Senate Inquiry into the prevalence of different types of speech, language and communication disorders and speech pathology services in Australia

Submission to the Senate Inquiry by the Broken Hill University Department of Rural Health, The University of Sydney

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The following key messages and key recommendations provide a summary to assist the Senate Inquiry in locating this submission within the National inquiry.

**Key Messages**

1. Rural, remote and Indigenous populations experience complex and interconnected challenges in accessing speech pathology services;
2. There is a substantial body of evidence that identifies low socio-economic status to the increased prevalence of delays in speech, language and communication yet the ‘inverse care law’ continues to apply to these communities;
3. Traditional referral for service models fail to address precursors to speech, language and communication delay through early identification and intervention strategies in high need locations;
4. Population health approaches are not widely embedded in speech pathology pre-graduate education and post graduate practice;
5. The role of rural, remote and Indigenous communities in identifying and developing ‘fit-for-purpose’ health and health workforce models remains marginalised resulting in poorly aligned and fragmented access to services at ‘point-of-need’;
6. Higher education institutions have a pivotal role to play in the development of a 21st century speech pathology workforce through an engagement agenda with marginalised communities that enhance pre-graduate population health experiences that align to addressing unmet need within these communities;

**Key Recommendations**

1. There is a need to rethink systems, policy, education, and practice approaches to service delivery and workforce development in the rural, remote and Indigenous speech, language and communication arena;
2. National and state health authorities need to commit time and resources to the development of new service and workforce innovations that align to contemporary rural, remote and Indigenous community need;
3. Communities need to be meaningfully engaged in the development of health service and workforce models;
4. Population health approaches need to be embedded into speech pathology pre-graduation curriculum;
5. Greater opportunities for population health clinical fieldwork experiences in these locations need to be established to enable the transference of population health theory to practice;
6. Cross-sector partnerships need to be established to address speech, language and communication deficits across the lifespan with identified areas of shared responsibility and accountability.
#### Contents

- Key Messages .......................................................................................................................................... 2
- Key Recommendations ........................................................................................................................... 2
- Submission Summary .............................................................................................................................. 5
- Introduction ............................................................................................................................................ 7
  - Far Western NSW ................................................................................................................................ 7
- The Contemporary Rural, Remote, and Indigenous Australian Speech Pathology Landscape .............. 8
- Service Inequity Implications ................................................................................................................ 10
- The Unmet Need for Rural, Remote and Indigenous Paediatric Speech Pathology Services ............... 11
- The Unmet Need for Rural, Remote, and Indigenous Aged Care Speech Pathology Services ............. 12
- The Cost of Geographical Isolation ....................................................................................................... 13
- Population Health and Primary Health Care Approaches ........................................................................ 14
- The Role of Rural, Remote, and Indigenous Communities in Health Service and Health Workforce Modelling .............................................................................................................................................. 15
- Service-Learning .................................................................................................................................... 16
- Community-Campus Partnerships ........................................................................................................ 19
- Case Studies .......................................................................................................................................... 20
  - Case Study 1: The Spin A Yarn Program (Paediatric Speech Pathology) ............................................... 21
    - Background ....................................................................................................................................... 21
    - Catalyst for Change ........................................................................................................................... 21
    - The Evidence ..................................................................................................................................... 22
    - Cross-Sector Partners........................................................................................................................ 22
    - The Model ......................................................................................................................................... 22
    - Impact ............................................................................................................................................... 23
    - Program Expansion ........................................................................................................................... 23
    - Evaluation Findings ........................................................................................................................... 24
    - Value Adds Associated with the Program ......................................................................................... 24
    - Challenges ......................................................................................................................................... 24
  - Case Study 2: Allied Health in the Aged Care Sector ............................................................................ 25
    - Background ....................................................................................................................................... 25
    - Catalyst for Change ........................................................................................................................... 25
    - The Evidence ..................................................................................................................................... 25
    - Cross-Sector Partners........................................................................................................................ 25
    - The Model ......................................................................................................................................... 26
Submission Summary

This submission primarily responds to items b, c, and e of the Terms of Reference associated with the Senate Inquiry into the prevalence of different types of speech, language, and communication disorders and speech pathology services in Australia:

- 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);
- 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;
- Evidence of the social and economic cost of failing to treat communication and swallowing disorders.

There is a specific focus in this submission on rural, remote, and Indigenous Australian populations, the prevalence of speech, language and communication deficits in these settings, the challenges experienced in accessing appropriately trained speech pathology professionals, and the role of these communities in health service and health workforce development.

This submission then goes on to describe a solutions focused approach to addressing protracted and entrenched inequities to speech pathology service access in far western NSW through the creation of a ‘fit for purpose’ health service and health workforce model that sees services developed and provided at ‘point of need’ through cross-sector collaborations.

This submission draws on the experience of the Broken Hill University Department of Rural Health (BHUDRH), The University of Sydney, in the development, delivery, and evaluation of speech pathology service-learning (Seifer S 1998, Jacoby B 2033) models that are underpinned by the principles of community-campus partnerships (CCPH 2013).
These educational models and service partnership approaches often align to population health and primary health care practices, challenging traditional approaches to speech pathology service provision that continues to preference targeted or specialist services to referred individuals. Challenges also exist for pre-graduate educators and accreditation agencies that struggle to respond to population health approaches delivered in contemporary rural, remote and Indigenous communities to respond to community needs and expectations.

Two case studies have been included in this submission to provide greater insight into the rationale and development of new and responsive service-learning models for paediatric and aged care speech pathology service delivery and workforce development in far western NSW.

Rethinking how we approach speech, language, and communication service delivery and health workforce development to ensure ‘fit for purpose’ services that are delivered by appropriately trained health professionals at ‘point of need’ is critical if we are to redress key precursors to poorer health, education, social, and economic outcomes across life stages for rural, remote, and Indigenous populations.
Introduction

This submission describes a number of complex challenges in speech pathology service access experienced in far western NSW. The authors acknowledge the individual uniqueness of rural, remote, and Indigenous Australian communities in relation to their health care needs, priorities and aspirations, internal and external partnerships, availability and access to health resources, and human and social capital. However, there are a number of shared experiences and needs across these locations that provide a strong platform for a broad range of shared learning experiences in the development and delivery of health services and health workforce strategies that challenge contemporary approaches ensuring ‘fit for purpose’ services, that are provided at ‘point of need’, by ‘fit for purpose’ health professionals.

Whilst acknowledging the complex and interconnected challenges confronting rural, remote, and Indigenous communities across a broad range of health determinants this submission also seeks to highlight the innovation and leadership in these regions that enables new community focused approaches to health service delivery and health workforce development.

Far Western NSW

Broken Hill is an outer regional population centre of 19,500 located in far western NSW. It is a socioeconomically disadvantaged community (SEIFA score 930: most disadvantaged category), with a high burden of chronic disease (significantly higher rates than NSW average for cardiovascular disease and diabetes), and increased prevalence of behavioural risk factors such as smoking in pregnancy, overweight and obesity, and physical inactivity (Kennedy K 2005, GWAHS 2010).

The proportion of young children at school entry classified as developmentally vulnerable or at risk in Broken Hill is greater than for NSW as a whole in the domains of physical health and wellbeing, social competency, emotional maturity, language, communication and cognitive skills (AEDI 2010).
Furthermore the community has limited access to a number of paediatric child health services, including speech pathology, physiotherapy and occupational therapy – services that are needed to deal effectively with child developmental issues and ensure the effectiveness of early intervention programs and Best Start initiatives, as well as allied health services for older adults residing in residential care or engaging with home based aged care providers.

There is a growing body of evidence that directly identifies the low socio-economic status of individuals and communities as a key precursor to the increased prevalence of speech, language, and communication deficits (Letts et al 2013, Fernald A et al 2012). Approximately 6 million Australian’s reside in regional and remote areas where income and educational levels are identified as lower than their metropolitan counterparts. In 2001 over 55% of people living in Very Remote areas were classified as being amongst the most disadvantaged people in Australia (AIHW 2007).

Despite this identified disadvantage the ‘inverse care law’ continues to apply to rural, remote, and Indigenous populations, those with greater disadvantage, and greater health need, have less access to health services to address those needs (Wakerman J et al 2009).

**The Contemporary Rural, Remote, and Indigenous Australian Speech Pathology Landscape**

The health workforce shortage and mal-distribution of qualified Speech Pathology practitioners, and the resultant inequity of service access for rural, remote, and Indigenous Australian communities has been comprehensively identified by key Australian agencies including Speech Pathology Australia (SPA 2005), Services for Australian Rural and Remote Allied Health (SARRAH 2012), and Health Workforce Australia (HWA 2011).

Rural, remote, and Indigenous communities are confronted with a number of major health challenges and inequities that are exacerbated by health workforce shortages, workforce mal-distribution, ageing populations, chronic disease, remediation models of service delivery, and the increasing scarcity of health system resources (SARRAH 2012).
The provision of speech pathology services to these communities fails to meet identified needs that require targeted, ‘fit-for-purpose’, initiatives that engage with, and align to, community requirements and expectations (SPA 2005).

In 2007 the distribution of health specialists in major cities was 2, 3, and 4 times as high than in inner regional, outer regional, remote, and very remote respectively (HWA 2011). In 2010 the Australian Institute of Health and Welfare (AIHW) identified that Allied Health professions, including Speech Pathology, experienced greater levels of mal-distribution in comparison to all health professions (AIHW 2010).

Speech Pathology Australia (2005) identified the following barriers to the provision of speech pathology services in rural, remote, and Indigenous communities;

- Professional isolation due to limited, or lack of, professional support, supervision, and mentoring;
- Poor career structures;
- Shortages of locum support to backfill sole practitioners;
- Lack of incentives for new clinicians;
- The perception that rural and remote clinical work is ‘unattractive’ and;
- The added complexity of knowledge and skill mix required to deliver culturally appropriate services in partnership with Indigenous communities. (SPA 2005)

Inequity of speech pathology services in rural Australian areas is supported by existing data that suggests that only 4.5% of speech pathology practitioners provide services to rural communities which constitute 30% of the total Australian population (Lambier J 2002).

Attracting Speech Pathologists to these regions is also hindered by the limited opportunity to support pre-graduate students in clinical fieldwork experiences in these locations. This is despite evidence that identifies the impact on place of practice post- graduation for health students who have been provided with a supported and valuable fieldwork experience in these settings (HWA 2011).
Between 1999 and 2009 the region had not supported the clinical placement experience of any pre-graduate speech pathology students limiting the regions capacity to influence pre-graduate exposure to population health practice in the region.

Far western NSW has experienced protracted and entrenched inequities of access to paediatric and adult speech pathology services over a 3 decade timeframe. Public health agencies struggle to recruit and retain appropriately trained speech pathologist, where and when private speech pathology services are available many residents in this location struggle to self- fund access, speech pathology services provided by Ageing Disability and Home Care are sporadic and ‘fly-in-fly-out’ (FIFO) in approach.

Regional schools are heavily dependent on service provision to their pupils that is provided and funded through public health agencies.

When public health speech pathology services are available they are heavily focused on addressing backlogs of service to referred individuals and addressing the needs of clients located within acute care facilities heavily privileging remediation approaches to service delivery.

Allied Health Professions Australia (AHPA 2013) highlight the inherent link between access to allied health services and health outcomes for consumers. The timely delivery of allied health services have been shown to enhance consumer outcomes, enabling them to contribute more fully to society, whilst reducing the likelihood of more expensive remediation based interventions and treatments that may be required at later life stages (AHPA 2013).

**Service Inequity Implications**

There is a body of evidence that identifies the later life impact of undiagnosed and/or untreated speech, language, and communication deficits across the broad set of socially determined health outcomes. These deficits directly impact on health outcomes, educational attainment, employability, social connectedness, and increase the likelihood of individuals coming into contact with juvenile and adult justice systems (Snow et al 2012, ASHA online 2014).
In 2006 the international Adult Literacy and Life Skills Survey (ALLS) identified that approximately 40% of employed and 60% of unemployed Australians had poor or very poor English language, literacy, and numeracy skills calling for improvement in these domains to enhance effective participation in training, the labour force, and society. The Australian Core Skills Framework identifies 5 key domains that are essential for employment and economic attainment. These domains are learning, reading, writing, oral communication and numeracy (Department of Industry 2010).

In a document published by the Australian Institute of Criminology (2012) it was identified that a high proportion of young offenders (up to 50% in Australian studies) were found to have had a clinically significant, but previously undetected or untreated oral language disorder (Snow et al 2012).

These young adults faced higher risks of long term disadvantage and social marginalisation. It was identified that in a significant number of cases marginalisation from mainstream education and socialisation commenced early in life, specifically within classrooms, where individuals experienced difficulties with language and literacy tasks, and the interpersonal demands of classroom environments (Snow et al 2012).

American studies have found that there is a high prevalence of speech, language, and hearing impairment within their state prison populations. However, it has also been identified that there is a need for additional research to be undertaken to gain a greater understanding of both the prevalence of disorders and contribution to incarceration rates (ASLHA 2004).

The Unmet Need for Rural, Remote and Indigenous Paediatric Speech Pathology Services

It is estimated that 10% of Australian children are developmentally vulnerable with regards to language and cognitive development by the time they commence school. In some Australian communities this may be as high as, or higher than, 33% (McLeod et al 2007). Developmental vulnerability encompasses literacy and communication skills, an ability to be understood by others, and participation with other children.
It is estimated that approximately 20% of children may be slow to develop spoken language and for 50% of these children, language problems may persist into early school years. In primary and secondary school years, communication disorders can affect as many as 13% of Australia’s school population (McLeod et al 2007).

Rural and remote Australian children are more likely to be identified as experiencing developmental vulnerabilities that impact on education and health attainment on entry into primary school than their metropolitan counterparts (NSW DEC 2013).

The link between educational attainment and enhanced life and well-being outcomes is well documented (DEEWR 2013, McCandish S 2012, Macey E 2013) however, these communities continue to experience significant challenges in health care access and service delivery (Humphreys J et al 2011), from across a broad range of early intervention and school based therapy services (Standing Council on Health 2012).

Indigenous children face elevated risks for delayed acquisition of Standard Australian English language and literacy (De Bortoli et al 2004) and may experience poorer health than their non-Aboriginal counterparts (Standing Council on Health 2012). Aboriginal children may experience Standard Australian English as a second or third language, or speak a Kriol language, placing them at a high risk for delayed oral English language development and educational disengagement (Parlington et al 2005).

Aligning this to the cultural determinants of communication behaviour (Eades 2000) these young people are particularly vulnerable in their interface with mainstream English language dominant education systems.

**The Unmet Need for Rural, Remote, and Indigenous Aged Care Speech Pathology Services**

Aged care providers and residents in rural, remote, and Indigenous communities are also confronted with complex challenges in accessing speech pathology services to address a number of clinical and social areas of need.
The traditional focus on speech pathology services to this client cohort and care providers has preferred swallowing assessments and other high end clinical requirements in favour of population health and primary health care approaches that focus on social engagement, resident advocacy, enhanced communication pathways, and improved life experiences.

Speech pathology service delivery to this sector in rural, remote, and Indigenous communities reflects the challenges previously identified however, the aged care sector and older adults within this sector also struggle to overcome ageist stereotypes that marginalise the prioritisation of their needs especially in environments where high unmet demand exists.

Pre-graduate student activity in this sector is also driven by curriculum and accreditation requirements which further focus skill and knowledge attainment on swallowing assessments and high end clinical acute fieldwork experiences. This approach fails to align Australia’s future speech pathology workforce to community need, priority, and expectations.

**The Cost of Geographical Isolation**

The geographical isolation experienced by rural, remote, and Indigenous communities directly impacts on service access, especially where speech pathology services may not be located on-site but are at a distance to communities. The economic status of residents precludes many from traveling these distances to access speech pathology services. Where private speech pathology services may be available in these locations the limited number of allied health Medicare items combined with socioeconomic disadvantage may also act to preclude these families from self-funded service access (AHPA 2013).

Far western NSW families that have financial capability can travel up to 300kms to access services in Mildura, Victoria, or 500kms to access services from Adelaide, South Australia.

A frequently forgotten cohort that has amplified geographical barriers to speech pathology service access are those children and families living and working on isolated properties in remote Australia. Many of these children are engaged in School of the Air (SOTA) education with infrequent visits to regional centres such as Broken Hill for mini school programs, classrooms, sporting carnivals and supervisor training sessions.
Broken Hill School of the Air provides education to approximately 140 children within a 300km radius. Primary educators are at a distance and rely heavily on the investment of parents and/or governesses. Providing speech pathology services to these individuals calls for additional innovation in therapy modalities and support structures for carers in these settings.

**Population Health and Primary Health Care Approaches**

Although there is an increasing policy move towards population health, primary health care practices (McCarty M 2012, Wylie et al 2013, Ferguson et al 2012), and cross-sector collaborations in addressing childhood educational and health disadvantage, challenges remain in the provision of integrated and sustainable cross-sector service delivery approaches and the creation of an appropriately trained health workforce to deliver services within these frameworks (DoHA 2010).

Health Workforce Australia (2011) identified 5 key themes in the national and international literature in relation to rural and remote health care:

- The need for locally planned and needs based health care models and services;
- Holistic, culturally safe care that embeds the social determinants of health and wellbeing;
- An emphasis on health promotion, disease prevention, and early identification;
- Access to a health workforce that is skewed towards generalism;
- A system that allows time and resources for addressing rural and remote specific challenges and opportunities (HWA 2011).

The role of population health and primary health care approaches for the delivery of speech pathology services and health workforce development is increasingly being raised by leading national and international experts as an alternative model for service delivery to marginalised, at risk, and underserved populations (Wiley et al 2013, Law et al 2013). These new perspectives challenge traditional approaches to speech pathology service provision that have preferred targeted or specialist services to referred individuals.
Child development, including speech, language, and communication skills, are key focus domains within population health and primary health care philosophies that are prevention, health promoting, and early identification and intervention focused (NSW MoH 2009, CoA 2013).

There are an increasing number of population health approaches being integrated into speech pathology university degree education. These approaches seek to develop the theoretical knowledge and insight of speech pathology students in population health strategies and practices as part of their pre-qualification education (Riegelman R et al 2008, Zenzano T et al 2011). However, clinical placement opportunities in locations where population health and primary health care models drive service delivery remain limited creating an educational disconnect between theoretical understanding and ‘real world’ health service practices in these contexts. The challenge of translating population health theory to practice for pre-graduate students limits their capacity to make informed decisions on place of practice and model of preferred practice post-graduation.

Currently there is no established range of systematic population health directed programs for the prevention and early intervention of speech, language, and communication deficits (Wylie et al 2013). There is a growing need to redress the imbalance and lack of continuity between and across prevention and clinical treatment models.

**The Role of Rural, Remote, and Indigenous Communities in Health Service and Health Workforce Modelling**

National and international health policy is increasingly identifying the role communities need to play in health care planning, design, delivery, and evaluation to address the failings of a ‘one size fits all’ approach (Kulig J et al 2012, Commonwealth of Australia 2012).

Calls for meaningful multi-sectoral partnerships with communities recognise that collaboration is central to ensure acceptable, appropriate, and effective responses to begin to tackle entrenched rural inequities. (Kenny et al 2013 p:1)
Drawing on the social and intellectual capacity of rural, remote, and Indigenous communities is essential in the development, establishment, and sustainability of locally responsive health services and workforce models.

This approach also enables communities and government agencies to work collaboratively in developing empowered communities that have the capacity to identify and implement local solutions to address areas of unmet need, priority and innovation (Kenny et al 2013). However, there remain gaps in the knowledge on how best to create effective community/policy/practice partnerships that devolve control and decision making to local communities (Kulig J. 2012).

There is a need to gain greater understanding on how best to engage meaningfully with communities in the development and delivery of health services and responsive health professionals (Kenny et al 2013, HWA 2011). Health workforce innovation and reform is required to encourage the development of health workforce models that enable new approaches to service delivery (McCarty 2012).

To date this submission has focused on the challenges and impacts experienced by rural, remote, and Indigenous communities associated with access inequity to speech pathology services. The following section will provide an overview of service-learning and community-campus partnerships as one foundation that can enable communities to actively seek out and implement place based solutions, in partnership with higher education institutions, to address speech pathology service and workforce deficits.

**Service-Learning**

Service-learning is one approach to education that seeks to positively influence a participating student’s cognitive, social, and civic learning and engagement. Service-learning has been an acknowledged educational approach in the United States of America for over 40 years (Beatty J 2010) and is an emerging approach to the education of Australia’s future health workforce (Peninsula Health 2012, Jones et al 2010).
Proponents of service-learning claim that this educational approach enhances health student learning outcomes by engaging students in challenging community settings that require the transference of theory (classroom based learning and course content) to new environments where students are exposed to unfamiliar issues, different perspectives, and solutions focused activity to health and social issues.

Service-learning is considered compatible with other changes in higher education approaches including a transition from teaching to student-led learning, autonomous work of students in collaboration with partners, and movement towards higher education and public agency partnerships to enhance democratic approaches to academic work of meaning (Jacoby B 2010).

Service-learning differs from traditional clinical education for health professions in that:

- Service-learning seeks to achieve a balance between health student service and learning objectives - in service-learning, partners must negotiate the differences in their needs and expectations;
- Service-learning places an emphasis on addressing community concerns and the broad social determinants of health;
- The involvement of community partners is integral to service-learning - service-learning involves a principle-centred partnership between communities, higher education institutions, and health professional schools.
- Service-learning emphasizes reciprocal learning - In service-learning, traditional definitions of "faculty," "teacher", and "learner" and power structures between communities and universities are intentionally blurred.
- Service-learning emphasises reflective practice - In service-learning, reflection facilitates the connection between practice and theory and fosters critical thinking.
- Service-learning places emphasis on developing citizenship skills and achieving social change acknowledging that many factors influence health and quality of life. In service-learning, health students place their roles as health professionals and citizens within a larger social context. (Seifer S 1998).
Service-learning activities have 2 main goals:

- Activities are reciprocal to community partners;
- Activities meet coursework objectives associated with reciprocal relationships, mutual investment and benefit, and well-coordinated partnerships between the community and the campus.

There is a mounting body of evidence that documents the efficacy of service-learning participation during pre-graduation years (Astin et al 2000). Studies on the effects of service-learning participation have shown an impact on personal, social, and learning outcomes for students. The integration of service-learning in the education of healthcare professionals has been shown to benefit students, faculty members, communities, and higher education institutions (Seifer 1998).

Service-learning experiences have been found to impact on a broad range of general outcomes for health students including critical thinking, communication, social interaction, decision making, social awareness, and responsibility. Enhanced competence and awareness of the needs of the population served and ethical issues within the public health and social arenas have also been identified (Kearney 2004).

Service-learning opportunities have been shown to create a positive change in health student’s perceptions of knowledge and understanding of the broader issues facing contemporary communities with enhanced opportunities for these students to develop as competent, engaged, and caring health professionals (Brown et al 2007).
Community-Campus Partnerships

Service-learning opportunities are underpinned by collaborative partnerships between community agencies and higher education institutions. These collaborations are typically referred to as community-campus partnerships. Community-Campus partnerships;

- Are formed to serve a specific purpose and may take on new goals over time;
- Have agreed and shared missions, values, goals, measurable outcomes and accountability for the partnership;
- Are characterised by mutual trust, respect, genuineness, and commitment;
- Build upon identified strengths and assets, but also work to address needs and increase capacity of all partners;
- Balance power among partners, enabling resources among partners to be shared;
- Make clear and open communication an ongoing priority by striving to understand each other's needs and self-interests, and developing a common language;
- Have principles and processes for the partnership that are established with the input and agreement of all partners, especially for decision-making and conflict resolution;
- Ensure feedback among all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes;
- Share the benefits of the partnership's accomplishments. (CCPH 2013)

As a strategic approach community-campus partnerships can contribute to a number of significant outcomes that include:

- The development of community-responsive, culturally competent health professionals;
- Diversification of the health professional workforce;
- Enhanced access to healthcare;
- Enhanced access to technology;
- Supported community development;
- Supported economic development; and
- Meaningfully engaged universities and communities (CCPH 2013).
Case Studies

Two case studies are now described that provide additional detail on the evolution, establishment, and impact of paediatric and aged care speech pathology pre-graduate programs in far western NSW that are underpinned by the educational pedagogy of service-learning and the principles of community-campus partnerships.
Case Study 1: The Spin A Yarn Program (Paediatric Speech Pathology)

Background

Children and families in far western NSW had experienced protracted and entrenched paediatric speech pathology service inequities for over 3 decades. These inequities had resulted from;

- Challenges in the recruitment and retention of paediatric speech pathologists resulting in service fragmentation or a void of service availability;
- Geographical isolation that required those families with economic capacity to travel distances of up to 500kms to access speech pathology services. Where these external services had been accessed there was an expectation that complex therapy plans would then be implemented in community by parents or school teaching staff;
- The lower socio-economic status of the region prohibited many families from accessing services external to the region;
- Siloed approaches to addressing this inequity of service frequently resulted in tension between school education providers, health services, and families in need;
- Policy and practice approaches were developed at a distance to communities of need and services then layered onto these communities.

Catalyst for Change

In 2007 the Broken Hill University Department of Rural Health (BHUDRH), The University of Sydney, established a relationship with regional secondary schools in far western NSW in the delivery of comprehensive health career development programs for secondary school aged students. Through this relationship the work of the BHUDRH was promoted across the school sector. In 2009 a delegation of primary school principals approached the BHUDRH to discuss their concerns associated with unmet need for paediatric speech pathology services and the resultant impact on the educational, health, and social outcomes for children who were experiencing speech, language and communication delays in their schools and the emotional distress this caused families.
This delegation requested support from the BHUDRH in developing a service that would be sustainable, offer continuity of therapy to children and families, be available onsite to address high levels of unmet need, and bring together key stakeholders across the region to work collaboratively on resolving the issue.

The Evidence

As a remotely embedded academic department the BHUDRH undertook an extensive literature review to identify health service models that were capable of responding to marginalised and underserved populations that centrally located community leadership and solutions focused engagement. Additional evidence was explored on educational pedagogies that would enable the Department to leverage of its core activities of pre-graduate clinical placement coordination enabling the Department to align proposed speech pathology student activity to community need.

The literature identified key themes associated with community-campus partnerships and service-learning as acknowledged evidence based approaches to student learning and innovation in addressing unmet need.

Cross-Sector Partners

1. NSW Department of Education and Communities Western Region
2. Far West Local Health District NSW Ministry of Health
3. Faculty of Health Sciences, The University of Sydney
4. Broken Hill University Department of Rural Health

The Model

• Speech pathology student cohorts (6-8 students) placed directly in primary school settings across Term 1 – Term 4;
• Structured theoretical orientation to region, program principles, aims, activities and aspirational outcomes;
• Population health approach to Kindergarten pupil screening, assessment, therapy development and delivery, and referral.
• Mixed model of clinical supervision provided by a Speech Pathology academic employed by the BHUDRH including face-to-face in school settings, weekly clinical case discussions, access via email and telephone systems, direct access to home university academics, and interdisciplinary supervision by other allied health academics such as Occupational Therapy and Dietetics.

• Weekly pastoral care sessions to support the students across social, professional, cultural and personal domains whilst undertaking a remote clinical placement.

Impact

• Approximately 200 Kindergarten children screened annually;
• Approximately 70% of children screened receive therapy sessions annually through the Speech Pathology Service-learning program;
• Children can receive up to 20 therapy sessions across the school year;
• Therapy provided on a one-to-one, group, or class based approach;
• Dramatic increase in the number of speech pathology students being exposed to remote and Indigenous population health and primary health care practice (n=24 students annually for a total of 144 student weeks in region);
• Speech pathology practice exposure to a diverse range of school educators;
• Enhanced school/community access to a Speech Pathology Academic;
• Enhanced social and intellectual capital located within the region.

Program Expansion

• Integration of Occupational Therapy, Dietetic and Orthoptic pre-graduation students into the program;
• Geographical expansion of program to the remote communities and high Indigenous populations of Wilcannia and Menindee;
• Proposals under development to further extend student engagement across the disciplines of Social Work and Exercise Physiology.
Evaluation Findings

• Post placement speech pathology focus groups have identified the acquisition of work readiness skills for participating students, enhanced understanding of primary health care practice, greater cultural understanding, enhanced capacity to work in an interdisciplinary model, capacity to translate theory directly to practice, and first-hand experience of the challenges associated with addressing high unmet health needs in these regions.

• High rate of school satisfaction with the program

Value Adds Associated with the Program

Enhanced ability of cross-sector partnership to attract additional infrastructure and funding resources to support program development and establishment:

• Health and Hospital Regional Priority Round - $4.7 million to establish health infrastructure directly on primary school sites in Broken Hill;

• $400K Health Workforce Australia to establish innovative clinical placement opportunities;

• 2014 announcement by NSW Department of Education and Communities of the establishment of a Specialist Centre in Broken Hill to consolidate and contribute to the expansion of cross-sector partnerships.

Challenges

• These models require time, commitment, and resources to establish and sustain;

• There are no systems approaches that recognise, endorse, or fund these models at a State or National level;

• Tensions can be created between proponents of traditional speech pathology approaches and proponents of innovative population health models;

• Aligning existing curriculum and accreditation requirements to new ways of understanding and service delivery;

• Policy lag in devolution of leadership and control to remote communities;

• Challenges remain in engaging parents from low socio-economic backgrounds in home therapy activity.
Case Study 2: Allied Health in the Aged Care Sector

Background

Residential aged care providers in far western NSW share similar experiences of inequity in accessing speech pathology services as their school education counterparts. The aged care sector is confronted with additional challenges associated with:

- The perception that aged care is a less attractive work environment than acute care settings;
- Hospital centric models that are remediation focused and hospital based;
- Costs associated with self-funded service access to private speech pathology services;
- Isolation from dominant health care systems and policy.

Catalyst for Change

In 2010 the Director of Resident Care, Southern Cross Care (BH) Inc, the largest aged care provider in far western NSW, approached the BHUDRH to discuss the potential transferability of the schools speech pathology and allied health program into the aged care sector to address entrenched allied health service access inequities.

The Evidence

See case Study 1

Cross-Sector Partners

1. Southern Cross Care (BH) Inc
2. Broken Hill City Council
3. Faculty of Health Sciences, The University of Sydney
4. Broken Hill University Department of Rural Health
The Model

The aged care model draws on the same principles of service-learning and community-campus partnerships that underpin the school based program. However due to the different needs and expectations of older adults and care providers service delivery was developed to reflect requirements.

- Cohorts of speech pathology students (4 students X 2 annually for a total of 32 student weeks);
- Clinical placement undertaken directly in the aged care sector;
- A mix of screening, assessment, therapy, staff capacity building, program development and referral services;
- A week of structured onsite pre-placement education prior to placement commencing;
- Mixed model of supervision (see Case Study 1);
- Weekly clinical discussions and pastoral care support.

Impact

- In 2013 25 residents were offered swallowing assessments;
- Focus areas of service delivery have been swallowing, communication, staff education and resident advocacy;
- Resources have been developed by students for reminisce kits, safe swallowing training, thickened fluid education, and resident advocacy

Program Expansion

Currently Speech Pathology, Occupational Therapy, and Dietetic students are engaged in the aged care service learning program. Consultation is currently underway for the development of an integrated Social Work and Exercise Physiology experience.

Students have extended their engagement to community based Indigenous aged care services and dementia respite services.
Evaluation Findings

- Participating students display a greater understanding of community engaged practice;
- Stereotypical myths associated with aged care service provision and the role of allied health professionals in these locations are challenged;
- Students have enhanced understanding that their contribution in aged care settings impacts on residents, families and care organisations;
- Students display an enhanced understanding of referral pathways and processes across disciplines and organisations.

Value Adds Associated with the Program

- Participating students are developing and delivering programs, evidence based procedural advice, and activities of value to residents and residential aged care providers;
- Students provide education for staff that seeks to build knowledge, skills, and capacity at the local level;
- Residential care providers are experiencing enhanced integration and feelings of being valued for the work they undertake;
- There is increased confidence within the aged care sector that the needs of older adults are equally acknowledged and prioritised;
- Participating students have shown an enhanced understanding of complex pathways of care for older adults as they transition through home, to home care, to low, and high care needs.

Challenges

- Participating students expressed challenges they confronted in extending their role to the provision of capacity building education for remotely located residential care partners;
- Students required additional support as they learnt how to transition from hospital based models of care to a client centred primary health care model;
- Students initially struggled to understand a residents right to decline assessment and services within aged care philosophies and principles of autonomy;
• Students feel driven by curriculum requirements and expectations and experience anxiety when these priorities do not align to the needs, priorities and expectations of community partners.
Transferability of innovation

Traditional National and State health care approaches of ‘one-size-fits all’ have frequently resulted in mal-aligned and unsustainable services for rural, remote, and Indigenous communities. Externally driven health care services fail to respond to local/regional needs, priorities and aspirations.

The experiences of the BHUDRH have identified that the development of shared principles of engagement with local community stakeholders and community engagement in health service and workforce modelling provides a solid foundation for program development and sustainability. These programs offer a greater level of flexibility, adaptability, and responsiveness in program design and delivery and promote transferability of concepts to other communities with shared experiences of inequity.

The BHUDRH approach integrates the principles of community-campus partnerships with the educational pedagogy of service-learning and solutions focused activity. It is these approaches that have enabled the BHUDRH to engage meaningfully with a diverse range of stakeholders and this approach has resonated with other communities seeking to address their entrenched unmet health needs.

The BHUDRH is actively engaged with the Combined University Centre for Remote Health (CUCRH) in Geraldton Western Australia as they draw on the experiences of the Department in the development of their own school based speech pathology service-learning program. The program principles are shared however it is envisaged, and expected, that the CUCRH model will differ from that delivered in Broken Hill based on local/regional need, relationships, resources, and expectations.

The BHUDRH has also provided academic support to the Flinders University Katherine Campus as they seek to develop a similar program of activity in the Northern Territory to address speech, language and communication delays in the primary school setting.

The BHUDRH acknowledges that communities such as Katherine are confronted with additional challenges in the provision of speech pathology services to children where Australian Standard English may be a second, third or Kriol language. Additional strategies and resources may be required to integrate linguistic and speech initiatives.
The BHUDRH has also been approached by the Shepparton UDRH who has also expressed an interest in extending their body of work to include allied health service-learning placements that align to unmet community need in their region.

Research Approach

The BHUDRH has been working towards the development of a multi-faceted research program that will explore:

1. The impact for community members engaged in the paediatric service-learning program from an educational, health, and social perspective;
2. The impact on allied health students who participate in the service-learning program;
3. The implications for community agencies engaged in cross-sector community-campus partnerships and;
4. The impact on higher education institutions in engaging with remote communities to address contemporary challenges.

An Australian Research Council submission was lodged in November 2013 to support this research proposal. The submission has been supported by a number of key stakeholders at the local, state and national level including;

• Far West Local Health District, NSW Ministry of Health;
• NSW Department of Education and Communities and;
• Health Workforce Australia.

Successful applicants will be notified in June 2014.

National Implications

The BHUDRH acknowledges that service-learning models and strong community-campus partnerships may not be achievable in a number of rural, remote and Indigenous communities however at the national level there are 11 UDRH and 17 Rural Clinical Schools embedded across rural and remote Australia with a health service and workforce mandate. These entities provide a strong academic foundation and a considerable geographical footprint across some of Australia’s most marginalised regions and populations.
By adopting service-learning approaches and opportunities for pre-graduate health education that aligns to learning experiences that seek to address unmet community health need, these rural and remotely embedded academic entities have the potential to impact across a number of complex health inequities.

**Systems and Policy Implications**

Community-campus partnership and service-learning programs and approaches challenge traditional systems approaches to health care where activity is typically undertaken in isolation from communities and dominated by health agencies who then layer practices onto communities.

Community-campus partnerships place community leadership at the forefront of health service and health workforce development ensuring future health professionals have the skills and knowledge required to practice and deliver services in these locations.

Designing systems that support community leadership and cross-sector collaborations is critical to addressing unmet health need.

Moving from policy approaches that are prescriptive and inflexible to a principle focused approach is required to ensure rural, remote, and Indigenous communities are enabled to think differently about how best to identify and implement solutions to their needs.

**The Role of Higher Education and Accreditation Agencies**

Higher education institutions have a critical role to play in engaging more meaningfully with rural, remote, and Indigenous communities. There are increasing community expectations that these entities will play a meaningful role in supporting contemporary Australian communities to address challenging health, education, economic, and social inequities.

Many Australian universities have a rural, remote, and Indigenous commitment statement within their strategic mandates providing a platform for academic engagement in these regions. The challenge for universities is to ensure that their engagement with marginalised communities privileges these communities as much as the academic institution. UDRH and RCS can play a key role in facilitating academic partnerships across rural and remote Australian communities.
Universities have a key role to play in advocating for educational innovation in pre-graduate speech pathology coursework that embeds population health and primary health care practices into curriculum delivery. The additional challenge and potential opportunity for higher education institutions is to engage meaningfully with a broader cross-sector of community agencies in the development of clinical placement opportunities within these service settings enabling students to translate their theory into practice whilst making a valuable service contribution that seeks to ameliorate unmet health need.

Accreditation agencies need to be supported in their endeavours to ensure pre-graduate speech pathology students have access to meaningful population health experiences within rural, remote and Indigenous communities.

**Conclusion**

This submission has focused on the experiences of the BHUDRH as it has sought to engage more meaningfully with communities and key agencies in far western NSW in the development of health service and health workforce models that draw on innovative approaches, are evidence based service and education pedagogies, align to community need and expectation and centred around community engagement and leadership.

Other communities will have different approaches to addressing their speech, language, and communication needs and the Case Studies provided in this submission do not seek to detract from other innovative solutions, rather these case Studies seek to contribute to the national debate on rural, remote, and Indigenous speech pathology need and service access.

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