# GUIDELINES FOR TELE-SPEECH AND LANGUAGE SERVICES

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# GUIDELINES FOR TELE-SPEECH & LANGUAGE SERVICES

***Advisory:***

*The published guidelines for delivering tele-speech and language services (Version-1, August, 2020) by the Delhi branch of the Indian Speech and Hearing Association (DISHA) are recommended practices which may be considered by Speech Language Pathologists and/or Audiologists while delivering tele-speech & language services. These guidelines are not mandated.*

## 1. Introduction

Tele-speech and language services refer to the application of telecommunication technology to deliver services by connecting clinicians and clients at separate locations for the purposes of assessment, and intervention.

Other related services conducted through telecommunication include supervision, consultation, conducting educational programs and client-clinician meetings.

Due to the current Covid-19 pandemic across India and around the world, it may be difficult to safely provide in-person speech and language services in clinics, hospitals and home settings. Given the current social distancing guidelines and/or requirements, tele-speech and language services will enable the continued provision of care for individuals with communication disorders and their caregivers.

Individuals with communication disorders can receive tele-speech and language services if they have access to tele communication technology (e.g., computer, laptop, tablet, phone with internet access) as recommended by a Speech Language Pathologist/Audiologist.

The following approaches may be considered while providing tele-speech and language services

a) *Direct Approach (Synchronous):* Direct approach uses a real time connection between clinician and client, to conduct an online session via audio-video modes.
b) *Indirect Approach (Asynchronous):* Indirect approach includes service provision through e-intervention materials, e-handouts, video clips etc. which may be shared by clinicians through viable channels (e.g., messages, e-mails). In this approach, there is no real time connection between clinician and client.
c) *Direct-Indirect approach (Mixed):* The third approach is a combination of direct and indirect approaches.

## 2. Qualified professionals who can provide tele-speech and language services

According to the Rehabilitation Council of India (RCI), speech & language services in India should be provided by a qualified Audiologist and/or Speech Language Pathologist/Speech Therapist, registered under RCI.

*"Speech Language Pathologist is a qualified professional who provides a comprehensive array of professional services related to identification, diagnosis and management of persons with communication and swallowing disorders. Speech Language Pathologists are involved in activities to promote effective communication and swallowing in individuals they serve and prevent disorders of these processes. The speech Language Pathologist is a professional who engages in clinical services, prevention, advocacy, education, administration, and research in the broad areas of communication and swallowing* (*scope of practice in Audiology and Speech Language Pathology by RCI (2015)".*

Audiologists and Speech Language Pathologist are qualified rehabilitation professionals with a minimum qualification of a bachelor's degree in Audiology & Speech language Pathology.Bachelor in Audiology & Speech Language Pathology (B.A.S.L.P) and Bachelor in Speech & Hearing (B.Sc. Speech & Hearing) are two of the commonly used degree titles by universities offering a 4 years course (including 1 year internship) currently.

Practicing Audiologists & Speech Language Pathologists should be registered as professionals under the Rehabilitation Council of India (RCI), with a unique registered number (RCI-CRR).

Individuals seeking speech and language services (in-person or via tele-communication) are advised to verify the qualification of their speech language Pathologist &/or Audiologist by visiting the Rehabilitation Council of India website. An Audiologist & Speech Language Pathologist registered with Rehabilitation Council of India is given a unique RCI-CRR number which starts with 'A' (e.g., A-*****).

Those holding a Diploma in Hearing, Language & Speech (DHLS) are also registered under the Rehabilitation Council of India and are given a unique RCI-CRR number which starts with 'B' (e.g., B-*****).

According to the Rehabilitation Council of India (scope of practice in Audiology and Speech Language Pathology by RCI -2015),*'though anybody with a diploma in speech-language in hearing or communication disorders can dispense services for the needy , he/she shall do so only under supervision of an Audiologist and Speech Language Pathologists professional with atleast graduate degree".* Independent practice by personnel holding a Diploma in Hearing, Language & Speech (DHLS) is not been advised by RCI.

## 3. Individuals who can seek tele-speech and language services

Individuals (any age groups) with communication and swallowing difficulties can seek speech and language services.

Table-1 lists some conditions for which individuals may avail tele-speech and language service.

Table1. Conditions that may require speech and language services

| S.No | Speech, Language, Hearing & Communication disorders | |
|---|---|---|
| 1. | Childhood-neurological communication disorders | - Cerebral Palsy (CP)<br>- Oro Motor Apraxia<br>- Attention Deficit/ Hyperactive disorder (ADHD)<br>- Autism Spectrum Disorder (ASD)<br>- Childhood Apraxia of speech<br>- Childhood Dysarthria |
| 2. | Adult-neurological communication disorders | - Aphasia<br>- Dysarthria<br>- Right Hemisphere Brain Injuries<br>- Apraxia of Speech<br>- Alzheimer's Disease<br>- Dementia(other, e.g., Primary Progressive Aphasia)<br>- Dysphagia |
| 3. | Hearing impairment & balance disorders | - Individuals with Hearing Impairment using Hearing Aids or Implantable devices like Cochlear Implant, Bone Conduction Implants, Auditory Brainstem Implants (ABI) etc.<br>- Auditory Neuropathy Spectrum Disorder (ANSD)<br>- Central Auditory Processing Disorders (CAPD)<br>- Balance disorders related to Meniere's' disease, Vestibular neuritis, BPPV etc<br>- Tinnitus & Hyperacusis |
| 4. | Voice and swallowing disorders | - Aphonia/Dysphonia<br>- Androphonia/ Puberphonia<br>- Professional voice disorder<br>- Functional Voice Care<br>- Hypo- and hyper- nasality of speech<br>- Laryngectomy<br>- Glossectomy<br>- Feeding & swallowing disorders (Dysphagia) |

| | | |
|---|---|---|
| 5. | Speech disorders (Dys-fluencies & Misarticulations) | - Cleft Lip & Palate (CLP)<br>- Oro-facial myofunctional disorders<br>- Speech sound disorders/misarticulations<br>- Stuttering/stammering<br>- Cluttering |
| 6. | Other communication disorders | - Communication disorders related to syndromes<br>- Intellectual Disability (ID)<br>- Learning Disability(LD)<br>- Specific Language Impairment (SLI)<br>- Social Communication Disorder(SCD) |

**4. General guidelines to conduct tele-speech & language assessment and intervention sessions**

a) Tele-speech and language assessment and intervention sessions may be conducted through direct, indirect and mixed approaches.

b) Good/high speed internet connectivity is recommended to ensure clear transmission of audio and visual signals. Digital applications such as Zoom, Meet, Skype, and GoToWebinar are examples of some platforms that may be used. Review their privacy and confidentiality agreements prior to choosing a platform.

c) Parents/clients and speech language pathologists/speech therapist/Audiologist would both require devices with a display screen and a cameras (e.g., laptop, desktop with webcam, tablet, cellphone, headset with microphone) may be required for direct and mixed approaches.

d) It may be beneficial to ensure that visual and auditory distracters (items that are not useful for sessions such a television and many people talking) are minimal at both ends (client-clinician).

e) There should be proper lighting at both ends (client-clinician) for better visibility.

f) Before initiating tele-speech and language assessment or intervention services, clients/caregivers should sign an informed consent form after a thorough explanation about the assessment and management procedures and fee structure.

g) After a preliminary assessment or screening in the first session, the clinician can determine the need for further assessment, document and share the same with the clients/caregivers.

h) A comprehensive assessment may require more than one session depending on a number of intrinsic and extrinsic factors like client's physical status, client's cooperation at the time of online sessions, type of assessment tools, internet connectivity etc.

i) Communication between clinician and caregivers should be documented. Client's/caregiver's email may be used to maintain confidentiality.

j) It is recommended that tele-speech and language assessment and intervention sessions be scheduled at a mutually agreeable time considering individual factors (e.g., when the child/client is most attentive in a day, when the caregiver is available to support etc).

k) Duration of a single speech and language assessment or intervention session may range from 30 minutes to 1 hour. The session may vary.

l) Usually, tele-speech and language intervention session are held once or twice a week. This may vary depending on client needs and goals.

m) To derive optimal benefit from the session, it is recommended to involve caregivers and significant others in assessment and intervention planning.

n) To record assessment and intervention sessions, prior written consent should be obtained from the client/caregiver and clinician. Dissemination of the same would require specific written consent of the parties involved for the specific purpose.

o) The organizations, clinics and professionals may consider to mention the refund policy (specifically in case of any cancellation of session either by clinician or client; in case of sudden termination of therapy), concerns related to any failure payment and others.

## 5. Guidelines for tele-speech and language assessment during intervention

### Baseline assessment

a) Obtaining baseline data on intervention goals is recommended at the beginning of the tele-intervention program.

b) Consider factors such as internet connectivity, environmental distractions, clarity of audio-visual transmission, and client's attention span while collecting baseline information.

c) Use of appropriate tele-intervention/assessment tools (preferably those examined for validity and reliability for use through the tele-mode) are recommended. When specific tools are not available it is suggested that a description of the tools used and their constraints be provided in documentation.

d) Document baseline data and keep the caregivers/client informed about the baseline performance through a suitable and secure channel.

e) If direct observation during tele-speech and language intervention is not possible, client/caregiver may be requested to share relevant communication sample through audio-video/audio recordings as deemed appropriate with an informed consent.

**Mid therapy assessment**

a) It is recommended that client progress on tele-intervention goals be monitored periodically through interim assessments.

b) Consider factors such as internet connectivity, environmental distractions, clarity of audio-video transmission, and child's attention span while collecting information.

c) Use of appropriate tele-intervention/assessment tools (preferably those examined for validity and reliability for use through the tele-mode) are recommended. When specific tools are not available it is suggested that a description of the tools used, and their constraints be provided in the documentation.

d) Document interim assessment data and keep the caregivers/client informed about their progress through a suitable and secure channel.

e) If measurable gains are not noticed or are limited, it is recommended that the clinician reviews the chosen tele-intervention approach and its suitability for the goals considered, as well as the client's needs, with client/caregiver.

f) If direct observation during tele-speech and language intervention is not possible, client/caregivers may be requested to share relevant communication samples through audio-video/audio recordings as deemed appropriate with an informed consent.

6. **Guidelines for tele-speech & language intervention**

a) Determine the tele-speech and language intervention approach that best fits the client's needs in conjunction with caregiver/ clients. Review its suitability periodically.

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b) Tele-intervention methods may vary depending on the needs of the client. Some approaches that may be used are (1) clinician interacts directly with the client (2) clinician interacts directly with the client with a support from the caregiver (3) clinician interacts primarily with the caregiver, while he/she works with the client (4) clinician works with the client or caregiver by providing home assignments based on intervention goals.

c) The frequency and duration of sessions to meet individual needs must be consented. Review the same with the client/caregiver periodically with reference to progress on goals considering other factors (e.g., attention of the child, client-clinician rapport over tele-mode, device access and internet connectivity).

d) It is recommended that clinicians work with clients directly (with or without caregiver support, as needed) whenever possible to obtain optimal benefit from tele-intervention, unless determined otherwise.

e) Ensure client/caregiver's preparedness in accessing the tele-intervention session.

f) Ensure client/caregivers understand the known pros and cons of a chosen tele-intervention method prior to intervention.

g) The performance on the intervention goals needs to be reviewed periodically regardless of the method chosen. If intervention data indicates limited gains primarily due to the chosen approach, consider a change in the method, as necessary.

h) Communicate about the needed materials and environmental modifications at the client/caregiver's end to ensure that the tele-intervention sessions run smoothly.

i) Choose appropriate tele-intervention materials based on factors such as attention span, age, goals, availability, accessibility and signal clarity at both ends (client-clinician) and motivation.

j) Clinicians can consider building a library of e-resources (e.g., multimedia content, e-books, speech and language intervention-based applications)

k) Client/caregiver may be requested to share relevant communication samples of performance during assigned home based tasks/activities through audio-video/audio recordings as deemed appropriate with an informed consent.

**Suggested Tele-therapy Models**

Below are the some suggestions for Tele- speech and language intervention services and are not mandated to be followed.

a) ***Client centered therapy session***- clinician should ensure to implement this model of intervention only wherein the active participation by the client is possible. Herein, the client should follow the clinician (who takes the lead) during the session, whereas the attendant shall facilitate the activities and interactions during the session.

b) ***Attendant-centered therapy session-*** This model can be implemented where the Client needs the activities to be done in person with him/her and the attendant needs the active guidance throughout the session. This therapy model relies on directing the attendant to carry out the activities and so herein, the attendant follows the clinician-lead.

c) ***Guidance/counselling session***-This therapy model is recommended wherein the attendant requires more skilled training to administer the sessions more effectively and also, to facilitate generalization of learned skills by client in different situations. The guidance session can be planned after 4 or 5 client-centered or attendant-centered sessions, or as required. This model shall allow the sharing of various reference links for the better training of attendant, via an email.

d) ***Home-training-programme session***- This therapy model can be considered as an extension of attendant-centered therapy session, wherein the attendant works with the client in-person, in accordance with the training given by clinician, without the real-time presence of the clinician with the client.

**7. Obtaining an informed consent and maintaining confidentiality**

a) An informed consent must be obtained from the client/caregiver prior to the onset of tele-speech and language assessment and intervention

b) The purpose of the consent must be clearly explained, and the client/caregiver must be given opportunities to seek clarifications.

c) Consent form must include information about the procedure, potential limitations, risks, benefits, and relevant financial requirements as per the setting.

d) The consent form must define the procedure in place for maintaining confidentiality of client records including audio and/or video recordings that may be required as a part of tele services.

e) It is recommended that documentation of the signed informed consent be maintained for record keeping and dissemination to the client/caregiver.

f) Any change to the tele-speech and language assessment and/or intervention should be indicated with a new consent form.

g) If there is a need for releasing/sharing client related records, consent should be obtained from the client/caregiver indicating the specific purpose/s.

A sample consent form is given below:

CONSENT FORM*(Sample)*
TELE-SPEECH & LANGUAGE SERVICES

I (Authorizing person's name :_____) authorize Speech Language Pathologist/Audiologist (Clinician Name: _____) to render (approach – Direct/Indirect/Mixed)_____ tele-speech and language services to (Client's name for (e.g., assessment, intervention, consultation) _____ .
I understand that the services will be provided by a qualified Speech Language Pathologist (SLP)/Audiologist. Potential risks and benefits of tele-services using the chosen approach have been explained to me and I understand the same.
I recognize and agree that I have the right to withdraw my consent at any time. I understand if for any reason, the tele-services cannot be provided, I will be informed about the same.
I hereby consent /do not consent to record the tele-sessions. I understand that the recordings will be kept confidential. I also understand that I will not record any tele-session without prior written approval from the Speech Language Pathologist (SLP)/Audiologist.
My preferred mode of contact is through (email/ phone call/text messages).

Client Name: _____ Age/gender: _____

Parents/Guardians Name: _____

Address: _____

Phone: _____ E-mail: _____

Parents/Guardians/Client signature: _____ Date:_____

## 8. Documentation for tele-speech &language services

Tele-sessions may be documented as in in-person speech and language services with a few additions. Consider including information on the following: -

a) Approach used
b) Connectivity
c) Signal clarity
d) Device/s used
e) Accommodations
f) e-material/s used
g) Response to the chosen approach
h) Troubleshooting method used (if any)

Samples of tele-speech and language intervention plan and session plans are given below:-

A) Sample form of tele- speech and language intervention plan

Tele-intervention plan
Client Identification/Record No.: _____
Date:

Client name: _____ Caregiver Name: _____
Relationship with the client _____ Age: _____ Gender: _____

Diagnosis: _____

Tele-intervention goals:

Long term goal 1. _____
Short term goal 1a. _____

Long term goal 2. _____
Short term goal 2a. _____

Tele-intervention approach:

Frequency and duration of sessions:

Remarks
(if any)

Parent Signature:
Date:

SLP/Audiologist Signature:
CRR no.
Date:

B) Sample form for tele-speech and language session notes

Tele-intervention session notes

Client Identification/Record No.: _____

Date:

Client name: Age: Gender:
Diagnosis:
Caregiver Name: Relationship with the client:
Session Duration: Approach: Direct/Indirect/Mixed
Tele-intervention goals:
Long term goal 1. _____
Short term goal 1a. _____
Long term goal 2. _____
Short term goal 2a. _____

Tele-intervention activities& materials used
Activity 1. _____
Activity 2. _____

Response:
1. Subjective: _____
2. Data on goal 1 & 2 _____
Other remarks during tele-session: (e.g., connectivity, signal clarity)
Recommendations (if any): _____

Parent Signature:
Date:

SLP/Audiologist Signature:
CRR no.
Date:

9. **Additional services/referrals**

a) It is recommended that clinicians continue making recommendations for additional services as during in-person speech and language services.

b) It may be beneficial to make oneself aware of the tele-services offered by other professionals.

c) Discuss the need for additional services/referrals with client/caregiver and document the same.

d) Include justification for referral to additional services.

e) Ensure that the sole reason for a referral is not due to change in performance during tele-services in comparison to in-person services.

f) Share a copy of the referral with client/caregiver through a confidential modality.

**References**

1. Scope of Practice in Audiology and Speech Language Pathology given by Rehabilitation Council of India in November, 2015

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