The ASHA Way: Growth through Standards

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To say that it is a pleasure to be here with you today would hardly capture the magnitude of my feelings about being asked to address this esteemed audience. The opportunity for the human communication professionals of two nations to open the door to a brand new working relationship is truly monumental. The professions of speech-language pathology, audiology, and speech and hearing science together make up a field which is like no other in health care or education. I say this, because the ability to communicate effectively is the compass by which all people navigate their way through life. It is so essential to quality of life, that for most people, the difficulties of being limited in how they communicate is virtually unthinkable. Yet you and I know that the world is full of *good, hard-working, creative individuals with communication disabilities* - many of them with *a lot* to say - these people look to *us* to help them learn how to say it. Yes, ours is a noble, if not always glamorous profession.

In my many years as a leader in the ASHA governance structure, I have observed that certain character attributes are common to an overwhelming number of people who enter our field. Probably the most common of these character attributes is that we care. Indeed, the very nature of the services we provide require an unusual level of interaction between the caregiver and the patient. This quality - the ability to genuinely care and relate to our patients - is responsible for the tremendous success our professions have enjoyed over the years in America, and it should not be overlooked.

While in South Africa I have observed your caring qualities in the various academic institutions that I have visited. In Cape Town, Durban, and Johannesburg the concern for high standards in the admission and matriculation of college students was consistently a priority. The programs cared about the professional preparation of every student and because of their high standards for academic preparation, students from South Africa are recruited for professional work all over the world.

But nowhere was the caring quality of professionals more obvious than in the community based service programs that I visited. Grass roots programs like IKANA LABANTU in Cape Town, community centers in Durban, and the community based rehabilitation workers of Johannesburg, all trying to provide quality of services because it is the right thing to do.

However, our caring nature alone tells only a fraction of the story. Ours is a profession of academic and scientific research that has progressed at a speed rivaling that of technology itself. Indeed, communication professionals today know more about the causes and possible solutions to an incredibly - and increasingly - diverse number of disorders. From the audiologist screening infants' hearing or utilizing space age devices to the Speech-language pathologist tailoring fluency, we know more about how to effectively and efficiently help our patients rise to the highest level of communication possible than we *ever* have in the past. The body of research and treatment techniques has grown at a mind-boggling rate over the last, say, 30 years. Most amazingly, that rate of growth of knowledge and technique is today growing faster than ever. There are a number of factors that are responsible for this whirlwind of growth. What I firmly believe is responsible, more than anything else, for the rapid advances in the field of communication disorder sciences, is the degree to which we have learned to work together.

What do I mean by working together? Understand where I am coming from. I am the president of an enormous association, strategically headquartered just outside of Washington, D.C. The American Speech-Language-Hearing Association, ASHA as we affectionately refer to it in America, is 87 THOUSAND members strong. That is huge, even by American association standards. As a central organization, with members who represent the diverse, and sometimes disparate, independent professions which exist within our field, ASHA has created an environment whose mission is: to promote the interest of and provide the highest quality services for professionals in audiology, speech-language pathology, and speech and hearing science; and to advocate for people with communication disabilities. In all kinds of ways, ASHA, by its very existence, has opened the door for interdisciplinary cross fertilization in research and the formulation of testing and treatment procedures. Our conferences, conventions, and educational programs provide opportunities for professionals to share their latest accomplishments, discoveries, and challenges with each other. Our numerous publications inform members of cutting edge developments. Our governmental affairs division makes sure that new and more effective treatment techniques are allowable and reimbursable in today's challenging health care insurance world. In America, ASHA's policy-making role sets the standard for what is considered best for the public.

* This article was presented as the keynote address by Dr C M Seymour at the SASLHA Annual general Meeting in Pretoria, 1997

My point is that not only is the association a tie that binds professionals together, but professionals are the tie that binds the association together. You see, the very foundation of the Association is built on the bedrock belief that we can achieve more together than any one of us could have achieved alone. That concept is the thread that runs through everything ASHA has ever accomplished. The very nature of an association is to work together - to benefit from each others' experiences.

I stand before you today as the representative of an association that has literally built a profession in America. ASHA has, over the years, defined and redefined what it means to be a speech-language pathologist or audiologist. In fact, even the very language the public uses to describe us - *speech-language pathologist*, for example - is determined by what ASHA policy stipulates that professionals in the field today can and should be expected to do for their clients. Even the fact that our professionals are described by the public as having "patients" or "clients", instead of "students" is a function of ASHA having brought the profession into the category of health care, even though a majority of our members still practice in a school-based setting. Both from within and without, ASHA sets the standard.

We have gotten as far as we have by the power of working together. The history of our association is a story of bridge building: Between individuals, between practice-settings, between disciplines, and yes ... between continents. ASHA is, for example, a proud member of the International Association of Logopedics and Phoniatrics. This is reflective of ASHA's view that it has much to gain and much to offer as an active partner in building the "massive international bridge" which is currently under construction in our profession.

It is from this perspective that I got on a plane and flew to South Africa. I am here to continue in the footsteps of my ASHA predecessors - to find new ways to work together with fellow professionals. This is a new and exciting adventure: To open up a relationship between ASHA and the South African human communications professional community. It is, in a manner of speaking, merely the next logical step in ASHA's continuing commitment to increasing the quality of care we provide by increasing the depth and breadth of the collaboration we employ.

I am here to play my part in opening a door. I firmly believe that we have a tremendous amount to gain from one another. More importantly, I firmly believe that our consumers - our clients and patients - have an inexpressible amount to gain from our working together. Our job right now, is to uncover opportunities. As rhetoric, this all sounds very lovely, I know. But there is no hiding from the stark fact that figuring out how to best benefit from a relationship worth one another is no small undertaking. To put it another way, we don't even know each other. Our educational systems are structured totally differently. It may be that our compensations and reimbursement procedures are totally different. We might not even recognize many of the daily activities in each others' workloads. I want to know in what ways we are similar and in what ways we are different. There is a lot we need to learn about each other. This is a daunting task. It is not our job today to finish the work, but I think we can make a pretty good start.

As I continue, there is one point which I wish to impress on you today more than any other. This will be the theme of my comments to you today:

ASHA is, at it's very core, an organization whose role is to set standards.

Standards. <PAUSE> That concept is what makes us who we are. It is by setting standards for our professions, that we have successfully increased our public recognition and respect. ASHA is not a federally chartered organization. No one forces the public, or even ever informed the public that some organization, namely the American Speech-Language-Hearing Association, will serve as a regulatory body for the professionals and treatment standards in the field of human communications. ASHA's role has been defined and fought for by its membership. The public recognition we enjoy is a direct result of carefully crafted efforts. The establishment of standards, and within that context, of a detailed Code of Ethics, is the cornerstone by which we define ourselves, and indeed, justify our powerful role.

In my remarks today, I hope to give you a sense of ASHA's history in America and the importance of standard setting as a key role for any association. I will then talk about some of the specifics of ASHA's standards program, including how it has evolved over the years, how it works today, and where it is heading in the future. Having given you a sound idea of who we are, I hope to paint at least a little bit of a picture of what it is like to be a speech-language pathologist or audiologist in America in the 1990s. It is my hope that this introduction to ASHA, to our standards program, and to the environment in which we practice today, will give us a base from which we can begin to learn about one another and, as I said earlier, uncover opportunities to work together to provide the highest quality of service to people with communication disorders and to promote the interests of professionals in audiology, speech-language pathology, and speech and hearing science.

The American Speech-Language-Hearing Association is a not-for-profit scientific and professional association for speech-language pathologists, audiologists, and speech and hearing scientists. ASHA is committed to the consumers of its services, the millions of Americans with communication disorders. According to the National Institute on Deafness and Other Communications Disorders (an arm of the United States federal government), there are more than 42 million people in the United States with hearing impairments and speech, language, or voice disorders. ASHA's mission has always been to ensure that all people with speech, language, and hearing disorders receive quality services from well-educated professionals.

The Association certifies practising clinicians, conducts and accredits educational programs for its members, informs the public about communication disorders, produces and markets educational materials, monitors legislation, and lobbies state and federal governmental bodies. ASHA's steadily growing membership, exceeds 87,000.

The ASHA story starts in the spring of 1925, when the first meeting to discuss an association of individuals with an interest in communication disorders was held. The purpose of the meeting was to discuss the need for an Association separate from the National Association of Teachers of Speech, the organization that at the time included those with an interest in communication disorders. Later that year, 11 clinicians and researchers formed the American Academy of Speech Correction. Members would meet certain requirements of study and practical experience, [We're talking about standards.] so that the people they treated would receive the highest quality care.

In 1930, the organization offered its first major convention program, voted to start its first official

publication, established new membership requirements [standards], and approved an ethical practice statement [also in the category of standards]. In 1947, making official the long-recognized link between speech and hearing, the organization was renamed the American Speech and Hearing Association. We are celebrating almost 50 years of having this focus. That association, numbering 1,859 members, established criteria in 1951 for members to offer clinical services, a major step to assure people with communication disorders that they would receive quality services. [Again, what am I talking about here? Standards. Again and again, the story of this organization is defining the profession through establishing ever more meaningful standards.]

By 1957, Association membership had increased to more than 4,700, and the Code of Ethics was revised and expanded. ASHA opened its first National Office in January of the following year, 1958. With the establishment of national headquarters, increased attention was given to dissemination of professional knowledge and to the development of professional standards. The *Journal of Speech and Hearing Research* was first published in 1958, and *Asha*, the Association's magazine, was introduced the following year. The Association began accrediting academic programs and clinical facilities in 1962. [Here they go again with the standards!]. In 1965, membership requirements were set at the master's level, guidelines for ethical conduct were established, and clinical certification standards were raised. Again you hear the message: Standards, standards, standards.

Throughout the 1960s, new programs were developed to improve and expand services to the membership and people with communication disorders. Additional journals were added. Programs were added. Programs were established to serve members based in schools and clinics. An office devoted to urban and ethnic affairs, now the Office of Multicultural Affairs, which I will talk about a bit later on, was created in 1969. Special attention was given to educating the general public and government officials about communication disorders. By 1976, membership reached 24,000.

In 1981, ASHA was renamed the American Speech-Language-Hearing Association. This new name, which remains today, reflects the professions' historic involvement with language disorders.

By the end of 1981, ASHA's membership totalled well over 35,000. The Association's growth continued throughout the 1980s as knowledge and technology increased and dramatic changes were made in the provision of health care services. The ASHA Continuing Education Program was established in 1980 [Standards again!]. To strengthen ASHA's influence in public policy making, ASHA created in 1985 a separate political entity, known in American politics as a Political Action Committee, or PAC. Certification standards were updated following a 3-year study, and in 1987, ASHA welcomed its 50 thousandth member.

In late 1994, a Science and Research Department was created to recognize and provide for the special needs of speech, language, and hearing scientists. In 1995, ASHA entered the information age by offering the membership such capabilities as fax-on-demand, e-mail, and internet.

To strengthen communication with members, a new communication plan has been implemented in recent years. This plan includes the publication of The *ASHA Leader*, a twice-monthly newspaper that informs the membership of the latest professional and Association news.

I think it is plain to see that standards, in the general sense of the word, are the ongoing theme that runs through ASHA's history.

The standards program has been a work in progress for the Association, evolving over a period of more than 30 years. The standards represent the collective input of thousands of professionals in speech-language pathology and audiology. They reflect, as well, the evolutionary trends in service delivery. Our Standards *reflect* and *define* the components and parameters of quality service delivery. They are the Association's basic foundation not only for assessing and recognizing specific programs, but also for stimulating and guiding the continued development and improvement of clinical services wherever they are offered. Client care, clinician performance, and administrative procedures are but a few examples of areas which have been dramatically improved by dynamic standards. The key word there is "dynamic". Standards must be fluid in a field where technological, clinical, and scientific advances occur so rapidly.

From 1925 to 1952, ASHA did not have a certification program, per se, and the minimum requirement to be a speech-language pathologist or audiologist was a bachelor's degree. In 1952, realizing that this requirement was antiquated, the Association established a formal certification program with requirements for a clinical practicum and passage of a written examination.

Later, in 1965, the term Certificate of Clinical Competence (CCC) came into being. The CCC, which required, among other things, the obtainment of a Master's degree was at that time adopted as the minimum requirement for membership into ASHA. C's, as this certification has come to be called in popular nomenclature, has since become THE standard for practice of audiology and speech-language pathology in America.

Additional requirements that encourage yet higher standards of quality continue to occur today at ASHA. The goal remains the same - to ensure that the high professional standards and consumer protection continue to elevate. An example of a recent development is the idea, currently under review, of requiring a professional-doctorate in audiology. Although the Au.D - as this proposed degree is being called - has not yet been adopted, the very fact that it has been suggested demonstrates clearly that the Association and its membership continue to investigate ways to raise the quality of the services we provide. Another example of a proposed change under review is the creation of a category of professionals called speech-language pathology assistants. By having standards that allow for the formal acceptance of a practice that has been going on in our field for years, speech-language pathologists may soon be able to spend more time addressing clinical issues that require complex decision making and less time on routine procedures. Assistants, who possess less expertise than certified speech-language pathologists, many people believe, have a beneficial role to play. They will help us expand and enhance the services of speech-language pathologists.

Our Standards, although formally written, have always allowed for autonomy and interpretation by the practitioner. This flexibility has become extremely important to our professional growth. More than ever, we currently strive to develop standards that are flexible rather than prescriptive. We value the ability of practitioners to be innovative in the way they perform their duties. ASHA's view is that services provided to consumers should be outcome-based. By

stretching the boundaries and encouraging our members to be more experimental within the context of our requirements, we hope to facilitate the development of cutting-edge services without sacrificing objective minimum standards.

You see, we use our standards as the *foundation* for continued educational and professional development and the improvement of clinical services. They are created to challenge the individual professional to strive to reach higher and further than previously imagined. Our Standards are truly just the beginning point for our members. Because our Standards have always been dynamic and continuously developing, they have enhanced rather than limited the growth of the field.

By having autonomous and constantly evolving Standards, the professions of speech-language pathology, audiology, and speech, language, and hearing science have been able to *expand upon their scopes of practice*. Individuals who would not have been treated for a communication disorder 25 to 30 years ago are now receiving the services they need. Infant hearing screening, cochlear implants, voice prostheses, treatment for orofacial myofunctional disorders are but a few of the many advances the professions have made because of ASHA's standard setting methodology.

Additionally, by having open-ended standards we have been able to facilitate the growth of the lifeblood of our Association - *research and science*. Through the creation of treatment outcome measurement tools, we have been able to collect data on prevalency of speech, language, and hearing disorders. This information is going a long way in showing the medical community the necessity of our services.

In addition to formulating guidelines and quality indicators for clinical competency, academic programs, and clinical programs, ASHA standards are currently being used:

- to educate consumers and the general public about clinical service programs in audiology and speech-language pathology;
- to inform other professions, accrediting bodies, funding sources, and other regulatory agencies of the essential elements of quality in programs that provide speech-language pathology and audiology services;
- to guide the process in the development of new clinical service programs;
- to provide a basic framework for self evaluation, program modification, and future planning in existing programs;
- to help students and practicing professionals understand the essentials required to provide quality care;
- recognize and stimulate creativity and diversity in thoughts and views; and
- promote the development of knowledge, skills, and procedures required for effective clinical practice.

Let's take a look at some of the specifics of ASHA's standards program as it exists today. In short, there are three areas in which we apply standards:

Clinicians	Certification
Academic Programs	Accreditation
Clinical Programs	Accreditation

The correlation between ASHA Standards and our Code of Ethics can be seen in how we define these three main components in becoming a certified speech-language pathologist or audiologist: Academic training, demonstration of clinical competence, and clinical experience.

Ethics, as embodied in the ASHA Code of Ethics, is the overarching concept that unifies the entire standards program. The Code of Ethics guides and shapes all ASHA Standards. Like our Standards, our Code of Ethics is a fluid document. It is rewritten and adjusted periodically to meet the new demands of the professions and the marketplace. The ASHA's Code of Ethics sets a minimal standard, a base on which to build.

Speech and hearing professionals have not always had such a reliable support. Concern over charlatans and unscientific and unscrupulous practitioners was one of the factors which sparked the formation of ASHA in the first place. We are now at the forefront in standards and ethics because of our historic commitment to the highest quality care for people with communication disorders.

ASHA's current Code of Ethics retains our commitment to high personal standards of excellence. But, the emphasis has now shifted from the clinician to the client. To illustrate, let me read to you the First Principle of our Code of Ethics: "Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally".

As you can see, we emphasize a strong commitment to our clients. They come first; we *exist* to serve them, to promote their well-being.

Ethics affects all areas of the professions and all practice settings. Ethics, however, is not an easy topic to discuss. With ethics, there are no absolutes. Although the underlying principles remain constant, matters of ethics are relative to time and place; quite frankly, they change. With our scope of practice continually expanding, understanding ethical aspects is crucial to our professional standards. We are working with a variety of diverse populations, with new technologies, and in a wide array of workplace settings. We work on interdisciplinary teams and as case managers. More and more of us are entering the field as private practitioners who need to cope with the pressures of running a business.

Ethical accountability has a significant role in helping students and practitioners deal with the changing practice situation. Overseen by ASHA's Ethics Council, a comprehensive and thoughtful program of ethics education is offered through a variety of workshops, conferences, and materials. This education program also infuses ethical considerations into the graduate curriculum and the workplace and enables us to provide ever higher quality services to our clients.

First and foremost in ethics is the issue of competency. Technological advances, the knowledge explosion, changing expectations and an expanding scope of practice present the Association with constant challenges. I believe that competence is a personal decision, a professional commitment and an ethical mandate. To put it in reverse, it is a violation of our Code of Ethics to provide services without the proper education, training, and experience in the specific area in which services are being provided. If a person wants to work with infants and toddlers in a neonatal intensive care unit, he or she must be prepared for that work - prepared by education, training and experience, not credentialing alone.

A second key issue in ethics is the pressure of the marketplace on practitioners in all settings. In schools, it may take the form of a heavy caseload and the over-reliance

on support personnel. In private practice, hospitals and clinics, it may take the form of confusion over reimbursement: what is and what is not reimbursable? Should services continue if they are not reimbursed? The pressure for accountability is heavy. Insurers, government agencies, private consumers and the general public are demanding that we set and apply standards of practice.

A third key ethical issue arises from the professional commitment embodied in our Code of Ethics to help all of those who need our services. We are required by our Code to strive to educate the public about communication disorders and professional services and to provide and increase services to persons who need them. Let me say that differently: It is our responsibility to ensure the accessibility of our services to all who need them. This means, for example, that we have an ethical commitment to ensure that unserved and underserved populations get help for communication disorders.

These issues are challenging. As individual professionals, we can face them effectively by basing our actions on the principles set forth in the ASHA Code of Ethics. As you can see, ASHA has promoted ethics by establishing standards and then enforcing them through a professional code of ethics. I feel confident in saying that ASHA has made communication professionals leaders in standards and ethics because of an unyielding commitment to the highest quality care.

Just as importantly, we have successfully made our standards THE STANDARDS for our profession. When members market their services to their clients and referral sources, it is the ASHA certificate that they reference. ASHA's Certificates of Clinical Competence are the backbone of credentialing for our professions and are the national standards against which state regulatory standards are compared. Additionally, requirements for the CCCs have been adopted by various federal agencies and by private and government financing systems in their own regulatory efforts.

ASHA certification has such respect with governmental, regulating, and advocacy groups that even though ASHA certification is optional, it is virtually mandatory for any audiologist or speech-language pathologist who realistically expects to practice in the United States.

We have talked about ASHA's history and taken a good look at our philosophy of standards. Before closing, I would like to spend just a little bit of time to paint for you a picture of what it is like to practice speech-language pathology and audiology in America in the 1990s. Hopefully, by giving you this view of what our day to day practice is like, we can begin to uncover ways in which we can work together. Let's take a look, then, at what's taking place in today's health care arena in the United States and what impact the current environment is having on speech-language pathology, audiology, and speech, language, and hearing science.

The health care marketplace in the United States is radically changing. Long criticized for being costly, fragmented, wasteful, and redundant, our health care system is in a state of continual reform, upheaval, and evolution. Shrinking health care dollars and the advent and evolution of managed care are changing the way we practice, where we practice, and how we are compensated for the services we deliver.

Changing demographics also have changed who we serve as well as who enters the professions. Our professions and the work we do reflect every aspect of diversity. We have been at the forefront when it comes to sensitivity to diversity. Our population, and therefore our consumers, are increasingly diverse, as are our colleagues.

The economics of health care and the profound diversity inherent in our society and our professions have had a tremendous impact on the changes in health care today. I want to elaborate on these two aspects for the purpose of describing today's health care environment - the environment in which we practice.

The financial realities of health care expenditures are staggering. In 1960, for example, the cost of health care in the United States totalled 27 billion dollars. By 1995, it was approximately 903 billion dollars. A remarkable increase! So, it's not surprising that today 'cost containment', 'managed care', and 'capitation' have become buzzwords in our professions. The message is clear - "*cut health care costs*"!

Controlling cost has become paramount which is one reason why managed care - which controls costs by restricting how and where people seek medical attention - and other cost-saving measures have thrived over the last several years.

Managed care is remaking health policy and forcing us to realign our profession in order to protect our place in the health care arena. Audiologists, speech-language pathologists, physical therapists, occupational therapists, and other non-physician health professionals have had to join efforts to ensure that managed care organizations and other health plans do not exclude non-physician health professionals from their plans solely on the license or certification they hold.

Government funded programs for the poor and for the elderly will likely be met with efforts to cut benefits or make structural changes in the programs. Once again, non-physician health professionals will need to fight against cutbacks in diagnostic and rehabilitation services, which would affect both the program beneficiaries as well as providers of those services. It's no longer business as usual.

As health care dollars shrink in the United States, the need for proof of quality care is increasing. For us to be valued in a managed care environment, we must be able to prove our worth. Health care financing demands it. We now must be able to document treatment outcomes and costs for treatment through accurate, comparative data. Today in the world in which we practice we must ask and answer these questions: What was achieved? How long did it take? How much did it cost? And did it make a difference? These are questions that many audiologists and speech-language pathologists are answering as they negotiate with managed care companies, state legislators, and health insurance administrators. And professionals in health care settings are not the only ones affected. Service providers from all disciplines, in all settings are being affected.

ASHA's Executive Board, and numerous other boards and committees have been very active in their efforts to influence health care reform decisions and to prepare our members for the resulting changes. We have formed the Task Force on Treatment Outcomes and Cost Effectiveness, offered marketing and reimbursement workshops, published manuals on the subjects of managed care with strategies for our practitioners, and tirelessly lobbied lawmakers.

But proving the value of the services our members provide to managed care organizations and lawmakers is not enough in our health care arena. Our professionals must

also prove their value to the general public. Another buzzword common in the world in which we practice is "marketing". Communicating the services we provide to the general public is important, but so too is the role of our professions to raise awareness about communication disorders. Practitioners must position themselves as players in the health care marketplace. Marketing is the way our members do this and it too is a significant part of the world in which we practice.

The current health care environment also has forced ASHA to make other changes as well. Changes in how it develops policy, changes in how quickly and efficiently it responds to critical issues, and changes in it's overall, day-to-day operation and scope of practice.

Another element so critical to understanding the world in which we practice is diversity. Not only demographic changes in our client base and among our colleagues but also the diversity inherent in an association that represents nearly 90,000 individuals who make up three separate but interrelated professions. To make certain that we hear from all voices, we reach out and listen to the concerns of the National Black Association for Speech-language and Hearing, formed about 20 years ago, as well as to the Asian/Indian Caucus; the Hispanic Caucus; Asian/Pacific Islander Caucus; Native American Caucus, and L'GASP - the lesbian, gay, and bisexual audiologists and speech-language pathologists. We reach out to our scientific communities and members through open-forum, face-to-face meetings too.

We continue to seek out racially and ethnically diverse future professionals in order to best represent the populations we are serving. ASHA works vigorously to get members from under represented groups to serve on committees, boards, and councils. ASHA has been proactive about infusing multiculturalism into every part of the association. One example is our Multicultural Action Agenda 2000 - an affirmative action plan designed to "promote parity among racial/ethnic minorities within all aspects of the association and the professions throughout the 1990s and beyond". This plan provides guidance for building the future of our professions with emphasis on our minority members and the minority consumers we serve.

Our population also reflects diversity. Immigration patterns have changed dramatically and the United States now has growing Russian, Middle Eastern, Indian, Filipino, and Laotion populations. These changing demographics will continue at a rapid pace as we approach the millennium.

Our work settings today also reflect a strong sense of diversity. The practice, work, and research of audiologists, speech-language pathologists, and speech, language, and hearing scientists take place in many, many types of facilities such as public and private schools, hospitals and rehabilitation centers, colleges and universities, private practice offices, home health agencies, adult day care centers, nursing facilities, and state and federal government agencies. Clinical services are provided to infants and children, adolescents and adults, and the elderly.

We continue to adapt to differences in the world in which we practice. As communication professionals, we need to be adept at "translating" each other, at "reading" each other. This is true even when we speak the same language. We recognize that the English language is composed of many linguistic varieties, including standard English, New York dialect, Spanish-influenced English, and Ebonics - or African-American English. In recognizing the diversity of this language we too must accept that a linguistic variety is not a disorder. But that the social dialects spoken by our diversity clientele and colleagues are symbolic representations of the historical, societal, and cultural background of the speakers. ASHA did recognize this by taking an official position on the topic of social dialects over 14 years ago.

We have come a long way to reach this understanding. Historically, some educators considered the use of nonstandard English a disorder and many students were referred for speech-language services or placed in special education classes. But thirty years ago there was no area within communication sciences and disorders that focused on multicultural studies, or cross-cultural communication. Since then, ethnolinguistic and sociolinguistic research has spurred a growing appreciation of how culture and social experiences affect the development and use of language and speech. The information gave way to greater understanding of the nature of language and led to clinicians' diagnosing communication disorders based on the individual's own linguistic background and community.

The recent attention to the Ebonics issue underscores the longtime commitment of speech-language pathologists to help children with speech and language problems develop their communication skills. The topic captured the attention of the nation and the news media for several months and consumed educators, legislators, parents, and civil rights leaders in a highly emotional battle to determine whether Ebonics was a language or a dialect and whether it had a place in America's public schools. But what is more important is the ability to distinguish a linguistic variety from a true communication disorder. We must be sensitive to all linguistic varieties.

Finally, diversity means difference and we must respect, value, and appreciate differences. Differences help build a stronger community. Differences invite us to tap into the creativity of all people. ASHA is very much an inclusive association that celebrates, expands, and encourages diversity within our organization. And diversity, perhaps more than any other single term, defines the world in which American communication professionals of the 1990s practice.

Finally, I want to thank you for giving me the opportunity to begin this relationship. I have shared with you what I believe to be the very essence of ASHA - Standards. Through standards, ASHA has been able to ensure that the quality of the services we provide is not only maintained, but is constantly improving and evolving. We have used our standards to stretch and expand our profession. We have never and will never allow our Standards to be complacent. As our profession continues to grow, standards will continue to evolve. Communication professionals of South Africa, let's evolve together.

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MANUSCRIPT STYLE AND REQUIREMENTS

Manuscripts should be accompanied by a covering letter providing the author's address and telephone numbers. All contributions are required to follow strictly, the style specified in the *Publication Manual of the American Psychological Assoc.* (3rd ed., 1983) (APA Pub. Man.), with complete internal consistency. **Four** copies of triple-spaced high quality type-written manuscripts with numbered pages, and wide margins should be submitted. They should be accompanied by **ONE** identical disc copy of the paper. Filenames should include the first author's initials and a clearly identifiable keyword or abbreviation thereof and should be typewritten on the last line of the last page of the Reference List (for retrieval purposes only).

As a rule, contributions should not exceed much more than 30 pages, although longer papers will be accepted if the additional length is warranted. The first page of **TWO** copies should contain the title of article, name of author(s), and institutional affiliation (or address). In accordance with the APA Pub. Man. style (1983, p.23) authors are **NOT** required to provide qualifications. In the remaining two copies, the first page should contain only the title. The **second** page of all copies, should contain only an abstract (100 words), written in English and Afrikaans. Afrikaans abstracts will be provided for overseas contributors. Major headings where applicable should be in the order of **METHOD, RESULTS, DISCUSSION, CONCLUSION, ACKNOWLEDGEMENTS, REFERENCES.** All paragraphs should be indented.

TABLES AND FIGURES which should be prepared on separate sheets (one per page), should be copied for review purposes and only the copies sent initially. Figures, graphs, and line drawings that are used for publication, however, must be originals, in black ink on good quality white paper, but these will not be required until after the author has been notified of the acceptance of the article. Lettering appearing on these should be uniform and professionally done, allowing for a 50% reduction in printing. On no account should lettering be typewritten on the illustration. Any explanation or legend should appear below it and should not be included in the illustration. The titles of tables, which appear above, the figures, which appear below, should be concise but explanatory. Both should be numbered in Arabic numerals in order of appearance. The number of illustrative materials allowed, will be at the discretion of the Editor (usually about 6).

REFERENCES

References should be cited in the text by surname of the author and the date, e.g., Van Riper (1971). Where there are more than two authors, after the first occurrence, *et al.* after the first author will suffice, except for six or more when *et al.* may be used from the start. The names of all authors should appear in the Reference List, which should be listed in strict alphabetical order in triple spacing at the end of the article. All references should be included in the List, including secondary sources, (APA Pub. Man. 1983, p. 13). Only acceptable abbreviations of journals may be used, (see DSH ABSTRACTS, October; or *The World List of Scientific Periodicals*). The number of references should not exceed much more than 30, unless specifically warranted.

EXAMPLES

Locke, J.L. (1983). Clinical Psychology: The explanation and treatment of speech sound disorders. *J. Speech Hear. Disord.*, 48 339-341.

Penrod, J.P. (1985). Speech discrimination testing. In J. Katz (Ed.), *Handbook of clinical audiology* (3rd ed.). Baltimore: Williams & Wilkins.

Davis, G.A. & Wilcox, M.J. (1985). *Adult aphasia rehabilitation: Applied pragmatics.* San Diego, CA: College-Hill.

EDITING

Acceptable manuscripts may be returned to the author for revision. Additional minor changes may also be made at this stage, but a note on the manuscript acknowledging each alteration made by the author is required. The paper is then returned to the editorial committee for final editing for style, clarity and consistency.

REVIEWING SYSTEM

The peer review of refereeing system is employed as a method of quality control of this publication. Peer reviewers are selected by the editor based on their expertise in the field and each article is sent to two independent reviewers to assess the quality of the manuscript's scientific and technical content. The blind peer review system is employed during which the name of the author/ authors are not disclosed to the reviewers. The editor retains the final responsibility for decisions regarding revision, acceptance or rejection of the manuscript.

REPRINTS: 10 reprints without covers will be provided free of charge.

DEADLINE FOR CONTRIBUTIONS: the preferred date is the 31st May each year, but papers will be accepted until 30th June by arrangement.

QUERIES, CORRESPONDENCE & MANUSCRIPTS: should be addressed to The Editor, *South African Journal of Communication Disorders,* South African Speech-Language-Hearing Association, P.O. Box 600, Wits, 2050, South Africa.

INLIGTING VIR BYDRAERS

Die *Suid-Afrikaanse Tydskrif vir Kommunikasieafwykings* publiseer verslae en artikels wat gemoeid is met navorsing, of handel oor krities evaluerende, teoretiese en filosofiese konseptuele kwessies wat oor menslike kommunikasie en kommunikasieafwykings, diensverskaffing, opleiding en beleid gaan.

Die *Suid-Afrikaanse Tydskrif vir Kommunikasieafwykings* sal nie artikels aanvaar wat reeds elders gepubliseer is, of wat tans deur ander publikasies oorweeg word nie.

MANUSKRIP: STYL EN VEREISTES:

Manuskripte behoort deur 'n dekkingsbrief vergesel te word wat die skrywer se adres en telefoonnommers bevat. Daar word van alle bydraers verwag om die styl, soos gespesifiseer is in die *"Publication Manual of the American Psychological Assoc.* (3rd ed., 1983) (APA Pub. Man."), nougeset te volg met volledige interne ooreenstemming. Manuskripte moet getik, van hoë gehalte en in drievoud-spasiëring met wye kantlyne wees. **Vier** kopieë van die manuskrip moet verskaf word. **EEN** hiervan moet 'n identiese skyfkopie van die artikel wees. Lêername behoort die eerste skrywer se voorletters en 'n duidelik identifiseerbare sleutelwoord of afkorting daarvan in te sluit en moet op die laaste lyn van die bladsy van die verwysingslys getik word (slegs vir naslaan doeleindes).

As 'n reël moet bydraes nie 30 bladsye oorskry nie, maar langer artikels sal aanvaar word indien die addisionele lengte dit regverdig. Op die eerste bladsy van **TWEE** van die afskrifte moet die titel van die artikel, naam van die skrywer(s), en instansie (of adres) verskyn. In ooreenstemming met die "APA Publ. Man." se styl word daar **NIE** van skrywers verwag om enige kwalifikasies te verskaf nie. Op die eerste bladsy van die twee oorblywende afskrifte moet slegs die titel van die artikel verskaf word. Die tweede bladsy van alle afskrifte moet slegs 'n opsomming (100 woorde) in beide Engels en Afrikaans bevat. Afrikaanse opsommings sal vir buitelandse bydraers voorsien word. Hoofopskrifte moet, waar van toepassing, in die volgende volgorde verskaf word: **METODE, RESULTATE, BESPREKINGS, GEVOLGTREKKINGS, ERKENNINGS en VERWYSINGS.** Alle paragrawe moet ingekeep word.

TABELLE EN FIGURE wat op afsonderlike bladsye (een bladsy per tabel/illustrasie) moet verskyn, moet vir referent-doeleindes gekopieer word en slegs die kopieë moet inisieel verskaf word. Figure, grafieke en lyntekeninge wat vir publikasie gebruik word, moet egter oorspronklike weergawes wees en moet in swart ink op wit papier van 'n hoë gehalte wees. Die oorspronklikes sal slegs verlang word nadat die artikel vir publikasies aanvaar is. Letterwerk wat op bogenoemde verskyn, moet eenvormig wees, professioneel gedoen word en daar moet in gedagte gehou word dat dit leesbaar moet wees na 'n 50% verkleining in drukwerk. Letterwerk by illustrasies moet onder geen omstandighede getik word nie. Verklarings of legendes moet nie in die illustrasie nie, maar daaronder, verskyn. Die opskrifte van tabelle (wat bo-aan verskyn), en die onderskrifte van figure, (wat onderaan verskyn), moet beknop, maar verklarend wees. Numering moet deur middel van Arabiese syfers geskied. Tabelle en figure moet in die volgorde waarin hulle verskyn, genommer word. Die aantal tabelle en illustrasies wat ingesluit word, word deur die Redakteur bepaal (gewoonlik nie meer as 6 nie).

VERWYSINGS

Verwysings in die teks moet voorsien word van die skrywer se van en die datum, b.v., Van Riper (1971). Wanneer daar egter meer as twee skrywers is, moet daar na die eerste verskaffing van al die outeurs, van *et al.*, gebruik gemaak word. In die geval waar daar egter ses of meer outeurs ter sprake is moet *et al.* van die begin af gebruik word. Al die name van die skrywers moet in die Verwysingslys verskyn wat aan die einde van die artikel voorkom. Verwysings moet alfabeties in trippel-spasiëring gerangskik word. Al die verwysings moet in die Verwysingslys verskyn, insluitende sekondêre bronne, ("APA Pub. Man." 1983, p.13). Slegs aanvaarbare afkortings van tydskrifte se titels mag gebruik word, (sien "DSH ABSTRACTS, October"; of *The World List of Scientific Periodicals*). Die aantal verwysings moet nie meer as 30 oorskry nie, tensy dit geregverdig is.

LET OP DIE VOLGENDE VOORBEELDE:

Locke, J.L. (1983). Clinical psychology: The explanation and treatment of speech sound disorders. *J. Speech Hear. Disord., 48,* 339-341.

Penrod, J.P. (1985). Speech discrimination testing. In J. Katz (Ed.), *Handbook of clinical audiology (3rd ed.). Baltimore: Williams & Wilkins.*

Davis, G.A. & Wilcox, M.J. (1985). *Adult aphasia rehabilitation: Applied pragmatics.* San Diego, CA.: College-Hill.

RESENSERING

Resensering deur vakkundiges word toegepas as 'n metode van kwaliteitskontrole van hierdie publikasie. Resenseerders word deur die redakteur geselekteer op grond van hulle spesialiskennis en elke artikel word na twee onafhanklike resenseerders gestuur om die kwaliteit van die manuskrip se wetenskaplike en tegniese inhoud te beoordeel. Die naam van die outeur/outeurs word nie aan die resenseerder bekend gemaak nie. Die redakteur behou die verantwoordelikheid vir die finale beslissings aangaande wysigings, aanvaarding of afkeuring van die manuskrip.

REDIGERING

Manuskripte wat aanvaar is, mag na die skrywer teruggestuur word vir hersiening. Addisionele kleiner veranderinge mag ook op hierdie stadium aangebring word, maar 'n nota ter aanduiding van alle veranderinge wat op die manuskrip voorkom, moet verskaf word. Die artikel word dan aan die redaksionele komitee vir finale redigering van styl, duidelikheid en konsekwentheid teruggestuur.

HERDRUKKE: 10 herdrukke sonder omslae sal gratis aan die outeurs verskaf word.

SLUITINGSDATUMS VIR BYDRAES: Bydraes word verkieslik teen 31 Mei elke jaar verwag, maar artikels sal nog tot 30 Junie vir aanvaarding oorweeg word.

NAVRAE, KORRESPONDENSIE EN MANUSKRIPTE: moet geadresseer word aan Die Redakteur, Die Suid-Afrikaanse Tydskrif vir Kommunikasieafwykings, Die Suid-Afrikaanse Spraak-Taal-Gehoor Vereniging, Posbus 600, Wits 2050, Suid-Afrika.