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Services for Australian
Rural and Remote Allied Health

Submission to the Senate Standing Committee on Community Affairs - References Committee

The prevalence of different types of speech, language and communication disorders and speech pathology services in Australia

February 2014

INTRODUCTION

Services for Australian Rural and Remote Allied Health (SARRAH) welcomes the opportunity to provide a submission to the Senate Inquiry into the prevalence of different types of speech, language and communication disorders and speech pathology services in Australia.

SARRAH is nationally recognised as a peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector.

The primary object for which the SARRAH is established is to advocate for, develop and provide services to enable AHP's who live and work in rural and remote areas of Australia to confidently and competently carry out their professional duties in providing a variety of health services to rural and remote Australians.

SARRAH's representation comes from a range of allied health professions including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These AHPs provide a range of clinical and health education services to individuals who live in rural and remote Australian communities. AHPs are critical for the management of their clients' health needs, particularly in relation to chronic disease and complex care needs.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and fundamental to Australians' health care and wellbeing.

Speech pathology is an important allied health profession represented within SARRAH and has also been recognised by the Australian Government as a core service required in providing early intervention for children with disability to enable these children to reach their maximum potential. This has occurred through the funding of the Helping Children with Autism (HCWA) and Better Start for Children with Disability (Better Start) programs. Speech pathologists (SPs) are also a key part of the allied health workforce delivering services through the National Disability Insurance Scheme (NDIS).

Rural and remote Australia is defined using the Australian Standard Geographic Classification system for Remoteness (ASGC) and comprises categories RA2 (Inner Regional), RA3 (Outer Regional), RA4 (Remote) and RA5 (Very Remote), with a particular emphasis on the RA3-5.

SARRAH recognises rural and remote as a continuum of communities outside major metropolitan centres of Australia and is committed to ensuring that people living in these areas have equitable and high quality access to speech pathology and other allied health services.

Scope of speech pathology practice

SPs are experts in two key areas: communication and swallowing. Both of these skills are essential in the daily life of every person and can become impaired for a number of reasons including:

- Developmental delays in children

- Children born with a syndrome for example. Fragile X, Down's Syndrome, Fetal Alcohol Syndrome etc
- People with a developmental disability such as Autism Spectrum Disorder
- People who have had a stroke (potentially impairing their communication and swallowing)
- People with degenerative diseases such as Parkinson's, Motor Neurone Disease etc
- People with an acquired brain injury
- People with a cancer that affects their swallow, speech and voice.

SPs in rural and remote Australia often work in a generalist role, whereby their client caseload consists of children of any age, all adult age groups, as well as elderly clients. Whilst in major cities SPs tend to have an area or age of practice/speciality (for example, acute adult care, paediatric disability), rural and remote SPs often work across the breadth of speech pathology practice that includes speech and language, voice, fluency (stuttering), disability and swallowing.

Many rural and remote SPs also work in sole positions, where they are the only SP working in a town, region, or particular service organisation. It is therefore not an unusual day for these SPs to review acute hospital in-patient clients, see children for speech and language therapy in the community, participate in a case conference for a child with a complex disability and then visit the nursing home to assess a new resident.

This 'rural generalist' role in and of itself is becoming increasingly recognised, with a number of national projects such as those being led by the Greater Northern Australia Regional Training Network (GNARTN) and Health Workforce Australia (HWA). These projects are seeking to formally define the competencies, training and governance frameworks required to strengthen workforce adaptation to meet the unique needs and challenges of rural and remote practice.

This recognition and support is vital to ensure that rural and remote SPs are acknowledged for their contextual expertise as generalist primary health care practitioners in rural Australia and so that they are attracted to stay for significant periods in rural practice. Rural generalists then need access to specialist SPs and services based in metropolitan centres that can support the generalist in their work with clients with complex conditions such as cleft lip and palate, enteral/nasogastric feeding or particular syndromes or diseases that affect communication and/or swallowing.

Having a networked, well-resourced and mobilised rural/remote speech pathology workforce to support these people with specific needs within their own home/community provides great benefits. By providing treatment and care locally, clients are not forced to relocate to regional centres or cities to attend special schools or live in nursing homes or hospitals as long term patients. This obviously creates an additional burden and cost on an already overwhelmed system, as well as on the family. The client can instead stay with their family and friends within their own community and access the speech pathology and other support services that they require to maintain or improve their health, learning and wellbeing.

Case Study 1

A family living on a remote cattle station were seeking services for their 4 year old son who had significant speech difficulties and participated in School of the Air. He did not fit the prioritisation criteria for the closest disability service and did not live in the catchment area of a non-government outreach service. The family subsequently decided to access the services of the private SP in the closest town and would make a round trip of 1200km once per school term. They would book accommodation and bring their child to speech therapy appointments 4 days in a row before driving back home and continuing with the therapy plan provided by the SP. Given the remote location, the estimated cost of this trip would be over $2000, with the speech therapy appointments being the cheapest part of the visit. At that time the family were not eligible for video link up facilities via their school, consequently no sessions could be conducted using telehealth. Phone and email support were provided and whilst the child made vast improvements, the family moved to a station in another state that was closer to public services.

Recommendation 1: Acknowledgment of the specialised generalist skills and knowledge that rural and remote SPs possess through ongoing funding and support for the rural generalist projects, as well as future implementation of the project recommendations.

Recommendation 2: Prioritisation of keeping people with specific communication and swallowing difficulties in their own community through investment in a well-resourced, regionally based, relevantly skilled SP workforce that has ready access to metropolitan-based clinical SP specialists.

COMMENTS AGAINST THE TERMS OF REFERENCE

The following comments aim to specifically address the first 4 areas listed under the terms of reference of the Inquiry, whilst highlighting the need to recognise the important contribution of SPs in the provision of services in rural and remote communities.

a. the prevalence of different types of speech, language and communication disorders and swallowing difficulties in Australia;

b. the incidence of these disorders by demographic group (paediatric, Aboriginal and Torres Strait Islander people, people with disabilities and people from culturally and linguistically diverse communities);

Whilst in many regards one would expect speech pathology caseloads to be similar across urban and rural settings, there are definite differences in the demographics of rural and remote clients.

- Many people living in rural or remote areas do not have access to a specialised stroke unit and consequently have poorer overall outcomes (Cadilhac et al, 2010). This could result in unresolved eating, drinking and communication difficulties, requiring the support of an SP[1].

[1] See http://speechpathologyaustralia.org.au/library/2013Factsheets/Factsheet_Communication_Difficulties_Following_Stroke.pdf for further information regarding SP involvement with stroke patients

- Injury rates are higher in rural and remote areas for adults and children and specific injuries such as traumatic brain injury will generally require the longer term involvement of an SP.
- 70% of Aboriginal and Torres Strait Islander people live in regional, remote and very remote areas and SPs are one of many professions involved in Indigenous health care. For example middle ear disease has high prevalence amongst Aboriginal and Torres Strait Islander children (up to 91%), which often leads to hearing difficulties and subsequent consequences such as speech and language delay, literacy difficulties and various social and emotional problems.
- Children living in rural and remote communities have less access to peer-based early learning opportunities such as playgroups and preschool, which can reduce social interaction and lead to delayed identification of communication or other developmental difficulties when early intervention is critical for optimal outcomes.
- Males living in outer regional, remote and very remote areas have a much higher incidence of head and neck cancers than those in inner regional and major cities (AIHW, 2008), which generally require the intervention and ongoing management of a SP for example laryngectomy care.
- There is a higher incidence of smoking during pregnancy in all areas outside of major cities, which can increase health risks for children and result in lowered cognitive development which impacts upon communication skills (AIHW, 2012).
- Males living in outer regional and remote areas have significantly higher rates of psychological distress than their inner regional and major city counterparts (AIHW, 2008). SPs can play a role in supporting clients with mental health problems[2].
- Males of all ages in rural and remote areas experience significantly higher rates of disability affecting daily function as compared to major city counterparts, with speech/sensory and acquired brain injury disabilities being the highest (AIHW, 2008).
- All regional areas have more people aged 65 and over than major cities (AIHW, 2008). SPs are increasingly involved in the care of ageing and elderly people[3].
- For families settled in rural areas under Humanitarian Programs, children who have experienced trauma will most likely demonstrate developmental and behavioural difficulties, including communication. They will also face the challenge of an English speaking environment.

In Gething's (1997) exploration into the experience of double disability of people living in rural and remote Australia, he found the major themes related to:

- limited transport options to access distant services,

[2] See http://speechpathologyaustralia.org.au/library/2013Factsheets/Factsheet_Speech_Pathology_in_Mental_Health_Services.pdf for information regarding SP involvement in mental health

[3] See http://speechpathologyaustralia.org.au/library/2013Factsheets/Factsheet_Speech_Pathologists_Working_With_Older_People.pdf regarding SPs working with older people

- relative social and service isolation,
- low consumer involvement,
- patchy service provision at the community base,
- low disability awareness in the community and education to address it,
- compromised protection of rights,
- accommodation and housing issues,
- challenges for caregivers and limited respite care, and
- employment, education, communication services and access to supportive equipment.

Recommendation 3: Despite less population density in rural and remote areas, the increased rates of morbidity and disability in the bush and the large geographical areas serviced require increased funding, special consideration and innovation in the resourcing of speech pathology services.

Recommendation 4: SPs, and other health professions, require specific undergraduate and post graduate training and ongoing supervision in their work with people from culturally and linguistically diverse backgrounds, in particular Aboriginal and Torres Strait Islander peoples, to ensure culturally appropriate, accessible and equitable service provision.

c) the availability and adequacy of speech pathology services provided by the Commonwealth, state and local governments across health, aged care, education, disability and correctional services;

Speech Pathology Workforce

SPs are a recognised core profession within allied health but are currently not a part of the Australian Health Professions Regulation Authority (AHPRA). As a self-regulating, rather than a registered profession, speech pathology is not included in allied health workforce data collection being undertaken by AHPRA for Health Workforce Australia (HWA) and the Australian Institute of Health and Welfare (AIHW) for inclusion in allied health workforce data analysis and reports.

Membership of the professional association, Speech Pathology Australia, is non-compulsory and as such reports relating to speech pathology workforce drawn from membership data are incomplete. There is currently no comprehensive data set that provides information on:

- The number of SPs in the Australian workforce.
- The geographic location of the SP workforce, including distribution across remote and rural Australia.
- The work practices of the SP workforce (full-time, part-time, private practice, public sector including health, disability and education, outreach services, specialty skills etc.

What is known has been gleaned from ABS census data and the following is drawn from the 2011 census.

Factor	Nationwide	Remote
Number of SPs	6796*	148^
Population	21,507,717	498,000
SPs per capita of population	1 SP per 3164 ppl~	1 SP per 3364 ppl+
Number of male SPs	417 (6%)	0
Number of female SPs	6325 (93%)	148 (100%)
Number SPs in 20-29 year age group	2164 (32%)	74 (50%)
Number SPs in 30-39 year age group	2256 (33%)	41 (28%)
Number SPs in 40-49 year age group	1342 (20%)	13 (8%)

* as compared to 15 929 physiotherapists, 18 603 psychologists and 16 916 social workers

^ 19 of the 148 SPs do not live in remote areas, they are FIFO or hub & spoke service model providers

~ as compared to 1 medical generalist per 495 ppl

+ whilst the number of SPs per capita of population is not significantly different for remote when compared with the nationwide figure; other factors require consideration such as higher morbidity rates and geographical distance to access SP services in remote regions.

As seen above, the majority of SPs in Australia are female. A study by Keane, Smith, Lincoln and Fisher (2011) exploring the characteristics of AHPs in rural New South Wales (NSW) found that of the speech pathology respondents 65% were married, 32% had dependents and were an average age of 33 years. It is anticipated that this would in turn translate into more part time/flexible hour workforce than other health professions.

From the field…*A SARRAH member commenced one of two public positions that had been vacant within a remote town for over one year. Upon meeting with the local GPs to clarify referral pathways, she was advised that due to the ongoing SP vacancies the GPs no longer bothered referring patients to speech pathology and that they would possibly make referrals to her "if they remembered"… they rarely did.*

Recommendation 5: Work towards an equally valued regulation system for all health professions in Australia, to ensure inclusion of self-regulated and non-regulated professions in policy, program and funding arrangements.

Recommendation 6: Reform Medicare and other Commonwealth funding programs to incentivise workforce models that meet community needs, including direct access to AHPs, address maldistribution of workforce through use of geographic provider numbers, team-based care, case management and greater use of technology.

Recommendation 7: Flexible employment models for example job sharing and/or part time employment opportunities for the predominantly female SP workforce are adopted to encourage people to join and return to the profession.

Service Coverage

Anecdotal evidence from around the country indicates high client numbers for many rural and remote SPs, with some SPs reporting caseloads of over **400 clients** across vast geographical distances. This often translates into lengthy waiting times and complex prioritisation criteria, which often means that children with non-complex speech and language difficulties can wait several years to be seen or worse yet are never seen. For example:

- In the Torres Strait, the sole SP provides birth to death service across all of the 17 islands, which is accessible by air, as well as the five communities of the Northern Peninsula Area on the mainland.
- SPs working in the Northern Territory, geographical distances such as those confronted in the Katherine Region, sees one or two SPs servicing an area of 336,674km²***; a small number of SPs providing services in the Central Australian region, which spans*** 546,046km²; and one or two SPs based in Darwin providing outreach at least 500km away to the Arnhem Land region, which is 97,000 km².
- Some services are so overwhelmed that they are instructed not to accept any more referrals, unless it can be actioned within 12 months and clinicians are often encouraged to try to discharge clients readily, which may mean that clients do not receive a sufficient service.
- It is common in many rural and remote areas that if SP positions remain vacant for too long, the funding is often absorbed by the health service and used for other purposes and the SP position disappears.
- In Palm Island, an Aboriginal community of over 3000 people in Queensland, the SP servicing the 0-4 years population, which represents a massive 11% of the total population, visits **4 days per year** from Townsville.

Recommendation 8: Urgent funding allocation is required for SP job creation and resourcing for chronically under-serviced rural and remote areas, with due consideration given to geographical coverage and unique client needs.

Service Delivery

Due to the need to be innovative in the provision of services, rural and remote SPs and their allied health colleagues utilise a number of service delivery methods including:

- Home-based or service-based speech pathology service
- Consultancy model of service delivery
- Issue based therapy focused model
- Traditional clinic-based model
- Telehealth utilising Skype, iPads etc
- Provision of home programs
- Family directed intervention approach for example the family are provided with initial assessment and therapy block then contact the service if/when they want another therapy block
- Response to Intervention (RTI) model in schools4
- Interprofessional practice models

[4] See http://cdq.sagepub.com.ezproxy.une.edu.au/content/34/1/3.full.pdf+html for an explanation of the RTI model

- Outreach models.

A common method of service delivery in rural and remote areas is the “hub and spoke” model, whereby health teams are based in a “hub” and provide outreach services along “spokes” to clients living in more remote locations (Dew et al, 2012). With a stable, consistent and skilled workforce this model can be an effective means of providing a regular service to people living in remote locations.

All of the above models can be of benefit to clients; however an ongoing concern raised within the speech pathology community is the increasing move towards consultative models and a move away from therapeutic approaches. This change has essentially arisen through budget and resourcing constraints, with the theory being if the SP assesses, diagnoses and provides a therapy program for the child, then they will be more efficient and see more children on the waiting list. SARRAH views this as short-sighted and also as a threat to the effective application of the speciality skills of SPs. SPs train at university for 4 years in order to be able to provide high quality therapy to clients as well as assessment and diagnosis services. Yet the consultative model significantly diminishes this role and can often be inefficient because the client receives therapy from an untrained facilitator, makes little improvement and requires ongoing consultation.

During 2009, SARRAH developed a paper titled Models of Primary Healthcare Service Delivery which is available on the SARRAH website and also by clicking here.

Recommendation 9: Budgets and resourcing must ensure speech pathology workforce levels that enable SPs to develop and implement their therapy skills to improve client outcomes and maintain professional specialisation, rather than being limited to consultative models of care.

Recommendation 10: Provide rural and remote health and education organisations with support, information and funding to staff and implement innovative and effective service delivery models that embed minimum levels of service provision.

Allied Health Assistants/Community Based Workers

There are many positive reports regarding the role of allied health assistants (AHAs) in regards to improving clinical outcomes, increasing patient satisfaction, higher-level services, and more “free” time for allied health professionals to concentrate on patients with complex needs.

In a rural/remote context, AHAs based in the local community can become key team members if they are provided with adequate training and support. SARRAH supports the exploration of this model, though it is mindful of the challenges relating to blurred role boundaries, which again raises issues associated with professional status and security (Lizarondo, Kumar, Hyde & Skidmore, 2010; O’Brien, Byrne, Mitchell & Ferguson, 2013). AHA’s cannot be a substitute for highly skilled health professionals and must work in close association with professionals like SPs if they are to be both safe and effective.

During 2011, SARRAH developed a paper titled Allied Health Assistants in Rural and Remote Australia which is available on the SARRAH website and also by clicking here.

Recommendation 11: Funding, training and career pathway support to facilitate the growth and expansion of the Allied Health Assistant and Support Workforce, as well as guidelines and training for speech pathologists to effectively engage and collaborate with this important workforce.

Telehealth

Many rural and remote clinicians with access to functioning telehealth are advocates of the benefits it can provide. For example, telehealth can enable clients to stay in their rural community with their local AHP, whilst linking up with a metro-based specialists for necessary consultations. However difficulties arise when telehealth facilities either do not exist or do not have the supporting infrastructure to make it a viable tool. Examples from the rural regional area of Griffith in NSW as to the barriers of using telehealth consistently include:

- Poor internet connection because many of the towns serviced do not have access to reliable broadband services and will not have access to the National Broadband Network for many years.
- Lack of infrastructure as clients cannot afford a computer or iPad etc that will enable them to engage with telehealth services. Although the client would have access to public facilities such as the local library or community hub, there is no privacy in those facilities for the client.
- Lack of educational opportunities for clients wanting to use telehealth services. A lot of clients would need to be trained to use tools such as Skype.
- A lack of local SP or AHP on the ground with the client to ensure that the telehealth session is effective and optimal for all concerned.
- Telehealth consultations may require expensive equipment which is not accessible by many practitioners in private practice and while there is support for medical professionals to access this technology it does not extend to AHPs. Telehealth consultations for private practitioners also do not attract either a private or Medicare rebate which either increases costs to the client or restricts their access further.

During 2012, papers developed by SARRAH included Rural and Remote Access to Medicare and Related Allied Health Services which is available by clicking here and Telehealth and Allied Health which is available by clicking here. Both papers are on the SARRAH website.

Recommendation 12: Greater access for SPs and their clients to e-Health systems including Personally Controlled Electronic Health Record and Telehealth as well as funding for equipment, infrastructure, technical support and training.

Collaboration between metropolitan and rural providers

A further factor influencing the effectiveness of rural and remote SPs and AHPs in general is the need for rapid and comprehensive handover of client information from specialist and hospital facilities in the cities to local community health services when clients are returning to their home communities. For example, a person suffering a stroke is likely to be transferred to a major regional or city hospital where they participate in a rehabilitation program in that

facility. After a period of acute rehabilitation they are then transferred back to their community with the assumption that rehabilitation will be continued and necessary home modifications will be made. There are a number of challenges inherent in this process:

- The metropolitan health professionals do not know what services or health professionals are available in the client's community and may not attempt to find out.
- The metro-based health professionals do not understand the particular environment that the client is moving back to for example, a client may be prescribed a wheelchair in hospital that does not account for the uneven or unsealed roads of their town or community.
- The local health centre may not be able to provide the allied health team with sufficient notice of the client's return meaning that necessary home modifications, services for example meals on wheels and programs such as rehabilitation group have not been arranged when the client returns.
- The metro-based service may assume that rehabilitation services are available in the client's community, where actually the client may be admitted to the general ward of the local hospital or immediately discharged home with no recourse to local allied health services.

As previously mentioned, embedded mechanisms for communication and collaboration between metro and rural SPs is necessary for optimal patient/client care, as well as the professional skill development of both parties.

Recommendation 13: Systems are required to ensure metropolitan based health services have a clear understanding of the environment, program and service availability in any client's home community and to guarantee that effective liaison has been undertaken with the relevant community based health professionals, including AHPs prior to patient discharge.

d) the provision and adequacy of private speech pathology services in Australia.

Due to a paucity of workforce data because of the fact that speech pathology is a self-regulated profession, the exact distribution of private SPs in Australia is not known. It is understood that there are very few private SPs working in rural and remote areas, particularly as sole traders. Although private speech pathology services can be profitable, especially due to the current strain on public services, there are a number of barriers to SPs establishing private practice in a full time capacity such as:

- Capital expenses: while many rural areas are considered to have a low cost of living, there are many remote places (particularly mining towns) where rental costs are incredibly expensive. This also translates to the rental of office premises and can be a disincentive for those wishing to start their own practice.
- Expenses of set up with clinical equipment: with rural SPs having a general caseload this leads to higher costs as a range of clinical assessment and intervention resources are required, which is a disincentive to set up practice.
- Difficulty navigating government programs: the application and administration processes for Medicare and federal programs such as Better Start for Children with Disability and Helping Children with Autism, as well as lack of time to do this leaves

families who have funding with no options to spend their money locally. The Department of Social Services has provided some funding to SARRAH to administer the National Rural and Remote Support Service, designed to facilitate SPs and other AHPs to register and provide services to children with disability under the above programs.

- Low remuneration in Medicare Primary Care items that include Allied Health consultations: the rebate is considerably lower than the consultation cost and whilst GPs are paid to write the care plan, SPs are not adequately reimbursed to deliver the therapy or complete the reporting requirements beyond their regular fee.
- Professional isolation: unless SPs join a private practice with other professionals working in similar fields, there is a risk of professional isolation.
- Instability: in private practice, SPs cannot be guaranteed a set income. This lack of certainty can be a disincentive for those seeking a stable and predictable income.

Previously, federal grants have been available in rural and remote areas to encourage practitioners to establish a private practice. In a workforce that is lacking in public service positions and favours flexible working hours, financial incentives such as these grants could encourage SPs not currently active in the workforce to set up small scale practices and provide much needed services.

Case Study 2

A SARRAH member was able to establish herself as a sole trader and commence a private speech pathology practice in a remote Northern Territory town. Office space was provided by the local hospital in exchange for the SP supplying services to the hospital. Over time the SP established herself with a steady clientele, often children who did not meet the criteria of the local disability service still required speech therapy. The SP also established a partnership with the local Aboriginal Medical Service (AMS) and commenced seeing a number of Aboriginal children and their families. Over a two and half year period the SP serviced the hospital, nursing home, schools, AMS as well as subcontracting work for the local disability service, child protection, a non-government organisation and a federally funded aged care project. She also began seeing clients in conjunction with a private occupational therapist. Delivering therapy for Medicare's Enhanced Primary Care Plans was an option but she did not have the time or resources to be able to apply for the Helping Children with Autism package. At the peak of this successful practice, the office space provided by the hospital was no longer available and with commercial office spaces costing over $1500 per week, the business could not be viable. The SP left town and approximately 40 regular clients were left without a local service.

Recommendation 14: Develop minimum data sets and conduct longitudinal eCohort studies as occurs with nursing, medicine and other AHPRA registered professions, to comprehensively detail and document the private speech pathology workforce.

Recommendation 15: Reform of Medicare and other Commonwealth funding programs to incentivise private workforce models that meet community needs, including direct access to Allied Health, address mal-distribution of workforce for example geographic provider numbers, team-based care, case management and greater use of Telehealth.

Recommendation 16: SPs are provided with mentoring and support in registering and participating in the Better Start and Helping Children with Autism program through continued and increased funding of the National Rural and Remote Support Service administered by SARRAH.

Recruitment and Retention

A well known issue in rural and remote communities is high staff turnover resulting in low retention rates of the health workforce. According to Bourke, Coffin, Taylor & Fuller (2010), this shortage "creates high workloads, leading to high rates of burnout and increased waiting times, which adds pressure on the existing workforce to be clinically focused and work long hours" (p. 3). This in turn creates ongoing difficulties in recruitment and retention.

There are a number of recent studies within Australia that explore the reasons behind the difficulties in recruiting and retaining rural and remote AHPs (Bond, Barnett, Lowe & Allen, 2013; Campbell, McAllister & Eley, 2012; Keane, Smith, Lincoln, M. & Fisher, 2011). Key findings highlight the multi-factoral influences upon AHPs' decisions to stay in their rural or remote positions, with a strong factor being job satisfaction.

SPs attending the annual rural and remote member network meeting at the 2013 Speech Pathology Australia conference identified the main areas relating to job satisfaction, which include:

- *Access to professional development:* many SPs reported that they often needed to travel to metropolitan centres to participate in workshops and conferences. This can be costly and time consuming and create limitations in the number of professional development activities that rural/remote SPs can access each year. Some SPs are provided with a professional development financial/leave allocation per year, which is helpful, but for some people living rurally and/or remotely, attendance at one workshop in a city could cost in excess of $2000. Consequently the success of the Scrap the Cap campaign was vital for AHPs living in rural and remote Australia. Furthermore, rural and remote positions are very rarely backfilled.
- *Professional isolation:* many attendees reported that they work in professional isolation and the inherent challenges in this such as being unable to easily discuss complex client cases, to learn from colleagues and to share new knowledge/experiences. Whilst many enjoyed working as part of a multidisciplinary team, their opportunities for discipline specific networking was limited. Informal and formal mentoring was discussed, as well as the need for SPs to proactively network and join special interest groups, member networks and committees.
- *Skills and knowledge:* separate to professional development opportunities such as workshops and conferences, participants identified that the specific skills and knowledge they required to work effectively in the rural and remote context were not readily provided through undergraduate training and they were not aware of the post-graduate opportunities available to them. The group identified inclusion of the following in speech pathology university courses:
    - Service delivery models
    - Indigenous communities
    - Rural and remote issues and cases studies built into all subjects

- Encouragement and preparation to work in rural and remote settings.

The group also discussed the collation of post graduate courses available in Australia, professional work shadowing in larger regional centres as well as cities and skills audits of SPs across different regions.

During 2009, SARRAH developed a paper titled Principles of Recruitment and Retention of Allied Health Professionals to Remote Australian Communities which is available on the SARRAH website and also by clicking here.

Case Study 3

An experienced SP doing a 2 week locum in a remote town (where there had been a longstanding vacancy) came across the large file of a child with a complex motor speech disorder known as dyspraxia. Dyspraxia is a condition that requires intensive and often long term therapy. Due to a combination of chronic SP retention problems and the enormous caseload and waiting list of the health service, the child had been assessed and re-assessed no less than 8 times by different SPs and had received a total of two weeks of therapy. When the locum SP arranged an urgent appointment with the child and his parents she found a 9 year old boy who was very difficult to understand, was regularly getting into trouble at school and was exceptionally reluctant to participate in therapy, which he perceived as something at which he was bound to fail. The SP provided a short burst of intensive therapy and passed the child onto whoever the next SP would be. The longer term outcomes for this child could quite readily be projected as low academic performance, disengagement from the education system, possible contact with the justice system and ongoing employment difficulties due to an unremediated complex communication disorder.

Recommendation 17: Rural and remote allied health services are required by funding bodies to develop and implement comprehensive recruitment and retention strategies for SPs (and all AHPs) that reflect the recommendations detailed in the above referenced SARRAH recruitment and retention paper.

Recommendation 18: Local organisations and Speech Pathology Australia must commit to the provision of regular, adequate and equitable professional development funding and opportunities, with possible subsidisation through government funding initiatives. Uncapped tax deductibility for professional development must remain for equitable access by rural and remote SPs.

Recommendation 19: Increase the number of scholarships available under the allied health component of the Nursing and Allied Health Scholarship Support Scheme in particular the undergraduate–entry level and post graduate scholarships administered by SARRAH on behalf of the government which continue to be oversubscribed.

Recommendation 20: SPs are provided with mentoring and supervision arrangements similar to the program proposed by SARRAH's National Rural and Remote Mentoring Scheme and integrated into relevant speech pathology networks to spend professional time with other SPs under professional work shadowing arrangements.

Recommendation 21: SP university courses adequately encourage and prepare students for rural and remote practice through the provision of subjects, case studies and clinical placements incorporating Indigenous health, service delivery models and other relevant rural and remote topics.

Recommendation 22: Facilitate equity of education and training, recruitment and retention of SPs and the broader AHP workforce through to establishing universal coverage of University Departments of Rural Health network supporting rural and remote allied health clinical education.

Evidence Based Practice and Practice Based Evidence

SPs and other AHPs working in rural and remote settings are often driving innovation in clinical service delivery through an integration of theoretical knowledge and practical application in environments that require unique considerations.

Due to a number of factors such as inexhaustible caseloads, frequent travel and a lack of access to universities, rural and remote professionals rarely have the opportunity to document and publish information about the work that they are doing. Whilst a large amount of grey literature exists in the forms of reports etc, there is very little in academic forums that can be utilised for the purposes of reprioritisation of resourcing, service delivery and policy.

Recommendation 23: Rural and remote organisations are linked in with relevant university and research departments to encourage and support the publication of relevant initiatives and projects that contribute to improved outcomes for rural and remote Australians.

Recommendation 24: Speech Pathology Australia commits to research and academic support for rural and remote professionals as well as the 'rural proofing' of all association documentation for example position papers, submissions, fact sheets.

CONCLUSION

The ability to communicate, eat and drink are core activities of independent living and basic rights that all Australians deserve. SPs are critical in supporting those who have difficulties in these areas and with early identification and intervention can prevent more chronic or longer lasting conditions. This in turn leads to healthier, better educated and more productive community members who can make an active contribution to society.

There are unique considerations for people and SPs living and working in rural and remote Australia. Whilst AHPs working in these areas often possess a breadth of skills and knowledge, are innovative and resourceful, there is a high rate of staff turnover. Health and education services are not addressing the core needs required for job satisfaction such as professional support and mentoring, access to professional development opportunities, formal acknowledgement of specialist generalist skills and mechanisms for career advancement.

SARRAH strongly supports this inquiry into speech pathology services and will continue to develop and support initiatives that adequately address the needs of rural and remote AHPs and communities in partnership with government and other stakeholders. Consequently, SARRAH would welcome the opportunity to elaborate on this submission.

REFERENCES

Australian Institute of Health and Welfare (2012). *A picture of Australia's children 2012.* Canberra, AIHW.

Australian Institute of Health and Welfare (2008). Rural, regional and remote health Indicators of health status and determinants of health. *Rural Health Series, 9*. Canberra, AIHW.

Bourke, L., Coffin, J., Taylor, J. & Fuller, J. (2010). Rural health in Australia. *Rural Society, 20*(1), pp. 2-9.

Cadilhac, D.A, Kilkenny, M. F., Longworth, M. , Pollack, M.R.P. & Levi, C. R. (2010). Metropolitan–rural divide for stroke outcomes: do stroke units make a difference? *Internal Medicine Journal, 41*(4), pp. 321-326.

Dew, A., Veitch, C., Lincoln, M., Brentnall, J., Bulkeley, K., Gallego, G., Bundy, A. & Griffiths, S. (2012). The need for new models for delivery of therapy intervention to people with a disability in rural and remote areas of Australia. *Journal of Intellectual & Developmental Disability*, *37*(1), pp 50-53

Gething, L. (1997). Sources of Double Disadvantage for People with Disabilities Living in Remote and Rural Areas of New South Wales, Australia, *Disability & Society, 12*(4), pp 513-531. DOI: 10.1080/09687599727100

Keane, S., Smith, T., Lincoln, M. & Fisher, K. (2011). Survey of the rural allied health workforce in New South Wales to inform recruitment and retention. *Australian Journal of Rural Health, 19,* pp. 38-44

Lizarondo, L., Kumar, S., Hyde, L. & Skidmore, D. (2010). Allied health assistants and what they do: A systematic review of the literature. *Journal of Multidisciplinary Healthcare, 3,* pp. 143–153

O'Brien, R., Byrne, N., Mitchell, R. & Ferguson, A. (2013). Rural speech-language pathologists' perception of working with allied health assistants. *International Journal of Speech-Language Pathology, 15*(6), pp 613-622.

Stute, M., Hurwood, A., Hulcombe, J. & and Kuipers, P. (2013). Defining the role and scope of practice of allied health assistants within Queensland public health services [online]. *Australian Health Review*, *37*(5), pp 602-606.