexity in the field of human communication, hearing and swallowing, and its typical development.

1.2. The study of atypical communication should be based on a foundation of the study of the range of different types of typical communication development (ontogenesis) through early mother/caregiver-child social interactions, and development of social-pragmatic skills.

1.3. The program should include an awareness of the wide range of social, linguistic and cultural differences, and a respect for these differences. A program could contain unique content or employ professionals outside of the field. Students should be informed about the possible role of the communication/swallowing professionals in establishing inter-professional networks in their communities. Students should also be able to respond to cultural diversity and the need to gather data across languages to develop and implement effective identification, assessment, diagnostics and intervention methods.

1.4. The program should include methods to enhance service delivery across the continuum of care to maximize value and functional outcomes.

2. Content

2.1. The study of CSD is highly dependent (or reliant) on supporting related disciplines of linguistics, behavioral (including social) sciences and biomedical sciences. The programme should cover the general content of these related disciplines. Such coverage should provide the students with an overview of the relevance of the content 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

[1] Clinical practicum = in field professional practicum related to CSD.
[2] Clinical competence = professional competence in CSD

of CSD should be made clear to the students. The study of each of these disciplines may include a practical component or guided fieldwork.

2.2. Supporting Related Disciplines

2.2.1 Linguistics

Linguistics, psycholinguistics, language acquisition, sociolinguistics, multilingualism, phonetics, acoustics are relevant to linguistic sciences. The study should include the production and classification of speech sounds, phonology, morphology, 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). The content of the above-mentioned domains of study should be relative to the country's major language/s.

2.2.2 Behavioural Sciences

Studies in the Behavioural Sciences should include cognitive psychology, social psychology, developmental psychology (across the lifespan), community and cross-cultural psychology, neuropsychology, special and inclusive education/pedagogy and studies of personality and individual differences, with guided fieldwork particularly in relation to understanding psychological assessment, systems theory and processes (health systems, educational systems, work and employment /social development).

2.2.3 Biomedical Sciences

Studies in Biomedical Sciences should include biological bases of language, speech, hearing and swallowing (gross and neuroanatomy and physiology); clinical medical sciences as applied in neurology, otorhinolaryngology, paediatrics, geriatric medicine, psychiatry (across the lifespan), 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 professionals in each field, who are sensitive to the specific relevance of their field to the needs of students of CSD.

2.3 Ethics: Issues in connection with research and practice.

2.3.1 The programme should be led by professionally and scientifically qualified teachers. Teachers providing clinical supervision and/or clinical teaching need to hold a professional certificate in CSD required in the local country.

2.3.2 Students should have knowledge of relevant ethical guidelines of research and practice and international standards for both research and practice. They should be familiar with laws, statutes and regulations related to professionals in private and public, education, 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 and regulations for health care/educational professionals.

2.3.3 They should understand the epistemology, ontology and methodology which underlies the production of professional knowledge including the formation of professional identity.

2.3.4 In support of an inclusive/global approach, students should exhibit a mutual respect for all and should understand the political and social contexts of their work (understanding issues such as power, gender, race, sexuality, etc.).

2.4 Core Academic Content includes:

2.4.1 The varieties of typical and atypical communication, hearing and swallowing, their characteristics and possible causal factors/aetiologies and interpretations of their nature from biological, cognitive and socio-cultural perspectives, considering excluded and marginalized populations; population health /public health; prevention of factors leading to breakdown in communication skills, improvement for atypical communication, and recognition and understanding of communication differences.

2.4.2 Theories of the assisted establishment/recovery/enhancement of speech, language and swallowing function, assessment, treatment and prevention methodologies for: (a) atypical developmental speech and language and acquired speech and language damage, and atypical social/ pragmatic language; (b) voice and resonance, (c) fluency, (d) swallowing (dysphagia) and feeding, (e) reading and writing and related praxis, (f) neurodevelopment and neurocognition.

2.4.3 Culturally and linguistically appropriate methods and resources for assessment, diagnosis and intervention taking into consideration excluded and marginalized populations.

2.4.4 Methods of evaluating the effectiveness of diagnostics and intervention.

2.4.5 Typical consequences (impact) of atypical communication and communication differences for the families, communities and social contacts of individuals, and culturally appropriate methods of counseling and support.

2.4.6 The social and organizational settings in which communication/swallowing professionals work, with respect to health, education, the work of allied professionals, legal and ethical issues, use of resources and professional responsibility.

2.5 Teaching and Clinical Considerations

2.5.1 The teaching of CSD should be provided by qualified communication/swallowing professionals, who maintain active involvement with clinical work, continuing education, and have clinical research experience[3] in specific areas of CSD.

2.5.2 The study of CSD must include practical work carried out under the supervision of qualified and experienced communication/swallowing professionals and be monitored by the CSD educational programme. This should be aimed at enabling the student to acquire generalist skills and systematic methods of working with target individuals and groups using interactive communication skills. Supervisors must have current knowledge of the profession and be trained in supervision.

2.5.3 The practicum should show how the studies identified under 2.4 above are applied. It is recommended that special consideration be given to the theory components outlined in 2.4.1 to facilitate the integration of theory and practice.

2.5.4 The student should be guided to explore pedagogical approaches which are aligned with social justice and change

2,5,5 Practicum should begin with observation of skilled practitioners followed by discussion and continue with direct interactive experience for each student in a variety of settings, with a variety of types of individuals

[3] Clinical work should be understood as clinical fieldwork -clinical practice in different fields (mainly health care, school based practice but possibly in clinical education practice or clinical social practice directly and essentially relevant to CSD practice).

seeking assessment and treatment, and with a variety of responsibilities, from screening to diagnosis, from planning to applying intervention programmes, from consulting to collaborating, and from coaching to supervising and/or teaching. Many different types of learning approaches can be used.

2.5.6 Depending on individual regulations within a country or locale, use of clinical simulations can be acceptable, in part, for clinical education.

2.5.7 Regarding varieties of cases (see 2.4.1 above), direct experience in clinical practicum should include work with *at least* the following with individuals seeking treatment in acquired and developmental disorders: (a) speech and language and social/pragmatic language, (b) voice and resonance, (c) fluency, (d) swallowing (dysphagia) and feeding, (e) neurodevelopment and (f) neurocognition.

2.5.8 In addition, the programme should provide some practical experience for the student to enhance communication secondary to at least some of the following: (a) hearing impairment, (b) neurocognitive issues, (c) atypical language-learning, (d) neurodevelopmental, behavioral and emotional issues (e.g., autism spectrum disorder, attention deficits, elective mutism), (e) mental health issues (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 issues, (g) symptoms secondary to social/sensory/cognitive/emotional deprivation, (h) multiple and complex impairments (e.g., combinations of any of the above), (i) swallowing and feeding impairments. (See also 2.5.6 and 2.4.2 above.)

To supplement (but not substitute for) the direct practical experience with some of the above, videotaped recordings (preferably interactive) may be used to make students aware of work with the above categories if direct access is not possible.

2.5.9 There should be summative examinations of the student's clinical and academic work at or near the end of the programme, in which the student's knowledge of content and ability to apply theory to practice is assessed. There should also be periodic formative assessments of students (both in courses and in practica) during the programme, to allow for remediation or redirection.

2.5.10 Clinical guidelines for practicum supervisors should be provided by a group (committee) of advanced communication/swallowing professionals with educational training in each country. Countries that are developing guidelines for supervisors may find successful models in other countries that can be adapted or they may contact the chair of IALP Education Committee directly

3. Differing Structures in Global Education

Following the tremendous changes which have taken place globally over the last decades, it is appropriate to describe different educational routes given that the profession has developed in different ways in different parts of the world.

3.1 For countries where the education of communication/swallowing professionals and service delivery models to maximize functioning are already well established.

In order to achieve the requisite competencies related to the CSD profession, educational programmes giving access to the profession must be undertaken at an Institution of Higher Education (first and/or second cycles[4] - ISCED[5] levels 6 or 7 - Bachelor or Master's degree). If possible, the doctoral degree (third cycle - ISCED level 8) 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 degrees, and with the "discipline related competencies" described as an integration of knowledge, understanding, discipline specific skills and abilities and organised into three competency areas:

3.1.1 *Clinical Practice*: prevention, assessment, diagnostics, training and therapy related to individuals with disabilities and their community.

3.1.2 *Organization*: working in and for an organization

3.1.3 *Professionalization*: development of the profession and the discipline, competence for self-reflexivity and critical consciousness.

[4] Also – level or degree.
[5] International Standard Classification of Education

3.2 **For countries where the education of communication/swallowing professionals and service delivery models to maximize functioning are still developing:**

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

3.2.1 A first cycle ("generic competencies" at BA or equivalent degree level - ISCED level 6) preferably distributed over 4 years and covering all necessary "domain specific competencies" related to good practice of the profession.

3.2.2 A second cycle or equivalent (ISCED level 7) in CSD, following a first cycle course in CSD of at least 3 years. It is recommended that the post graduate degree be distributed over at least 2 years.

3.3 **For countries where the education of communication/swallowing professionals does not currently exist and where service delivery models are not yet established or are provided by practitioners of other disciplines, such as by teachers, physiotherapists, or by nurses:**

The aim of this section is to facilitate the initiation of appropriate professional education in CSD in countries which have chosen to set up separate and identifiable programmes for the education of practitioners in a CSD service.

It is recognised that some countries may choose to develop other patterns of service which include help for individuals to maximize communication or swallowing function, and that different means of training workers might be used as a supplement to, or instead of, education in CSD.

In such countries there may be a service but provided by other workers. In this context, a CSD degree may be adding an additional service for those providing communication or swallowing assessment and intervention but may not necessarily be required by any local governing bodies.

The most important presumption is that the prime motivation for such education should arise locally, with external advisors, where sought, acting as facilitators rather than as directors.

Community needs in many countries, particularly in low-moderate-resourced countries, will invariably be different from needs in well-resourced countries. These needs must be considered first and foremost.

Local leaders and a cross-section of local populations must be consulted and respected to establish a CSD programme which meets needs most important to them, and which will be culturally determined and valued. There are many examples worldwide of the imposition of the values and methodologies of well-resourced countries, including in CSD, resulting in poor, inadequate and unsustainable programmes.

Local staff should take ownership of a new programme and determine which roles are most appropriate in their situation. Educational guidance from external advisors should be driven by local requests and facilitated by those with a thorough knowledge of local culture and priorities.

A crucial first stage should be to identify needs and major cultural issues and to evaluate these needs, as determined by the full range of stakeholders including service users, community, other health and education staff, relevant government ministries etc., including a review of existing services and resources within the local context. In particular, the local educational and healthcare systems should be taken into consideration when developing a new CSD programme as the importance of local staff and their roles become essential in this case.

External facilitators should be sensitive to aspects of local culture and circumstances. Some points for consideration are given below:

3.3.1 CSD services need to be sustainable, adequately financed, and intermeshed with, and take advantage of other existing health and educational services.

3.3.2 Steps should also be taken to initiate the development of an appropriate status for the profession, as well as employment opportunities and career progression for practitioners.

3.3.3 The stated rehabilitation aims of working towards an individual's achievement of independence must consider possible conflicts with cultural values where mutual dependence is considered more acceptable.

3.3.4 Where other professional services are unavailable, those who work to improve communication or swallowing may be likely to extend the boundaries of their professional responsibilities beyond that which is conventionally accepted in better-resourced countries. Therefore, external advisors and organisers need to be made aware of the points at which such tolerances could endanger the welfare of individuals with communication or swallowing disorders and inform their local trainees who could

unknowingly cause harm in the name of communication or swallowing interventions.

3.3.5 There may be linguistic variations and a range of coexisting languages which will have implications for the educational programme.

3.3.6 Educational models may differ from practices that are standard in countries with well-established practices (e.g., community-based services may be more prominent; there may be lone workers who do not have the support of interprofessional/multi-disciplinary teams, equipment, mentors, and professional bodies). Interprofessional learning, online learning supports, how to seek appropriate resources and innovative pedagogies may be employed.

3.3.7 Training programmes may need to provide greater emphasis on preparing trainees to manage programmes and develop service delivery teams due to limited support services and use of individuals who are not fully qualified in CSD.

3.3.8 The balance of the programme content may need to be adjusted to facilitate meeting of local needs.

3.3.9 Students should be made aware of the limitations of using materials and resources which have been developed by professionals in other countries (or in other regions of the same country) where cultural and linguistic needs may be different.

3.3.10 The programme's curriculum design should be adapted according to whether new services are being established, or whether practitioners are being educated to practice where services already exist.

3.3.11 Materials such as textbooks must be appropriate for the culture and circumstances, particularly regarding pictorial illustrations.

3.3.12 Equipment and technical resources must be appropriate to the circumstances, and availability of technical support staff.

3.3.13 In countries where communication or swallowing intervention services do not exist, local clinical practicum for students may be challenging, and the advisability of placing these students in well-resourced countries for their clinical experience needs to be carefully considered. However, it is

recognised that this may be inappropriate or impossible and thus consideration should be given to experienced professionals being brought in to a low-moderate-resourced country in order to build practical experiences for students.

3. Research

Academics and clinicians, as well as PhD and other doctroal students in programmes should be active in research in CSD 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 foster a research-oriented approach (evidence based) to clinical work and assist students in the systematic reviewing and critical examination of research in the field.

4. Program Evaluation

Programmes should periodically undertake their own self- evaluation. Additionally, external accreditation is required. Accreditation of health and education training leading to a professional qualification is established in many countries through governmental processes, independent recognised organisations and/or independent professional accreditation bodies.

5. Continuing Education and Scientific Study

IALP considers that continuing professional development is essential to ensure best practice. Communication/swallowing professionals should continue to maintain their competence through updating and advancing their knowledge and skills. They may contribute to the development of the discipline and of the profession by supporting, conducting, publishing, applying, or disseminating research or research results. Experienced communication/swallowing professionals have a responsibility to mentor CSD students and to supervise their clinical practice. It is recommended that assistance support and encouragement be offered to communication/swallowing professionals who are recently qualified.

APPENDIX 1

The history of the development t of the educational IALP Guidelines

At its meeting in Hanover, Germany in August 1992, the Education Committee of the IALP (*International Association of Logopaedics and Phoniatrics*, now doing business as *International Association of Communication Sciences and Disorders*) agreed to take steps towards preparing international guidelines for the initial education of students preparing to provide services to individuals with communication and swallowing needs.

A first draft of guidelines was prepared and discussed by the Education Committee of the IALP, three national professional bodies and other associations and individuals. A second draft was presented at a conference organized by the Education Committee of IALP 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 of IALP 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. In 1995, these guidelines were published in *Folia Phoniatrica et Logopaedica.* 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, across state regions.

The professions encompassed under the term ‘Communication Sciences and Disorders’ (CSD) and the term ‘communication/swallowing professional have historical roots in interests in physiology and pathology of voice, speech, and language dating back to ancient times. In more recent times, pioneering strategies to address voice and speech issues for individuals with severe hearing impairment have been added to the methods pused in CSD. These methods have been further informed by the medical and health care approaches arising from the developing fields of otorhinolaryngology, audiology, linguistics, neurology, and other sciences. Over time, CSD developed into an autonomous profession, based on transdisciplinary knowledge, and professionally supervised practice. Because of the remarkably wide scope of practice and competencies required for practice as well as the variable political, economic, cultural, religious, social, language, regional, and unique personal conditions and the resulting challenges, these guidelines seek to describe a transformational agenda for academic and professional education for preparation of individuals to practice in this professional area.

Since the original adoption, many cultural, political, and educational changes have taken place globally, including changing views on need for services for individuals with

communication and swallowing needs and terminology describing those receiving services. As a result, several terms are now viewed as disrespectful or offensive, including ‘impaired’, ‘challenged’, ‘low-functioning’, and ‘handicapped’. It is anticipated that terminology and views are dynamic and will continue to change over time, so it will be critical to be attentive to the social, political, and educational contexts of each local community. Also, perceptions continue to change regarding use of descriptive vs. person-first language (e.g., stutterers vs. individuals who stutter). For consistency, this document will use the person-first convention.

Given the number of changes, it was necessary to review the educational guidelines for their current appropriateness. Several countries are developing an awareness of the need to provide services to persons with atypical communication and swallowing. Others are finding it necessary to expand their educational preparation programs to meet the needs of an expanding and changing client base. In view of the wide range of roles, especially the growing consultative and public health roles and inclusive approach to implementation, CSD is also addressing the issues of social disadvantage related to communication and swallowing functions and working to improve quality of life by maximizing these functions. Because communication issues are under-treated in low - moderate-resourced countries, these areas will require special considerations.

Members of the Educational Committee of the IALP 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 next Education Committees discussed the main comments and proposals for the new revision, introduced these issues at the 2017 and 2019 IALP Congresses in Dublin and Taipei, and finalized the changes in 2022. The following is the revised version resulting from this process.

APPENDIX 2

Definition and Roles of the Communication/swallowing professional

The definition and roles of the communication/swallowing professional has developed and expanded over the last 50 decades and is continuing to expand in the current century. Scientific and technical developments, along with changes in law and funding related to the provision of health, social education, and social services influence the continually evolving definition and roles of the communication/swallowing professional

1. Definition

The central concern of the profession of CSD is that people who need to maximize communication and swallowing function to improve their quality of life and social participation should receive the best possible service. To achieve these goals, the communication/swallowing professional's involvement is in the prevention, assessment, intervention, management and scientific study of typical and atypical human communication, feeding and swallowing (dysphagia). In this context, human communication comprises all those processes and functions associated with the production of speech, spoken language and with the comprehension and production of oral, written or signed language, as well as forms of vocal and non-vocal communication. Feeding (oral and non-oral) and swallowing (dysphagia) in CSD refers to safe intake, processing and transit of food and drinks through the oro-pharynx or via non-oral feeding mechanisms (e.g., percutaneous endoscopic gastrostomy (PEG) to ensure optimal nutrition and hydration.

2. Roles and Functions of the Communication/swallowing professional

Communication/swallowing professionals require both scientific knowledge and clinical competence to achieve optimal levels of care. The communication/swallowing professional has the following roles:

Prevention

The prevention of the occurrence or the development of atypical communication and swallowing:

- education of the public and other professionals about the nature of communication, the facilitation of speech and language development, and the enhancement of communication and swallowing
- early identification of atypical communication and swallowing and associated factors
- collaboration with other professionals as relevant to the role of the communication/swallowing specialist in the facilitation of communication and

swallowing.

Assessment

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

Intervention/Coaching

The communication/swallowing professional carries out intervention for communication and feeding/swallowing (dysphagia) to assist individuals to achieve the best possible function, and to reduce or eliminate the impact of developmental or acquired disruptions to typical communication and feeding/swallowing. Intervention/coaching represents a joint undertaking between the communication/swallowing professional and the individual/family and subsumes treatment, including the selection of goals and procedures. Intervention goals are based on assessment and individual/family priorities and may include early intervention, rehabilitation, counselling, consultation, and participation in management through teamwork. An essential part of intervention or other relevant professional activities (e.g., coaching, consultation, collaboration, and guided self-management) is the evaluation by the communication/swallowing professional of the efficacy of their activities.

3. Professional Conduct

Communication/swallowing professionals must maintain professional responsibility for the welfare of those they always serve. 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.

4. Continuing Education and Scientific Study

It is an ethical responsibility of the communication/swallowing professional to participate in continuing education and scientific study to update their knowledge and skills, and to maintain their competence to practice. Where possible, communication/swallowing professional should contribute to the development of the discipline and of the profession by undertaking and publishing research and therapy reports. Further, it is recommended that assistance be offered to communication/swallowing professionals who are recently qualified to facilitate their professional growth and skill development.

APPENDIX 3

Competencies Defined

1. What are Competencies?

1.1 Competencies underpin the achievement of occupational standards set by the accreditation body.

1.2 Competencies involve taking a holistic approach, concerned with the integrated functioning of the student, not solely with isolated skills or attributes.

1.3 Competencies are not as concerned with what students know but with HOW they use and apply their knowledge.

2. Competencies for initial education in speech-language pathology

A separate document listing and describing specific competencies for assessment and evaluation of CSD students was prepared by the IALP Education Committee in 2022 and can be found in the IALP Competency Guidelines.