The Senate

Community Affairs References Committee

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

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44th Parliament

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACN	Australian College of Nursing
ADHD	Attention Deficit Hyperactivity Disorder
AEU	Australian Education Union
AIHW	Australian Institute of Health and Welfare
AISSA	Association of Independent Schools of South Australia
ASD	Autism Spectrum Disorder
CALD communities	culturally and linguistically diverse communities
CH.I.L.D.	Association for Childhood Language and Related Disorders
CL/P	Cleft lip / palate
DECD	South Australian Department of Education and Childhood Development
DHHS	Tasmanian Department of Health and Human Services
DSA	Down Syndrome Australia
ECIA	Early Childhood Intervention Australia
HCWA	Helping Children with Autism program
HECS	Higher Education Contribution Scheme
HWA	Health Workforce Australia
LDCs	Language and Development Centres
MCRI	Murdoch Children's Research Institute
MRBS	Medical Rural Bonded Scholarships
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NESB	Non-English speaking background

NHMRC	National Health and Medical Research Council
PDD	Pervasive Developmental Disorder
SES	socio-economic status
SPA	Speech Pathology Australia
TBI	Traumatic Brain Injury
THO	Tasmanian Health Organisation

LIST OF RECOMMENDATIONS

Recommendation 1

3.13 The committee recommends that the federal Department of Health in collaboration with key stakeholders consider the data that is currently available through the Research Centres, and the data that is necessary to identify the areas of current and prospective need. It should then consider where there are gaps, the need and the benefit of filling these gaps, and how this information could best be gathered.

3.14 The committee recommends that the federal Department of Health assess the need, the practicality and the likely cost of gathering further data through the Australian Bureau of Statistics. In particular, the committee recommends that the Department of Health carefully consider Speech Pathology Australia's proposals to gather more specific data on communication disabilities through:

- **the National Census;**
- **the Disability Services National Minimum Data Set; and**
- **Nationally Consistent Data Collection on School Students with Disability tool.**

Recommendation 2

5.77 The committee recommends that the federal government, in collaboration with state and territory governments and other key stakeholders, investigate the current service delivery model for speech pathology services in aged care residential homes in Australia. The federal government should seek information on:

- **the capacity—in terms of both skills and resources—of nursing staff within a residential aged-care facility to screen for communication and swallowing disorders;**
- **the number of speech pathologists directly employed by an aged care residential centre; and**
- **the number of residential aged care facilities that opt to contract out private speech pathology services, and of these, the number of cases—in a calendar or financial year—where a private speech pathologist has been contracted.**

5.78 On the basis of this evidence, the committee recommends that the federal government form a view as to whether these practices are compliant with aged care Accreditation Standards. The findings should be considered as part of the federal government's ongoing aged care reforms.

Recommendation 3

5.89 The committee recommends that the federal Department of Health work with the most relevant stakeholders to make an assessment of the financial cost, timeframe and research benefits of a project that maps language support services across Australia against the Australian Early Development Index information about vulnerable communities.

5.90 Pending an assessment of this proposal, the committee recommends that the federal government consider funding a project along the lines proposed. The findings of this research should inform future policy decisions to fund public speech pathology services in Australia. The findings should also guide private practitioners as to those locations where their services are most likely to be needed.

Recommendation 4

5.93 The committee recommends that the federal government provide funding and/or support for an appropriate research institute to conduct a thorough and systematic audit of the adequacy, strengths and limitations of existing speech and language services for children in Australia. The audit should consult with children's health and education providers, including but not limited to early childhood education and care centres, primary schools, secondary schools, speech and language therapists and special needs coordinators.

5.94 The committee recommends that this research proceed as soon as possible. The research would provide a foundation for the federal Department of Health to conduct its work into paediatric speech and language disorders.

Recommendation 5

6.22 The committee recommends that the federal Department of Health work with the National Disability Insurance Agency to develop a position paper on the likely impact of the National Disability Insurance Scheme (NDIS) on speech pathology services in Australia. The paper should consider:

- **the possible impact of the NDIS on the demand for speech pathology services in Australia, and the likely drivers of this demand;**
- **the need for greater numbers of trained speech pathologists as a result of increased demand for speech pathologist services arising from the introduction of the NDIS;**
- **the need for the speech pathology profession to develop telehealth practices to cater for NDIS participants requiring speech pathology services; and**
- **concerns that the withdrawal of State funding for speech pathology services in anticipation of the NDIS may leave some people worse off if they are ineligible to become an NDIS participant.**

The position paper should be circulated to key stakeholders for consideration and comment and to assist in decision making.

Recommendation 6

6.43 The committee recommends that the federal Department of Health develop a strategy aimed at broadening the opportunities for speech pathology students to undertake clinical placements that satisfy the profession's Competency-based Occupational Standards. The strategy should be developed in consultation with:

- **the relevant heads of Department from each of the 15 Australian universities offering speech pathology courses; and**
- **Speech Pathology Australia and a broad cross-section of its membership.**

Recommendation 7

6.51 The committee recommends that the federal Department of Health investigate the evidence of geographical and demographic clustering of speech pathology services in Australia. This investigation should look at:

- **the number of new graduates in speech pathology moving directly into the public health care system;**
- **the proportion of new graduates moving into regional and remote areas of Australia;**
- **the proportion of new graduates from regional universities (such as Charles Sturt) opting to remain in a regional area to practice; and**
- **the attitudes of those graduates who work in a regional or remote area of Australia following the completion of their studies, including:**
    - **the reason why they opted to work in a regional or remote location; and**
    - **whether they intend to remain working in that location; and**
- **the attitudes of those graduates who work in metropolitan areas following the completion of their studies as to:**
    - **the reason why they opted to work in a metropolitan location; and**
    - **the attractiveness of various financial incentives to encourage them to relocate to a regional or remote area.**

6.52 The committee recommends that this investigation should be considered in the context of:

- **the findings of the project to map language support services across Australia against the Australian Early Development Index (recommendation 3); and**

- **the findings of the proposed audit of the adequacy, strengths and limitations of existing speech and language services for children in Australia (recommendation 4).**

Recommendation 8

6.68 The committee recommends that the federal Department of Health, in collaboration with state and territory governments, Speech Pathology Australia, and other key stakeholders, prepare a position paper on the most appropriate model of service provision for speech pathologists working in:

- **early childhood intervention services;**
- **the education system;**
- **the justice system;**
- **the health system; and**
- **the residential aged-care environment.**

Recommendation 9

6.73 The committee recommends that the federal government commission a cost-benefit analysis of:

- **the current level of funding for public speech pathology positions. This should include:**
    - **the impact on individuals of existing waiting lists;**
    - **the limited provision of speech pathologists in the education, aged care and youth justice settings;**
    - **the impact on individuals where services are not available;**
    - **the impact of limited clinical placements and job opportunities for the speech pathology profession; and**
    - **the impact on the Australian community of underfunding these services.**
- **the various service delivery models proposed by the federal Department of Health (see recommendation 8).**

Recommendation 10

7.12 The committee recommends that the federal government working with state and territory governments, consider the costs to the individual and to society of failing to intervene in a timely and effective way to address speech and language disorders in Australia and address these issues in the development of relevant policies and programs.

7.13 The committee recommends that the federal government work with state and territory governments and stakeholders to ensure that parents and carers have access to information about the significance of speech and language disorders and the services that they can access to address them.

Chapter 1

Introduction

An overview

1.1 The capacity to communicate verbally is fundamental to a person's development and wellbeing. The ability to learn effectively, to form meaningful and supportive relationships, to influence others, and to obtain and maintain employment can be significantly affected if a person is unable to verbally communicate. Undiagnosed or untreated, a person who suffers from a speech or swallowing disorder is susceptible to poorer educational outcomes, reduced employment prospects and increased likelihood of social, emotional and mental health issues.[1] The personal cost to the individual, and to society at large, can be significant.

The establishment of this inquiry

1.2 On 9 December 2013, the Senate referred to the Senate Community Affairs References Committee (committee) an inquiry into the prevalence of different types of speech, language and communication disorders. A parliamentary inquiry along these lines had been advocated by the national peak body, Speech Pathology Australia (SPA), for some time. In June 2011, SPA National President, Ms Christine Stone, wrote to the committee noting that without Australian data on the prevalence of speech, language and communication disorders, 'it is impossible for government and health professionals to adequately plan and provide comprehensive prevention, promotion and therapeutic services to those individuals with communication and swallowing impairments'.[2] Ms Stone suggested that a parliamentary committee would be the right forum to advance these inquiries, and offered SPA's help in refining the scope and terms of reference for the inquiry.

The committee's areas of interest

1.3 The terms of reference for this inquiry are presented at the front of this report. In the first instance, this inquiry is concerned with the dimensions of speech and swallowing disorders in Australia. What are the types and symptoms of these disorders, and how do they affect the person's ability to function in everyday life? How prevalent are these types of disorders among children, among Aboriginal and Torres Strait Islander people, among people with disabilities and among people from culturally and linguistically diverse backgrounds? What data are available on these issues, and what is needed for policy makers and governments to understand the dimensions of the problem and frame an appropriate response?

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1 Speech Pathology Australia, *Submission 224*, p. 5.

2 Letter from Ms Christine Stone, National President of Speech Pathology Australia to the Committee Secretary, Senate Community References Affairs Committee, dated 24 June 2011.

1.4 The inquiry is also concerned with how effectively current demand for speech pathology services is being met. Are publicly funded and operated speech pathology services offered within Australian hospitals, clinics, schools, nursing homes and correctional centres, and are these adequate to meet current demand? What is the cost and the adequacy of private speech pathology services? And, moreover, what is the projected demand for speech pathology services in Australia?

1.5 These questions raise several others: how are families and carers alerted to the types of speech pathology services that are available in Australia; are they able to access speech pathology services when they need to; what are their travelling times to these services, particularly for people in remote regions; are they satisfied with the quality of the service that they receive; what are the out of pocket costs of private speech pathology services; how are people made aware of ancillary services?

The conduct of this inquiry

1.6 Shortly after the referral in December 2013, the committee called for written submissions by 21 February 2014. It received 305 submissions, which are listed at Appendix 1. Submissions were received from a wide range of stakeholders:

- the parents and grandparents of infants and children with speech and swallowing disorders;[3]
- adults who have either had a speech or swallowing disorder since birth or childhood, or who have acquired a disorder as a result of injury or stroke;[4]
- SPA, the peak body representing 70 to 80 per cent of practising speech pathologists in Australia;[5]
- speech pathologists operating in both the public system and in private practice;[6]
- leading Research Centres specialising in particular speech and language disorders and/or the incidence of these disorders among a particular demographic;[7]
- various Centres, Societies, Associations and Services representing a range of interests associated with speech and swallowing disorders, as well as disability advocacy groups;[8]

3 See submissions 89, 95, 103, 106, 108, 113, 115, 119, 166, 167, 179, 181, 183, 184, 189, 193, 198, 207, 211, 215, 219, 237, 241, 248, 249, 251, 252, 254, 281, 287–298.

4 See submissions 88, 102, 154, 162, 200, 205, 206, 246, 255, 267.

5 Submission 224

6 See submissions 62, 64, 83, 86, 91, 93, 94, 96, 99, 104, 127, 141, 144, 146, 148, 149, 151, 152, 232, 235, 238, 239, 242, 244, 245, 253, 264.

7 See submissions 121, 161, 169, 188, 263.

8 See submissions 90, 100, 117, 118, 120, 122, 123, 124, 130, 131, 132, 134, 155, 172, 174, 185, 209, 214, 216, 220, 222, 226, 230, 231, 233, 256, 259, 260, 269, 270, 275.

- a range of academic contributors, often comprised of multidisciplinary teams;[9]
- school principals, school teachers and representatives of parents associations;[10] and
- state government departments.[11]

1.7 These submissions are available on the committee's website. Where a child's name or photo was provided in a submission, it has been redacted to protect the child's identity.

The committee's public hearings

1.8 The committee held four public hearings:

- in Melbourne on 11 June 2014;
- in Sydney on 12 June 2014;
- in Canberra on 20 June 2014; and
- in Brisbane on 27 June 2014.

1.9 The public transcripts from these hearings are available on the committee's website.

The committee's site visits

1.10 The committee also conducted several site visits:

- In Melbourne on 11 June 2014, it visited North Melbourne Primary School where it met with students with developmental delays and several staff members including the school's speech pathologist, Ms Alison Clarke. As chapters 4 and 5 of this report discuss, it is not uniform for Australian states and territories to have a speech pathologist employed within a school. The North Melbourne Primary School demonstrates the progress that can be made where a school commits to funding a speech pathologist, and provides the person in that role with access to the teachers of students with speech, language and communication disorders.
- The committee then visited Parkville College, a school for juvenile offenders up to the age of 18 who have been remanded or sentenced to Custody by the Court. The committee met with the College's speech pathologist, Ms Laura

9 See submissions 15, 32, 53, 72, 73, 75, 81, 85, 97, 98, 105, 139, 160, 161, 169, 202, 203, 213, 217, 225, 234, 236, 257, 261, 262.

10 See submissions 65, 70, 71, 83, 90, 99, 107, 142, 170, 171, 177, 178, 228, 272, 286.

11 See submissions 111 (Tasmanian Education Department), 147 (South Australian Department of Education), 265 (Tasmanian Department of Health), 268 (Queensland Premier), 271 (NSW Health), 273 (ACT Chief Minister).

Caire, who noted the high incidence of speech and language disorders among the student population (see chapter 3). The committee highlights the uniqueness of the Parkville College set-up: it is the only youth custodial education facility to employ a speech pathologist to work on underlying language disorders;

- In Sydney on 12 June 2014, following the public hearing, the committee visited the Australian Stuttering Research Centre. The Centre's Director, Professor Mark Onslow, emphasised the importance of addressing a child's stuttering problem early in life. He noted the high success rate of early intervention and the long-term benefits of intervention, not only to the individual's wellbeing but to society as a whole. The Centre's research is world-leading;
- On 27 June in Brisbane, prior to the public hearing, the committee had the opportunity to visit the Glenleighden School in the suburb of Fig Tree Pocket. The school, which was established in the late 1970s, has as its principal aim to support children and young people with language disorders to achieve their educational and personal potential. At the school, the committee met with the Principal, Ms Cae Ashton, who facilitated a discussion between committee members and several parents of children attending the school. The committee was very impressed with the level of care provided by staff, and the range of multi-disciplinary programs offered by the school.

Acknowledgements

1.11 The committee is grateful to people and organisations that have helped the committee with its deliberations.

- Firstly, the committee extends its sincere thanks to the many individuals, parents, grandparents, family members and carers who made a submission to this inquiry. It appreciates their willingness to share personal accounts. These accounts are often heart-wrenching, but they are also offer hope that early and effective diagnosis and intervention can provide positive outcomes for both the sufferer and their family.
- Secondly, the committee thanks SPA for arranging the site visits and the organisations themselves for giving their time and insights. It is particularly grateful to the parents of students at the Glenleighden School who came to share their personal experiences with the committee (see above).
- Thirdly, the committee thanks SPA for its leadership during this inquiry. As mentioned earlier, the organisation proposed this inquiry in 2011 and since the referral late last year, has made itself available on many occasions to discuss matters of interest and concern with the committee and has provided written information on request.
- Finally, the committee thanks all those organisations who gave submissions and verbal evidence to the committee. The level of engagement from a wide range of stakeholders throughout this inquiry has been impressive.

Background

1.12 This report presents the key issues and themes that emerge from the submissions against each term of reference. The central themes are the strong demand for speech pathology services in Australia, the long waiting lists in the public system and the need to target speech pathology services to areas of high current and projected demand.

Types and causes of speech, language and swallowing disorders

1.13 Box 1.1 sets out the main types of speech and language disorders, and some of the possible causes of these disorders.

Box 1.1: Types of speech, language and swallowing disorders

- voice disorder: production of voice in speaking has disordered pitch, quality, loudness, resonance or when someone cannot sustain their voice
- stuttering: involuntary sound repetition
- cognitive communication disorders: result from underlying cognitive deficits due to neurological impairment. These are difficulties in communicative competence (listening, speaking, reading, writing, conversation, and social interaction) that result from underlying cognitive impairments (attention, memory, organisation, information processing, problem solving, executive function).
- developmental language disorders—trouble understanding others (receptive language), or sharing thoughts, ideas, and feelings completely (expressive language)
- aphasia—impaired ability to understand or use language (such as after a stroke)
- dysarthria—problem with the motor act of producing sounds given neurological disturbance (common among people with TBI, Cerebral Palsy)
- childhood apraxia of speech: problem with planning and programing of sounds, syllables, words
- dysphagia —swallowing disorders
- voice aphasia

Possible causes of these disorders

- cleft palate
- traumatic brain injury (TBI)
- Cerebral Palsy
- progressive neurological diseases: Parkinson's disease, Motor Neurone Disease, Multiple Sclerosis, Huntington's disease
- stroke—can result in aphasia or a language disorder
- head and neck cancers inside the sinuses, nose, mouth, salivary glands, pharynx and larynx
- autism, intellectual impairment,
- developmental delay, sensory impairment
- dementia
- FOXP2 mutation (genetic condition associated with childhood apraxia)

1.14 Box 1.2 summarises the process for accessing and claiming speech pathology services through Medicare Chronic Disease Management Items and the *Helping Children with Autism* Package.

Box 1.2: A general guide to accessing and claiming for speech pathology services

To claim a Medicare rebate for a speech pathology service (Chronic Disease Management Items), you must have received an Enhanced Primary Care Plan from a GP. Eligibility for an Enhanced Primary Care Plan is based on the presence of a chronic condition—one that has been present for six months or longer.

A GP will make the assessment for a Primary Care Plan and then make a referral to a speech pathologist. The client may request to see a particular speech pathologist or the GP may recommend one. (A person can self-refer directly to a speech pathologist but will not then be eligible for the Medicare rebate.)

For a rebate to be claimed, the speech pathologist must be registered with Medicare and have a Medicare provider number. A maximum of five sessions can be claimed per calendar year. These sessions may be with one health professional or a number of allied health professionals. A client may claim a rebate using an invoice provided by the speech pathologist.

The rebate is currently $52.95 for each 20 minute speech pathology session. The scheduled fee for a 20 minute session is currently $62.25, with the rebate calculated at 85 per cent of this fee. The speech pathologist may recommend a longer session and charge accordingly. There will be a gap fee—the amount between what the speech pathologist charges and the rebate. Ms Julie Carey (submission 64), a private speech pathologist, has noted that the cost of a standard consultation is around $180.

The client may not claim a Medicare rebate and a private health insurance rebate for the same service. The client must choose which rebate they are going to claim for a service. The fund *Health.com.au* offers a basic policy—with a fortnightly premium of $84 a fortnight—which covers 65 per cent of the cost of a speech pathologist up to a maximum of $200 in a calendar year.

Helping Children with Autism Package

The **Helping Children with Autism Package** is an initiative to assist families with children diagnosed with Autism Spectrum Disorder. Medicare rebates for specialist and allied health services are available to assist in the diagnosis and treatment of children with Autism Spectrum Disorder (ASD), or Pervasive Developmental Disorder [PDD]).

Up to four Medicare Benefit Schedule (MBS) services in total will be available for eligible allied health professionals, including speech pathologists, to collaborate with the referring practitioner in the diagnosis of a child (aged under 13 years) and/or the development of a child's PDD treatment and management plan.

A further 20 Medicare rebate services in total will also be available for eligible allied health professionals, including speech pathologists, to provide treatment to a child (aged under 15 years and who was under 13 years at the time of receiving their diagnosis from the specialist and the PDD treatment and management plan) for their particular condition, consistent with the treatment and management plan prepared by the referring practitioner.

The Medicare rebate for the Chronic Disease Management Items is different from that under the Helping Children with Autism Items. Source: http://www.speechpathologyaustralia.org.au/information-for-the-public/frequently-asked-questions

The structure of this report

1.15 This report has seven chapters:

- chapter 2 looks at why early and effective treatment of speech and language disorders is so important;
- chapter 3 examines the evidence on the prevalence of different types of speech, language and communication disorders and swallowing difficulties in Australia, and the incidence of these disorders by demographic group;
- chapter 4 presents the committee's evidence on the current and projected level of demand for speech pathology services in Australia;
- chapter 5 looks at the availability and adequacy (supply) of speech pathology services in Australia. It notes the evidence of gaps in this supply and the lengthy waiting lists for children to access services in the public system and for those seeking these services in rural and remote areas;
- chapter 6 examines the various factors that affect the supply of speech pathologists in Australia and proposes ways in which these obstacles can be overcome; and
- chapter 7 summarises the committee's recommendations.

Chapter 2

Why is early and effective intervention in speech, language and communication disorders so important?

2.1 It is fundamental to this inquiry's interest in speech, language and communication disorders to ask why it is so important that these disorders are treated promptly and effectively. What are the costs of doing nothing? More particularly, what are the benefits of early and effective treatment, not only for the individual sufferer but for society as a whole and the Australian taxpayer?

The costs of not acting or delaying intervention

2.2 It is clear from the evidence before the committee that failing to treat childhood speech, language and communication disorders contributes to significant lifelong problems. These include limited employment options often leading to periods of unemployment, a dependence on welfare, the psychological and emotional distress to the sufferer and their family and carer, and in many cases interactions with the justice system. Accordingly, diagnosing and addressing speech, language and communication problems in childhood are crucial to an individual's wellbeing and to the level of services and supports that society must provide.

2.3 Many submitters identified the societal costs from failing to address speech and language disorders. Speech Pathology Australia (SPA) wrote in its submission:

> Communication and swallowing disorders are largely invisible (even silent), poorly understood by the general community, and rarely addressed in public policy. The cost to affected individuals is measured in dollars, limitations to participation in the wider society, and in negative impacts on social and emotional wellbeing.
>
> There is a cost also to the wider community, a cost which can be measured in many ways. Untreated swallowing disorders give rise to increased costs in terms of length of hospital stay and people with undiagnosed difficulties are frequently referred to other health practitioners – often for expensive and invasive investigations – when a speech pathologist could readily manage the problem. Failure to adequately remediate communication problems in childhood adds to the support costs required throughout schooling. It also has implications for future employment, with associated costs likely in welfare payments. Problems related to over-use of the voice lead to costs associated with sick leave. Failure to recognise the high levels of communication problems in individuals within the justice system may contribute to increased costs associated with recidivism.[1]

1 *Submission 224*, p. 6.

2.4 Professor Mark Onslow, the Foundation Director of the Australian Stuttering Research Centre, explained the importance of early intervention in treating stuttering in children:

> Stuttering is a prevalent and disabling disorder of verbal communication that begins during the first years of life. If not controlled at that time it has subsequent educational, occupational, social and psychiatric consequences.
>
> Clinical trials have established an effective early intervention for pre-school children younger than 6 years that speech pathologists can use successfully during everyday clinical practice. This treatment can prevent these lifetime problems occurring later in childhood and during adolescence and adulthood. However, speech pathologists with their current level of service provision cannot meet the clinical needs of this prevalent patient population, and immediate planning for adequate health care services is essential for this public health problem.[2]

2.5 Professor Onslow emphasised that it is clear from recent research that psychiatric problems in adult stuttering patients have origins during the school years of life. In his submission, he noted that the speech pathology profession is not equipped to manage the psychiatric issues encountered by adult patients. He argued that 'immediate planning is required…so that these patients have ready access to clinical psychology services'.[3]

2.6 The Centre for Excellence in Childhood Language[4] wrote in its submission that 'early detection and intervention programs have economic and social benefits at the individual, familial, community and national level'.[5] Associate Professor Sheena Reilly was awarded the National Health and Medical Research Council (NHMRC) grant to establish the Centre in 2012.[6] At the public hearing in Melbourne, Professor Reilly gave evidence that adults (aged 34 years) who had a language

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2 Australian Stuttering Research Centre, *Submission 188*, p. 1.

3 *Submission 188*, p. 1.

4 The Centre for Excellence in Childhood Language incorporates research by the Murdoch Children's Research Institute, Deakin University and the Parenting Research Centre in Melbourne, as well as international collaborators at the University of Newcastle in the United Kingdom and the University of Iowa in the United States. The project is funded by the National Health and Medical Research Council until 2017.

5 *Submission 161*, p. 2.

6 Associate Professor Reilly currently holds various positions. She is Associate Director of Clinical and Public Health at the Murdoch Children's Research Institute, Professor of Paediatric Speech Pathology at the University of Melbourne, and Honorary Speech Pathologist at the Royal Children's Hospital. She has held an NHMRC Practitioner Fellowship since 2008 and is a Fellow of the Australian Academy of Social Sciences, the UK Royal College of Speech and Language Therapists and Speech Pathology Australia. Professor Reilly is also an Honorary Professor with the Australian Stuttering Research Centre at the University of Sydney, a Visiting Professor at the Neurosciences Unit with Institute of Child Health at the University of London and a Visiting Fellow at the University of Newcastle upon Tyne. *Submission 161*, p. 17.

impairment at the age of five have up to seven times higher odds of poor reading, five times higher odds of mental health difficulties and three times higher odds of unemployment.[7]

2.7 The Centre for Clinical Research Excellence on Aphasia Rehabilitation drew on various sources of clinical research to identify the impact of failing to treat aphasia. These are that:

- stroke patients with aphasia experience longer length of stays, greater morbidity, and greater mortality than those without aphasia and therefore incur greater costs;
- language and cognitive impairment have been found to be highly associated with difficulty communicating healthcare needs. The ability to communicate with healthcare staff is essential if patients are to receive adequate, appropriate and timely healthcare. People with aphasia are less able to communicate with healthcare staff and therefore less able to receive adequate, appropriate and timely healthcare in hospital;
- patients with aphasia have a higher incidence of depression (62 per cent to 70 per cent) than stroke survivors without aphasia. Caregivers of people with aphasia also have significantly worse caregiver outcomes than caregivers of non-aphasic stroke patients, with the increased risk of depression persisting over time;
- people with aphasia are much more likely to lose friends after stroke and social exclusion has been found to be a common experience for people with severe aphasia. Loss of friendships post-stroke has been found to contribute to long-term psychological distress; and
- research has revealed that family members of people with aphasia also experience changes to their functioning and disability as a result of their family member's aphasia.[8]

2.8 Brain damage from stroke and traumatic brain injury are the leading causes of aphasia. The National Stoke Foundation identified a range of potential side-effects from failing to treat swallowing problems following a stroke:

> Poorly managed acute swallowing care relating to stroke can lead to severe complications such as aspiration pneumonia, dehydration and malnutrition. This in turn can lead to chest infections, death, disability, longer hospital stays and increased number of discharges to nursing homes… This in turn has significant social and economic cost. Not treating communication deficits such as aphasia can lead to increased isolation and depression also increasing social and economic costs of stroke.[9]

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7 *Committee Hansard*, 11 June 2014, p. 17.

8 *Submission 169*, p. 5.

9 *Submission 233*, p. 5.

2.9 The committee received a submission from a group of researchers from the University of Sydney and the Murdoch Children's Research Institute which focussed on childhood apraxia of speech. This is a lifelong condition where the sufferer has difficulty learning to say new sounds and consistently use the sounds that they have learnt. The researchers' submission provided the following case study highlighting the impact of this condition on the sufferer:

> Trent (pseudonym) recently completed high school and received an excellent university entry rank, however, he has decided to become a dental appliance maker so that "I don't have to talk to anyone". Throughout his life Trent has had difficulty with verbal communication, despite above average intelligence and an intense desire to communicate. At 3 years of age, when his peers were starting to talk in simple sentences, Trent was only able to say 'ma' and 'da'. As the research literature repeatedly suggests, this very delayed oral communication was followed by delayed expressive language development, psycho-social distress, and bullying at school. At 18 years, he has had 1000s of hours of speech pathology treatment. His speech is now 80% intelligible to a stranger but only when he is concentrating, alert and calm. When he is tired or upset most people cannot understand him. His parents estimate that they have spent over $30,000 on private speech pathology treatment on top of maximum contributions from both their health fund and the public health system.[10]

2.10 The Peninsula Model for Primary Health Planning—Children's Health Alliance[11] (Alliance) and the Frankston–Mornington Peninsula Medicare Local emphasised the significant effects on the individual in later life from even mild to moderate speech and language delays in childhood. As it explained:

> Longitudinal studies demonstrate that delays set a poor trajectory for later learning across all areas of development. Communication skills are essential in all aspects of life including health and wellbeing, education and training, family and social relationships, recreation, and work. It has been documented that difficulties in communication skills may have major implications for school success, self-esteem, independence, teacher-student relations, peer relations, literacy and numeracy development, behaviour and problem solving, occupation, economic self-sufficiency and costs to society. The impacts on later life include early pregnancy, incarceration and poor vocational outcomes.[12]

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10 Associates Professors Patrica McCabe and Kirrie Ballard; Drs Angela Morgan, Elizabeth Murray and Alison Purcell; Ms Donna Thomas, Ms Jacqueline McKechnie and Ms Jacqui Lim, *Submission 225*, p. 1.

11 The Peninsula Model is a partnership model to support local service providers and other stakeholders work together in planning and improving primary health services across the Frankston and Mornington Peninsula catchment. The Model initiated the Children's Health Alliance. *Submission 134*, p. 3.

12 *Submission 134*, p. 15.

2.11 The Alliance emphasised that where intervention does take place, the benefits will be greater the earlier that it occurs:

> Interventions at a later stage are more costly and less effective. Early Speech Pathology interventions have been shown to result in significant improvements in a child's speech, language and self-esteem; foundations for successful longer term outcomes.[13]

2.12 Many submitters with children with speech and language disorders, as well as adults reflecting on their childhood, explained the effect of the disorder on the child. The mother of twin boys, both diagnosed with autism, Attention Deficit Hyperactivity Disorder (ADHD) and anxiety, wrote in her submission:

> Due to their lack of age-appropriate speech my boys were bullied, teased and often ostracised. Making friends was extremely difficult and the lack of communication often meant they would lash out physically, which in a mainstream school meant they would spend many a lunchtime in detention.[14]

The cost of inaction in Aboriginal communities

2.13 The committee heard that there are particular challenges in diagnosing and seeking treatment for speech and language disorders in Indigenous communities. Ms Sonia Schuh, a teacher-director at the Napranum Preschool in Weipa, told the committee:

> …there is something wrong with these kids. They are not speaking. Because it is not a physical disability or anything like that, I guess in our culture we do not see special needs as a big thing; we just take care of it. It is only that we have to diagnose it and label it before they go to school, so the school can get some funding to deal with our troubled kids. The parents would generally say: 'He's just a little bit off. He's a little bit crazy. Don't worry about him, as long he's not hurting anyone.' About 80 or 85 per cent of our kids have some kind of learning difficulty, and that is not to mention the big language barrier before going to school, because our community is Aboriginal English, not standard Australian English.[15]

2.14 In its submission to this inquiry, the Apunipima Cape York Health Council highlighted the links between communication impairments and incarceration rates in Indigenous communities in Australia. It wrote:

> The effects of communication impairments for people in the criminal justice system are linked with staggeringly high rates of hearing impairments. In correctional facilities in the Northern Territory, 94% of Aboriginal inmates had a significant hearing loss and 76% of these inmates reported communication difficulties with the criminal justice system as a

13 *Submission 134*, p. 15.

14 Name withheld, *Submission 95*, p. 1.

15 *Committee Hansard*, 27 June 2014, p. 53.

> result (Vanderpoll and Howard, 2012). Communication difficulties and inadequate verbal responses in criminal justice systems can be misinterpreted as rudeness or willful non-compliance and serve to further marginalise offenders. The high rates of hearing loss in the Northern Territory correctional facilities is likely related to there being more hearing loss and general disadvantage among Aboriginal people from remote and regional areas of Australia.[16]

2.15 The Apunipima Cape York Health Council argued the need for early intervention to focus on children at risk 'to ensure they have the best possible start in life and are provided with the foundations for future education'. It added:

> The social and economic costs of failing to provide early intervention for language disorders and the subsequent effects on poor education, poor employment prospects, disengagement and impacts on the health, welfare and criminal justice systems are huge. Comprehensive speech pathology intervention early in life in at risk populations provides an opportunity to reduce these costs in a preventative framework.[17]

The cost of inaction among young people

2.16 The committee received evidence of the high incidence of speech and language disorders among juvenile offenders. This subject is considered in chapter 3 of this report. It is important here to acknowledge the following evidence from Associate Professor Pamela Snow, a speech pathologist and psychologist from Monash University:

> Between 46 and 52% of young male offenders have clinically significant (yet previously undiagnosed) language disorders; such deficits tend to "masquerade" as poor motivation, disengagement, rudeness, and inattentiveness…
>
> The best "early intervention" that a child can receive is evidence-based reading instruction. Academic success can mitigate some of the other adversities present in the lives of vulnerable young people and promote their chances of breaking inter-generational cycles of poverty and social marginalisation. Speech Pathologists have knowledge and expertise that is directly relevant to the training of pre-service teachers and to the support of teachers in classroom settings, particularly with respect to children who struggle to make the transition to literacy.[18]

2.17 Associate Professor Snow added:

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16 The Apunipima Cape York Health Council, *Submission 126*, p. 14. Vanderpoll, T., & Howard, D. (2012). Massive Prevalence of Hearing Loss among Aboriginal Inmates in the Northern Territory. *Indigenous Law Bulletin*, pp 3–7.

17 The Apunipima Cape York Health Council, *Submission 126*, p. 14.

18 *Submission 32*, pp 2–3.

> There are many young people whose circumstances do not result in youth justice involvement but who never-the-less are educationally and socially marginalised and developmentally vulnerable as a result of undiagnosed or mis-attributed communication impairments. Such young people fail to achieve their potential and will make disproportionate demands on government-funded services, such as housing, mental health, substance abuse, and vocational training programs. Although prevention and early intervention are optimal, intensive and specialist services must be made available to vulnerable young people in their still formative adolescent and early adult years.[19]

The impact on older workers

2.18 In her evidence to the committee, Professor Reilly provided a graph showing the shift in the structure of workforce professions since the mid-1960s. In the mid-1960s, roughly 55 per cent of the Australian workforce was employed in blue-collar occupations, with 45 per cent of workers in white collar positions. By 2011, the proportion of blue-collar workers had progressively declined to around 30 per cent while the proportion of white collar positions had increased to around 70 per cent. Of course, the direction and the dimensions of this shift are common to most Western industrialised countries.[20] Professor Reilly told the committee:

> We talk about it being the shift from brawn to brain. There were a lot of jobs you could do if you did not have good language or you could not read. But those jobs have almost disappeared with automation. You cannot stack shelves now without using a scanner. You cannot drive a truck without reading a GPS.[21]

Committee view

2.19 The committee is concerned at the impact of these economy-wide changes on the employment prospects of older manual workers with language difficulties. It notes the comments of Dr Julia Starling, a lecturer in speech pathology at the University of Sydney, who told the committee that older people with language disorders may well have faced discrimination from school and throughout their working lives.[22]

Weighing the benefits against the costs of intervention

2.20 On the basis of the immediate and the long-term costs of failing to intervene, submitters underlined the importance of early and effective intervention. For example, the Centre for Cerebral Palsy (Western Australia), put the following argument:

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19 *Submission 32*, p. 4.

20 *Committee Hansard*, 11 June 2014, p. 17.

21 *Committee Hansard*, 11 June 2014, p. 17.

22 *Committee Hansard*, 12 June 2014, p. 22.

> The provision of speech pathology services is by no means a cheap option. The labour intensive interventions are resource intensive. However, on balance the provision of speech pathology services to those who need them is a less expensive option than the impact created by those who should receive the services but either opt not to have them or are unable to access them.[23]

2.21 The committee received some submissions that were glowing in their praise for the role of the speech pathologist. These accounts—as much as the costs of inaction—underline why early and effective intervention in speech language disorders is so important. A mother, whose daughter was diagnosed with the metabolic illness galactosaemia, wrote in her submission:

> The speech pathologist to whom I was referred was excellent. I honestly do not know what we would have done without her. She provided us with support in so many ways. In regard to my daughter's feeding she monitored her growth, health and nutrition intake, she answered the questions I had, she suggested techniques to try, she held a feeding group in order that my daughter may interact with her peers while eating, and she kept up to date with new treatments both nationally and internationally and applied these to the consultations. In addition, she suggested other avenues that may benefit such as meeting with an occupational therapist for example. When our family went overseas to follow a treatment in a clinic in the Netherlands she gave us much practical support and advice.
>
> In relation to my daughter's speech and language delay, the speech pathologist was extremely effective in improving my daughter's speech and language. The fortnightly consultation and the group consultations had a very positive effect in both areas. In addition, the speech pathologist provided me with the tools, techniques and activities for me to do at home with my daughter which was very helpful. My daughter started prep this year and had she not had the assistance of this speech pathologist her communication would have been far poorer and would have had a severe impact on her learning and socialising at school.[24]

2.22 Chapter 6 of this report returns to this issue of the social and economic cost of failing to treat communication and swallowing disorders. Chapter 7 makes a key recommendation to publicise the costs of inaction and the benefits of early and effective intervention. It is important here, at the outset, to recognise that the benefits of early and effective treatment of speech and language disorders extend not only to the individual and their family and carers. There are also benefits to society in terms of forgoing the costs that can arise from these disorders throughout life.

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23 Centre for Cerebral Palsy, *Submission 117*, p. 3.

24 Name withheld, *Submission 115*, p. 1.

Chapter 3

The prevalence of speech, language and swallowing disorders in Australia and the incidence of these disorders by demographic group

3.1 This chapter addresses the first two terms of reference for this inquiry:

- the prevalence of different types of speech, language and communication disorders and swallowing difficulties in Australia; and
- 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 lack of national data on the incidence of speech and language disorders

3.2 Data on the prevalence of speech and language disorders in Australia is patchy. The 2012 *Australian Survey of Disability, Ageing and Carers* conducted by the Australian Bureau of Statistics (ABS) found that there were 215 000 Australians under 65 years of age with a disability who require assistance with communication.[1] These are people with profound or severe core activity limitation.

3.3 The peak professional body, Speech Pathology Australia (SPA), which represents around 70 per cent of speech pathologists in Australia, estimated that there are over 1.1 million Australians with a communication disorder (around five per cent of the population).[2] It added:

> We consider that this is likely to be an underestimation, given that we have not included in this figure disorders where there is a known (or likely), but as yet unquantified, overlap with disorders that were counted. Within these figures, there is evidence that some specific groups—for example, Australians of Aboriginal or Torres Strait Islander descent, and people who are socio-economically disadvantaged—are over-represented. It is clear also that the figures will likely increase exponentially as the population ages.[3]

3.4 SPA argued in its submission that a figure on the prevalence of communication disorders across Australia is difficult because of the number of

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1 Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia, Summary of Findings 2012*, Catalogue Number 4430.0, http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0 (accessed 28 August 2014). Speech Pathology Australia, *Submission 224*, p. 21.

2 Speech Pathology Australia, *Submission 224*, p. 21.

3 Speech Pathology Australia, *Submission 224*, p. 21. See also Ms Gail Mulcair, *Committee Hansard*, 11 June 2014, p. 3.

specific disorders and the potential for overlap between these disorders.[4] SPA noted that there are many people who have difficulty communicating that do not have profound or severe core activity limitation. As the President of SPA, Professor Deborah Theodoros, explained at the Melbourne public hearing:

> One of the big problems with the collection of data is that communication disorders or swallowing disorders are not seen as the primary disability, and a lot of the data sets might be for people with hearing loss or the deaf population, or for the cerebral palsy population, or the autistic population, but the actual communication disability is the primary. Disability is embedded within those broader types of disability, and what we would like to see is that it becomes the primary disability and we get some data on the actual prevalence of that particular type of disorder. Clearly you cannot separate it entirely from the overarching disability, but I think that is part of the reason why we do not have that data—because communication disabilities and swallowing problems are embedded in other data sets.[5]

3.5 The Chief Executive Officer of SPA, Ms Gail Mulcair, told the committee that the organisation was 'doing a lot of work' with the ABS on the upcoming survey of people with disability in ageing and carers. She explained that the point of these discussions was to try to adapt some of the questions, or introduce others, such that information is gathered on the specifics on the communication disorder that people may have.[6]

3.6 SPA did note in its submission that there have been many 'high quality research studies' that have estimated the prevalence of a disorder by age group or disorder type.[7] The committee received submissions from the researchers involved in several of these studies, which noted and discussed the findings. This chapter and later chapters of this report draw on this evidence.

The need for improved data on the incidence of speech and language disorders

3.7 SPA argued in its submission that there is a need for better data on the incidence of speech and language disorders in Australia. It noted that while there are significant gaps in data for many populations, 'there is an even greater paucity of data for groups such as Aboriginal and Torres Strait Islanders, culturally and linguistically diverse populations and populations in correctional institutions'.[8] In evidence to the committee, Ms Mulcair stated:

> What we believe is necessary is, firstly, some comprehensive work across the whole of the Australian population in terms of identifying people who

4 Speech Pathology Australia, *Submission 224*, p. 21.

5 *Committee Hansard*, 11 June 2014, pp 10–11.

6 *Committee Hansard*, 11 June 2014, p. 4.

7 *Submission 224*, p. 21.

8 *Submission 224*, p. 79.

have speech, language, communication and swallowing problems, to fully understand the scope of the needs of people across Australia.[9]

Box 3.1: Speech Pathology Australia: recommendations on data resources

1. The Australian Government develop a framework to support collaboration across existing Centres of Clinical Research Excellence and other research groups which focus on specific cohorts, including, but not exclusively:

- Centre of Clinical Research Excellence: Aphasia;
- Centre of Clinical Research Excellence in Childhood Language;
- Australian Stuttering Research Institute;
- Centre for Community Child Health;
- Telethon Institute for Child Health Research; and
- Centre for Research Excellence in improving health services for Aboriginal and Torres Strait Islander Children.

2. The Australian Government commits to developing an approach to collection of data on communication and swallowing disabilities so that every individual who has a communication and/or swallowing disability is identified and may receive the supports needed to participate in life.

3. [T]he Australian Government work with Speech Pathology Australia to ensure that communication disability is conceptualised and adequately captured in National Minimum Data Sets and other universal standardised data collection methods relevant to the disability, education, health, aged care and justice sectors.

4. The Australian Bureau of Statistics in consultation with Speech Pathology Australia develops and includes questions in the National Census to gather data about the prevalence of communication and swallowing disability.

5. The Australian Institute of Health and Welfare works with Speech Pathology Australia and other stakeholders to improve the specificity of the data collected in the Disability Services National Minimum Data Set.

6. The Australian Bureau of Statistics work further with Speech Pathology Australia to refine categories and questions around communication limitation and primary disabilities, as they relate to communication in the Survey of Disability, Ageing and Carers.

7. The Commonwealth Department of Education review the Nationally Consistent Data Collection on School Students with Disability tool and explicitly include communication (including speech and language) disorders, recognised as a primary disability in their own right.

8. The Commonwealth Department of Health endorse the National Framework for Self Regulating Health Professions (which will include speech pathology), once this is finalised and released.

9. The Australian Bureau of Statistics includes an individual category of Speech Pathologists in the occupation data section of the National Census. Revision of the Australian and New Zealand Standard Coding of Occupations coding is required to separate Speech Pathology and Audiology at the Unit Group Level.

10.Health Workforce Australia and/or the Australian Institute of Health and Welfare (AIHW) determine/s that Speech Pathology is a priority profession for comprehensive workforce data collection and demand projections, and undertake a comprehensive analysis of the speech pathology workforce, including the availability (taking into account part time working), demand (current and future) and geographic spread of speech pathologists in Australia.

9 *Committee Hansard*, 11 June 2014, p. 3.

3.8 SPA argued the need for a 'standardised, coordinated and congruent approach to data collection'. To this end, it made ten recommendations which are presented in Box 3.1 (above).

3.9 The first of these recommends that the federal government develop a framework for the various research centres to collaborate on their findings. SPA told the committee that there are research centres around the country with 'very good data': '[W]hat is missing is an overarching framework or body who is able to pull that research material together.'[10]

Committee view on the need for more data

3.10 The committee believes that this is a practical, common sense and necessary recommendation that deserves the attention of government. Without question, the work and research output of these Centres is of an extremely high standard and should be used as much as possible.[11] However, it appears that what is lacking is a mechanism for these Centres to communicate in a structured way on—among other things—the data requirements of the profession. If the community is to benefit from the skill and professionalism of speech pathologists, it is crucial that there is accurate data on the prevalence of speech and language disorders, and the incidence of specific disorders by location and demographic group. The recommendations made later in this report underscore this imperative.

3.11 The federal Department of Health should consider—among other matters—the data that is currently available through research Centres and academic studies, and the data that is necessary to identify the areas of current and prospective need. It should then consider where there are gaps, the need and the benefit of filling these gaps and how this information could best be gathered.

3.12 As part of this discussion, the Department of Health should assess the need, the practicality and the likely cost of gathering further data through the ABS. In particular, the committee recommends that the Department of Health carefully consider SPA's proposals to gather more specific data on communication disabilities through:

- the National Census (point 4, Box 3.1);
- the Disability Services National Minimum Data Set (points 3 and 5, Box 3.1); and
- Nationally Consistent Data Collection on School Students with Disability tool (point 7, Box 3.1).

10 Ms Gail Mulcair, *Committee Hansard*, 11 June 2014, p. 3.

11 The committee has received written submissions and taken verbal evidence from many of these Centres and has been impressed with their work programs and detailed research output. It was particularly impressed with the work of Professor Mark Onslow of the Australian Stuttering Research Centre.

Recommendation 1

3.13 The committee recommends that the federal Department of Health in collaboration with key stakeholders consider the data that is currently available through the Research Centres, and the data that is necessary to identify the areas of current and prospective need. It should then consider where there are gaps, the need and the benefit of filling these gaps, and how this information could best be gathered.

3.14 The committee recommends that the federal Department of Health assess the need, the practicality and the likely cost of gathering further data through the Australian Bureau of Statistics. In particular, the committee recommends that the Department of Health carefully consider Speech Pathology Australia's proposals to gather more specific data on communication disabilities through:

- **the National Census;**
- **the Disability Services National Minimum Data Set; and**
- **Nationally Consistent Data Collection on School Students with Disability tool.**

3.15 The committee notes that some submitters expressed scepticism that government would address the need for Australia-wide data on the prevalence of speech and language disorders. Notably, the Australian Education Union (AEU) argued that governments are reluctant to discover the level of unmet need for speech pathology because 'this knowledge would create a public expectation that they do something about it'.[12] The committee does not believe that this is the case. It hopes that the government's positive response to the recommendations made in this report will demonstrate the federal government's commitment to understanding the dimensions of speech and language disorders in Australia.

The incidence of speech and language disorders by demographic group

3.16 The committee has received considerable evidence on the impact of speech disorders among children, Aboriginal and Torres Strait Islander people, people with disabilities and people from culturally and linguistically diverse (CALD) communities. Analysing these disorders by demographic group is important to identify the dimension and nature of the problem and to inform a public policy response.

Speech and language disorders among children

3.17 The ABS has gathered data on children with disability. *Children at School with Disability* (4429.0, Profiles of Disability, 2009) has a 'Core Activity Limitation' category titled 'communication difficulties'. It reported that 64 400 children with

12 *Submission 257*, p. 7.

disability attending school between the ages of 5 and 20 experienced 'communication difficulties'. The same survey also presents data by 'disability group' where one group is titled 'sensory and speech'. It found that there were 99 600 children between 5 and 20 years of age with a speech and sensory disability.[13]

3.18 The lack of ABS data and State data on children with speech and language disorder was a source of frustration for some submitters and witnesses. The AEU, for example, observed in its submission:

> There appears to be a lack of comprehensive national data on the extent of children and young people experiencing speech disorder problems and the level of access to speech pathology services. ABS data (such as Children at School with Disability 4429.0, Profiles of Disability, 2009) runs together sensory and speech disability into a single category group for data collection purposes. Data about the demand for speech services collected by Education Departments as part of their disability funding policies are a significant under-estimation of need. Students with speech difficulties who fall outside of the criteria for funding are not included in Departmental statistics. There is also no documentation of levels of parental use of private providers. Often parents use these providers because there is no timely access to publicly-funded providers.[14]

3.19 The AEU also noted the conclusion of Victorian Auditor-General's report into Programs for Students with Special Learning Needs that:

> DEECD (Department of Education and Early Childhood Development) does not know how many students in Victoria have unfunded special learning needs. It cannot identify these students nor can it determine if they are being adequately supported by schools.[15]

3.20 There have been some significant studies in Australia into the prevalence of speech and language disorders among children. In one of her submissions to the inquiry, Professor Sharynne McLeod of Charles Sturt University, summarised the findings of her study of 14 514 children across 44 schools in New South Wales. The study was conducted in two waves. Professor McLeod found that:

> There were 14 514 students in the first year of data collection (wave 1) and 14 533 students two years later (wave 2). Overall 5 309 (36.57%) students were identified as having some area of learning need in the first year and 4 845 (33.33%) students were identified 2 years later. Specifically, the areas of learning need (in order) were:
>
> - specific learning difficulty (17.93% in wave 1; 19.10% in wave 2)

13 Australian Bureau of Statistics, Profiles of Disability—Australia, 2009, Catalogue No. 4429.0, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4429.02009?OpenDocument (accessed 16 August 2014).

14 *Submission 257*, p. 7.

15 *Submission 257*, p. 7.

- communication disorder (13.04%; 12.40%)
- English as a second or other language (9.16%; 5.80%)
- behavioural/emotional difficulty (8.16%; 6.10%)
- early achiever/advanced learner (7.30%; 5.50%)
- physical/medical disability (1.52%; 1.40%)
- intellectual disability (1.38%; 1.20%)
- hearing impairment (0.96%; 0.80%)
- visual impairment (0.16%; 0.30%).[16]

3.21 Professor McLeod provided a table in her submission summarising the findings of 15 Australian studies on the prevalence of children with speech, language, and communication needs. The largest of these studies, in terms of sample size, was conducted by the Centre for Community Child Health and Telethon Institute for Child Health Research using the Australian Early Development Index. Using teachers' reports of 261 203 students, it found that 8.9 per cent of four to five year olds were developmentally vulnerable to language and literacy disorders, and 9.2 per cent were developmentally vulnerable to communication disorders.[17]

3.22 The Peninsula Model—Children's Health Alliance drew on various findings of Professor McLeod's research (published in 2007, 2008, 2009 and 2011) to present the following picture:

> The prevalence of speech and language impairment in school aged children is significant, with studies revealing that 13% of children at primary & secondary schools in Australia have communication impairment.[18] Other studies put this figure at a higher level (see below).[19] Communication difficulty in pre-schoolers predicts poorer educational and social outcomes at school age. Based upon 2013 Australian school enrolments approximately 474 000 school children currently suffer from communication impairment. Australian teachers report that 21% of school students have an expressive language difficulty upon entering schooling.

16 *Submission 72*, p. 2.

17 *Submission 72*, p. 2.

18 McLeod, S., & McKinnon, D. H. (2007), 'The prevalence of communication disorders compared with other learning needs in 14,500 primary and secondary school students', *International Journal of Language and Communication Disorders, 42* (S1), 37–59.

19 Harrison, L. J., McLeod, S., Berthelsen, D., & Walker, S. (2009). Literacy, numeracy and learning in school-aged children identified as having Speech and language impairment in early childhood. *International Journal of Speech-Language Pathology*, 11(5), 392–403. McCormack, J., Harrison, L. J., McLeod, S., & McAllister, L. (2011). A nationally representative study of the association between communication impairment at 4-5 years and children's life activities at 7–9 years. *Journal of Speech, Language and Hearing*, 54(5), pp 1328–1348.

> Furthermore, 16% have a receptive language difficulty.[20] Australian data also estimates that 14% of 15 year olds are unable to read at even a baseline level of proficiency, and 21% have only minimal reading proficiency.[21]

3.23 The Centre of Research Excellence in Child Language noted in its submission that the incidence of obesity in Victorian children (under the age of 14) is as high as the incidence of language impairment: 5 000 cases per 100 000 children. Further:

> Among four year olds, this can be as high as one in five (20 per cent), which equates to 50 000 Victorian children—the same number of obese children. These figures are thought to be nationally representative, equating to some 220 000 language-impaired Australian children. While obesity has been a National Health Priority area since 2007, Language Impairment is often not viewed as a disability of consequence, despite costly, persistent and far-reaching consequences…
>
> Of those four year olds with Language Impairment, around 2 per cent also have general learning disabilities while 7.5 per cent have a specific Language Impairment. Although children with Language Impairment come from all socio-economic backgrounds, Language Impairment is more common in children who live in a vulnerable or disadvantaged community. In the most socially disadvantaged populations, up to 50 per cent of children can have Language Impairment. For Aboriginal and Torres Strait Islander children, the figure may be higher still. We also know that more and more Australian children are being raised in culturally and linguistically diverse environments and that the wide heterogeneity in bilingual children's communication skills may also represent a subset of children with unique language needs.[22]

Speech and language disorders among young offenders

3.24 The committee received evidence on the high incidence of speech and language disorders among juvenile offenders both in Australia and internationally. Associate Professor Pamela Snow of Monash University, presented to the committee the following findings from her research:

> Between 46 and 52% of young male offenders have clinically significant (yet previously undiagnosed) language disorders; such deficits tend to "masquerade" as poor motivation, disengagement, rudeness, and inattentiveness. These language disorders are pervasive, compromising expressive and receptive language skills across all domains – vocabulary, narrative skills, ability to understand figurative (non-literal) language…

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20 Harrison, L. J. & McLeod, S. (2008, November). *School adjustment and achievement in children identified as having speech and language impairment at age 4-5 years*. Australian Association for Research in Education, Brisbane.

21 *Submission 134*, p. 8.

22 *Submission 161*, p. 5.

> There is a relationship between severity of offending (in particular convictions for violent offences) and the severity of language impairment…Young people who have been in out-of-home care via Child Protection orders face an elevated risk of language impairment (62%).[23]

3.25 In her testimony to the committee, Associate Professor Snow expanded on the motivation for, and implications of her research. In so doing, she noted that her findings were consistent with similar international research:

> Our research in Australia resonates very strongly with the international research carried out in the United States and in the UK that indicates that around 50 per cent—the percentages vary slightly, but broadly around 50 per cent—of young males in the youth justice system have a clinically significant but previously unrecognised language impairment. So they are actually operating in a clinical range when we administer standardised measures of everyday expressive and receptive language skills.
>
> Now that has clear implications in a number of realms. A key one for me, and a key one that informs some of the current research that I am doing, is around strengthening that early transition to literacy…
>
> But there are also implications for how we manage young people in the youth justice system with respect to the counselling services that they are provided with. Most forms of counselling are verbally mediated. Cognitive behaviour therapy is an evidence based counselling approach, but it does not get much more verbal than being asked to sit down and think and talk about your thinking with a very articulate clinician. So we operate therapeutically in a very verbal space with young people of whom 50 per cent, at least, have significant but unrecognised verbal deficits. One of the problems in classroom situations is that communication difficulties often masquerade as other behaviours, so they masquerade as disinterest, poor motivation, disengagement or rudeness, and then that can stand to further disadvantage the young person with respect to how they are viewed, how they are managed, how their behaviour is interpreted in the classroom. So we see very high rates of suspension and exclusion.[24]

3.26 Ms Laura Caire, the speech pathologist at Parkville College in Melbourne (see Box 3.2), noted in her submission that juvenile offenders with communication impairment face discrimination at every stage of the justice process, from when they are questioned by police, to when they are arrested and then in court. She noted the huge challenge of her role as a speech pathologist in a juvenile detention centre:

> Every day I come into work, I feel overwhelmed by the need I see around me, from the classroom to therapeutic interventions to the care provided in the residential units. Staff have genuine care and concern for the children in their care, and a strong desire to help these young people get back on track and create happy and productive lives for themselves, however often lack

23 *Submission 32*, p. 2.

24 *Committee Hansard*, 11 June 2014, p. 12.

> the awareness, knowledge and skills required to fully understand the extent of a young person's communication difficulties, the impact these difficulties have on their everyday functioning, and how to best facilitate optimal communication. Speech pathologists can help improve this situation through provision of assessment, consultation, training and treatment/intervention but only if there are enough to go around. Until more speech pathologists are employed, young people with communication impairment involved in the justice system will miss out on the intervention and support they desperately require.[25]

Box 3.2: Parkville College

On the recommendation of Speech Pathology Australia, on 11 June 2014, the committee had the opportunity to visit Parkville College in Melbourne. The College is a school for juvenile offenders, up to the age of 18, who have been remanded or sentenced to Custody by the Court. There are currently around 80 students.

The committee had the opportunity to speak with the College's speech pathologist, Ms Laura Caire. Ms Caire noted the high incidence of speech and language disorders among the student population. The committee commends the work that SPA and Parkville College have done in identifying the importance of how speech, language and communication difficulties are treated in youth justice systems.

Speech disorders among Aboriginal and Torres Strait Islander people

3.27 There have also been important studies into the incidence of speech and language disorders in rural and Aboriginal communities. Ms Debra Jones, Professor Michelle Lincoln and Assistant Professor Maeva Hall from the Broken Hill University Department of Rural Health, noted that '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'.[26] They observed that Indigenous children are particularly vulnerable to language and learning difficulties:

> 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

25 *Submission 26*, p. 4.

26 *Submission 105*, p. 12.

> young people are particularly vulnerable in their interface with mainstream English language dominant education systems.[27]

3.28 Several submitters highlighted the higher incidence of ear disease in Aboriginal communities than in the general Australian population. *Deadly Ears*, a Queensland-wide Aboriginal and Torres Strait Islander ear health program, noted in its submission that Aboriginal children experience ear disease earlier, and that the disease is more severe, persistent and frequent than their non-Indigenous peers.[28]

3.29 The Apunipima Cape York Health Council wrote in its submission that:

> 14.7% of children in remote Far North Queensland communities had Chronic Suppurative Otitis Media, with almost 25% of the children in Aboriginal predominant communities affected. World Health Organization (WHO) identifies an incidence greater than 4% as a public emergency and a massive public health problem requiring urgent attention.[29]

3.30 Ms Sonia Schuh, the Teacher-Director of Napranum Preschool in Weipa, told the committee that hearing and speech impairments are common among students at the school. As she explained:

> A lot of our children—I would say about 80 per cent—have some kind of learning difficulty related to hearing impairment and speech. With the otitis media, our wet season goes for six months, and you can tell the parents, 'Don't let them play in the sprinklers; keep them out of the rain,' but that is not going to happen. Usually all the surgery happens just before the wet season…and there is no way you can keep the kids out of the water at that time. So there is the hearing impairment with the kids, the runny ears and all that kind of stuff. It is all about the parents, for early intervention with the little ones—the nose blowing, all that stuff. You can only do so much of it when they are with you for, say, five hours a day at the school but then going home, going down the beach, playing in the sprinklers 24/7, at night-time, not blowing their noses properly. I would say it is about 80 per cent.[30]

3.31 A 2014 study by Professor Sharynne McLeod and Ms Sarah Verdon of Charles Sturt University found that there is a similar prevalence of speech, language and communication need for Indigenous and non-Indigenous Australians. In a joint submission to the inquiry, Professor McLeod and Ms Verdon contrasted the findings of this study with the findings of a 2009 study with Professor Linda Harrison. The 2014 Longitudinal Study of Indigenous Children (LSIC) was based on data from 692 three to five year-old Indigenous children; the 2009 Longitudinal Study of Australian

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27 Flinders University, *submission 75*, p. 2; Broken Hill Rural Department of Health, *Submission 105*, p. 12.

28 Deadly Ears, *Submission 130*, p. 1.

29 *Submission 126*, p. 11.

30 *Committee Hansard*, 27 June 2014, p. 53.

Children (LSAC) was based on data from 4,983 four to five year-old Australian children. Professor McLeod noted that:

> A similar number of parents of Indigenous Australian 3- to 5-year-olds in LSIC had concerns about speech and language skills compared with parents of 4- to 5-year-olds in LSAC (LSIC: 24.3% versus LSAC: 25.2%). "Speech not clear to others" was the area of highest concern for both groups (LSIC: 13% versus LSAC: 12.0%).[31]

Speech & language disorders in the culturally and linguistically diverse community

3.32 The committee received a second submission from Ms Sarah Verdon and Professor McLeod which concluded that:

> …there is a mismatch between the languages and locations in which speech pathology services are offered in Australia and the languages spoken by Australian children. Therefore, there is an inequity in the services available for Australian children who speak language other than English.[32]

3.33 The academics found that while 20.9 per cent of Australian paediatric speech pathologists in the study offered services in languages other than English, the languages spoken by these speech pathologists 'are not reflective of the most common languages spoken by Australian children'. Specifically, they note that 'multilingual speech pathology services were often not offered in the location of the children who speak those languages'.[33]

3.34 The Multicultural Disability Advocacy Association of New South Wales (Association) focused in its submission on the challenge of ensuring that people from a non-English speaking background are made aware of the speech pathology services that are available. The Association noted that currently:

> People from CALD / NESB [non-english speaking background] with disability, their families and carers often are not aware of the availability of supports and services due to a lack of culturally appropriate information available. The role of the service providers, who are the first point of contact, is essential in ensuring that pathology services are utilised to full capacity. Such service providers for example, general practitioners (GPs), need to have the ability to identify when there is a need for pathology services, then appropriately communicate the options that are available so as to get the best possible outcomes for each individual.[34]

3.35 The Association also emphasised that ongoing support is crucial to ensuring the best outcomes for people from CALD communities. It noted that one challenge in

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31 *Submission 73*, p. 1.

32 *Submission 187*, p. 1.

33 *Submission 187*, p. 2.

34 *Submission 191*, p. 3.

this regard is to ensure that strategies designed by speech pathologists for the home environment are properly communicated to carers.[35]

Prevalence by type of speech or language disorder

3.36 The committee also received evidence noting the prevalence of particular types of speech and language disorders in the Australian population. The Centre for Clinical Research Excellence Aphasia Rehabilitation, for example, made the following observation on the prevalence and incidence of stroke and aphasia in Australia:

- in 2012, 25 831 Australian males and 23 235 Australian females had a stroke;
- Aphasia has been estimated to effect approximately one third of first ever stroke survivors (Disability Policy and Research Working Group, 2011; Frattali, 2013);
- a recent Australian study reported that 37.2 per cent of acute stroke admissions to the Royal Perth Hospital over a ten month period had a confirmed diagnosis of aphasia;
- based on an incidence of 37.2% it is estimated that in 2012, there were 18 253 new cases of aphasia in Australia;
- in 2012, 420 000 people (1.77 per cent of the Australian population) were living with the effects of stroke; and
- assuming that Aphasia affects approximately one third of stroke survivors, and 60 per cent of this number still experience the effects of aphasia 12 months after their stroke, it is estimated that in 2012 between 93 744 and 156 240 Australians were living with the effects of aphasia.[36]

3.37 Professor Mark Onslow from the Australian Stuttering Research Centre noted in his submission that the first prospective cohort study of childhood stuttering was recently completed in Melbourne. Children were assessed before the onset of the disorder and cases of stuttering were diagnosed by experts. It found that at four years of age, one in nine Australian preschool children is stuttering. A United States Government report published in 2011 found that—from a sample size of 119 367 children—stuttering was present in two per cent of 3–10 year olds and 1.2 per cent of 11–17 year olds.[37] Professor Onslow noted that the lifetime cumulative stuttering

35 *Submission 191*, p. 3.

36 Centre for Clinical Research Excellence Aphasia Rehabilitation, *Submission 169*, p. 2.

37 Boyle, C., Boulet, S., Schieve, L., Cohen, R., Blumberg, S., Yeargin-Allsopp, M., et al. (2011). Trends in the prevalence of developmental disabilities in US children, 1997–2008. *Pediatrics, 34*, 385–395. Referred to in submission from Professor Mark Onslow, *Submission 188.*

incidence—the risk of being affected at some time during life—was estimated as 'at least as high as 10 percent'.[38]

3.38 Professor Leanne Togher, a speech pathologist at the University of Sydney, provided the committee with information on communication disorders from traumatic brain injury (TBI). She wrote:

> In Australia, there are more than 2 500 cases of moderate-severe TBI each year…Overall, TBI is most common in the very young (0–4 years) and the elderly (65+). Falls are a common reported cause in these groups (32%) as are sporting injuries (18%) (especially in school aged children). However, more serious brain injuries show a different distribution. In this case, males outnumber females 1:2 and the highest incidence occurs in the 15–24 year age group. Motor vehicle accidents are by far the most common cause of serious TBI in general and specifically in the peak (18–25) age group.
>
> …
>
> Communication disorders following severe TBI comprise a range of problems, the most common of which is cognitive communication disorders, which occur in up to 70% of cases. Cognitive-communication disorders are "communication impairments resulting from underlying cognitive deficits due to neurological impairment. These are difficulties in communicative competence (listening, speaking, reading, writing, conversation, and social interaction) that result from underlying cognitive impairments (attention, memory, organization, information processing, problem solving and executive functions)". This definition is based on the premise that basic language functions such as syntax and semantics are intact, by contrast to disorders such as aphasia and developmental language impairments, in which impairments in basic language functions are the defining characteristic.[39]

3.39 The Melbourne Cleft Service at the Royal Children's Hospital noted in its submission that in 2008, the Victorian Birth Defects Bulletin stated that clefting occurs in Victoria at a rate of 1 in 531 births. The number of cases per year ranged from 110 to 150. The Melbourne Cleft Service estimated that 'at any one time there are over 6000 individuals under the age of 18 born with CL/P receiving some form of treatment across Australia'.[40]

Committee view

3.40 The committee notes that considerable research has been undertaken in recent years in Australia into the prevalence of particular speech and language disorders and the incidence of these disorders among various demographics.

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38 Bloodstein, O, & Bernstein Ratner, N. (2008). *A handbook on stuttering* (6th Edition). Clifton Park: Delmar. Referred to in submission from Professor Mark Onslow, *Submission 188.*

39 *Submission 81*, p. 5.

40 *Submission 90*, p. 2.

3.41 It is clear from the committee's inquiry, however, that there needs to be greater capacity to consolidate these findings and assess the areas of overlap and where there are gaps. In the committee's view, this need is clearly indicated by the lack of Australia-wide data on the prevalence of speech, language and communication disorders.

3.42 Collecting and analysing Australia-wide data serves a clear policy objective and need. As the following chapters of this report emphasise, one of the key challenges for the speech pathology profession in Australia is to identify the areas of current and prospective unmet demand within schools, hospitals, aged care facilities, correctional services, and rural and remote communities (see chapter 4). The related challenge is to use this information to ensure there are adequate numbers of speech pathologists with the appropriate skills to meet this demand (see chapter 5 and 6). Both these challenges will require careful planning. The committee foresees an important role for the federal and state governments in collaboration with key stakeholders to lead in these processes.

Chapter 4

The demand for speech pathology services in Australia

4.1 The previous chapter's focus was on the prevalence and incidence of speech and language disorders in Australia. It found that, notwithstanding several studies into the prevalence of particular speech and language disorders and the incidence of these disorders among particular demographics, Australia-wide data is lacking.

4.2 This is an important starting point for this chapter's concern with the demand for speech pathology services in Australia. If there is no reliable data on the prevalence of these disorders in Australia, it is difficult to identify properly the dimensions of the demand for speech pathology services.

4.3 The committee has gathered anecdotal evidence from witnesses and submitters that the demand for public speech pathology services exceeds supply of these services. Many people join already lengthy waiting lists or, if there is no service, simply go without. The extent and cause of these waiting lists, particularly for paediatric speech pathology services, are discussed in detail in chapter 5 of this report. Much of the evidence in this chapter, on the strength of demand for services, foreshadows the themes of under-supply, under-service and unmet demand that are the focus of chapters 5 and 6.

4.4 This chapter discusses the following issues:

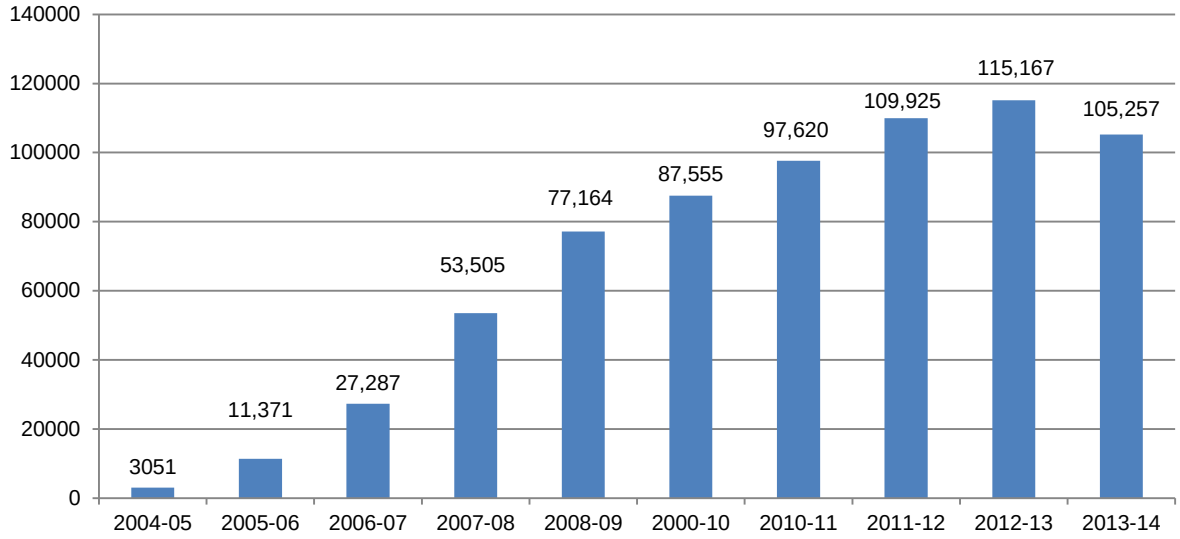
- the number of speech pathology Medicare service items;
- the lack of reliable data on the demand for speech pathology services;
- demand as reflected in public waiting lists;
- demand for private speech pathology services;
- demand for speech pathology services in rural areas;
- mapping demand for speech pathology services;
- the projected demand for speech pathology services in light of;
    - the National Disability Insurance Scheme;
    - public awareness and research breakthroughs;
    - an impact of an ageing population; and
    - efficient delivery of services through different models of care.

The number of speech pathology Medicare service items

4.5 Figure 4.1 (below) shows the number of speech pathology Medicare items processed for the calendar years of 2004 and 2013. The table is drawn from Medicare statistics, compiled by the federal Department of Human Services.

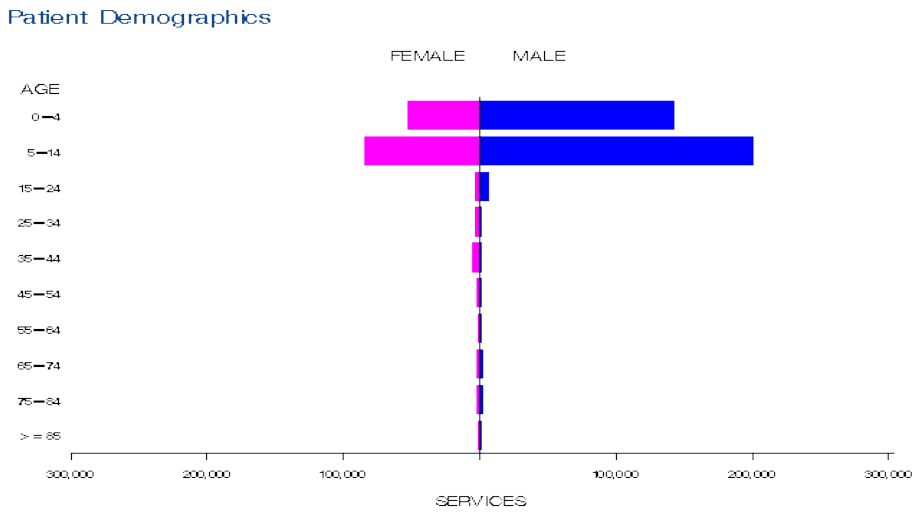
4.6 There has been dramatic growth in the number of speech pathology service claims made to Medicare. In 2004–05, only 3,051 speech pathology Medicare service items were reported; in 2012–13, this number had increased by a factor of 38 to 115 167. Over the last three financial years, however, there appears to have been a slowing in the rate of speech pathology services reported to Medicare. In the ten months to April 2014, the number of recorded speech pathology services was 105 257.

Figure 4.1: Number of speech pathology Medicare items—July 2004 - April 2014



Source: Department of Human Services, Medicare Statistics, https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml Item number 10970 (accessed 15 August 2014)

Chart 4.1: Medicare speech pathology services by age & gender, 2009– 2014



Source: Department of Human Services, Medicare statistics, *Item number 10970*, (accessed 15 August 2014)

4.7 Chart 4.1 presents reported speech pathology Medicare service items over the past five years (2009–2014) by age and gender. It shows that the overwhelming

majority of speech pathology Medicare services were in the 0–14 years of age category. Further, the number of boys receiving a service in this cohort outnumbered girls by a factor of more than 2 to 1. Over the period, there were roughly 50 000 girls in the 0–4 age cohort and 80 000 girls in the 5–14 age cohort, compared with roughly 140 000 boys in the 0–4 age cohort and 200 000 boys in the 5–14 age cohort.[1]

The lack of reliable data on the demand for speech pathology services

4.8 The exact dimensions of the demand for speech pathology services in Australia are not clear. There are several reasons for this, some of which are indicated in the following comments from (the now defunct) Health Workforce Australia:

> We do not at this point have particularly good data on expressed demand or on the occasions of service in speech pathology people are receiving. The areas you might look to as areas of expressed demand would be in the data from the private health funds although that will be incomplete because of capped amounts of services that receive support through private health. The national hospital morbidity data set would provide some information. Under Medicare, services are provided under the Chronic Disease Management plan but not otherwise. The ABS undertook an Australian health survey in 2011 and 2012 which sought to gain an understanding of access to services across a range of health professions. I do not have that data to hand.[2]

4.9 The 2011–12 Australian Bureau of Statistics *Australian Health Survey* does not provide a breakdown of the number of people who visited a speech pathologist in the previous 12 months.[3]

4.10 Some submitters argued the need to collect data on the demand for speech pathology services in Australia. The Tasmanian Department of Health and Human Services recommended quantifying this demand:

> …there is currently very limited data relating to the workforce and prevalence and treatment of speech related disorders in Australia. In the absence of adequate data regarding incidence rates, it is not possible to project future demand for services…
>
> the Tasmanian Department of Health and Human Services recommends that: further work be undertaken to quantify the demand for speech pathology services…[4]

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1 Department of Human Services, Medicare statistics, *Item number 10970*

2 Mr Benjamin Wallace, *Committee Hansard*, 20 June 2014, p. 2.

3 Australian Bureau of Statistics, *Australian Health Survey: Health Service Usage and Health Related Actions, 2011–12*, Catalogue No. 4364.0.55.002, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4364.0.55.002Contents2011-12?opendocument&tabname=Summary&prodno=4364.0.55.002&issue=2011-12&num=&view= (accessed 28 August 2014).

4 *Submission 265*, p. 7.

4.11 The Centre for Clinical Research Excellence Aphasia Rehabilitation identified the need for data on the incidence and prevalence of aphasia as 'essential to allow for adequate resource allocation and the formulation of realistic projections of future demand on aphasia services'. It noted that current estimates are often based on stroke figures with little information on the prevalence of aphasia arising from other causes such as Primary Progressive Aphasia.[5]

Demand as reflected in public waiting lists

4.12 One of the key indicators of pent-up demand for speech pathology services is the waiting list for these services. This issue is examined in detail in the context of the availability of services in chapter 5. It is worth noting here the following findings of a 2010–11 survey, conducted by researchers at the University of Sydney, of parents who sought access to speech pathology services:[6]

- parents reported being on long waiting lists with 25 per cent waiting more than six months, 15 per cent waiting more than 1 year for assessment and 18 per cent waiting more than 1 year after assessment for treatment;
- qualitative responses revealed concerns such as; a lack of available, frequent, or local services, long waiting times, cut-off ages for eligibility, discharge processes, and an inability to afford private services;
- parents were overwhelmingly happy with their treating speech pathologist and unhappy with the frequency, length and total number of treatment sessions received;
- parents in regional centres, and rural and remote locations were more likely to have difficulty accessing any services including private practitioners;
- children in capital cities attended private practices more frequently than those from small towns or rural and remote areas and children from lower socio-economic areas attended private practices less often than children from high-SES areas despite assistance from Medicare;
- public sector services were reported to provide less frequent services of shorter duration for fewer weeks than private practitioners and University clinics. This exacerbates the gap in access to speech pathology for disadvantaged families;
- eighty per cent of parents indicated they would like their children to receive individual sessions however many reported only being offered group therapy or parent delivered home therapy. Only four per cent of parents indicated that they would like such parent training or a home program;
- the most commonly preferred session frequency was once per week;

5 Centre for Clinical Research Excellence in Aphasia Rehabilitation, *Submission 169*, p. 6.

6 Associate Professors Patricia McCabe and Kirrie Ballard, and Dr Natalie Munro, *Submission 85*, pp 1–2.

- children were most commonly reported to be discharged from speech pathology services at age 5–6 years across all states and territories. Sixty per cent of parents believed that their child's discharge was inappropriate for reasons such as 'Child had not improved enough'; and
- parents were angered that their children had become ineligible for public services at a certain age, particularly if they had endured a long waiting list only to reach the upper limit of services soon after.

4.13 The following selection of quotes—from practising speech pathologists, occupational therapists and teaching staff—offers another perspective on the strength of demand for speech pathology services:

> In my position as learning support coordinator I have had contact with a number of Speech Pathologist (sic). I have always found these professionals to be extremely helpful and supportive of what we as a school are implementing for particular students…The greatest difficulty experienced is the wait time for the service to have an assessment; this is due mainly to demand.[7]
>
> In each setting I have worked in, there are barriers to accessing the service. In private services, this is obviously the cost of accessing the service. Many families, who are vulnerable and most need the supportive services, are prevented from accessing a health service…Within public services, long waiting lists and demand exceeding supply.[8]
>
> I have never worked in a service that didn't have some sort of waiting time to access speech pathology services. In multi-disciplinary services, the speech pathology waiting list was always the longest. This is due to the fact that most children with developmental difficulties will have some level of communication and / or feeding difficulty which are often parents' primary concern. It is not uncommon for public services to have waiting lists of up to or over 12 months.[9]
>
> [There is] difficulty [in] increasing service provision even with documented evidence that the demand is increasing. Even with documented waiting lists and increased referral rates, it is difficult to obtain increased funding to meet these demands.[10]
>
> Client access to Speech Pathology Services is impacted by cost, location and availability. Limited funding for Speech Pathology Services within the public health care system equates to limited access with long waiting lists and a need to discharge clients quickly from services.[11]

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7 Name withheld, *Submission 142*, pp 1–2.

8 Ms Monique Thompson, *Submission 146*, p. 1.

9 Name withheld, *Submission 148*, p. 2.

10 Name withheld, *Submission 148*, p. 2.

11 Ms Ellie Thompson, occupational therapist, *Submission 152*, p. 1.

> The demand for Aspect's [Autism Spectrum Australia] services is continually increasing and we endeavour to respond rapidly to requests for service; however, this is not always possible. We currently have a waitlist of 150 families with children aged zero to eight waiting for service. A further 700-plus children are waiting for school based programs. Families with young children may have to wait up to three months to commence service, and Aspect will only be able to respond to a small proportion of those waiting for school based services. The principal barriers to accessing Aspect's services are location, availability of government funding and families' financial capacity to purchase services…We are of the view that there are significant opportunities to improve the availability of speech pathology services across Australia to assist people with communication impairments.[12]

> The demand for therapy became so great and waiting lists so long that some parents of young children entitled to funding were highly distressed to find that they could not receive services before their child turned 6 and aged out.[13]

> Most schools get only very limited funding for students with autism (I will use our school as an example. In 2013, we had 12 children diagnosed with an ASD but only 4 funded and of these only 3 were funded on the basis of autism). This means that access to speech therapy is either non-existent or again, comes from school's SRP [global budget] if schools can afford a private practitioner. (Metro Primary School)[14]

4.14 The Sydney-based not-for-profit organisation, Northcott, argued in its submission that in its experience 'there is extreme unmet demand for one-to-one, individual speech pathology services for school children'.[15] The Australian Education Union noted in its submission that:

> There is anecdotal evidence from teachers and principals that the level of demand for speech pathology services is rising. They report an increasing number of students identified as having speech and language difficulties who require some form of intervention and support.[16]

4.15 The committee also received evidence on the type of conditions for which services are in high demand. Dr Gabriella Constantinescu, a lead researcher at the paediatric Auditory-Verbal and Implantable Technologies organisation *Hear and Say*, told the committee that there is high demand for chronic middle ear pathologies. She argued that funding support should reflect this level of demand and there needed to be

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12 Mrs Catherine Vardanega, *Committee Hansard*, 12 June 2014, p. 29. See also Mrs Catherine Vardanega, *Submission 172*.

13 The Anne McDonald Centre, *Submission 231*, p. 5.

14 Australian Education Union, *Submission 257*, p. 9.

15 *Submission 190*, p. 1.

16 *Submission 257*, p. 6.

increased education at all levels of the medical, allied health and general community about the risk of delays in spoken language. Dr Constantinescu told the committee that:

> When looking at microtia and atresia, which is earlobe and canal malformations, there is also a definite need for intervention. As these children have primarily unilateral hearing loss, Better Start funding is not available for them; therefore, they are currently underserviced. We think that increased awareness of the condition is needed as well as a range of options and services and, alongside those, increased funding to support the services.[17]

Demand for private speech pathology services

4.16 The demand for private speech pathology services is also high. For those able to afford it, private pathology services appear readily accessible, at least in metropolitan regions. However, the cost of these services is a barrier to meeting the high demand for them. The Australian College of Nursing (ACN), for example, argued that these costs were deterring people in aged care from seeking assistance:

> ACN members who work in aged care have indicated that private speech pathology services are underutilised due to high costs. Speech pathology services are often used only for acute problems experienced by older people and rarely accessed for their treatment plans, rehabilitation or ongoing therapy.[18]

Demand for speech pathology services in rural areas

4.17 Identifying the demand for speech pathology services in rural areas is potentially a more challenging task than mapping demand in metropolitan regions. In cities and larger regional centres, the services—both public and private—are typically there which means that the services used and waiting lists are a rough proxy for demand. In rural and remote regions, however, services are often not there (see chapter 5). There will be people who, despite needing a speech pathologist, will forego the time and expense of travelling to access a service. It is difficult to identify this unmet demand.

4.18 Ms Debra Jones, the Director of Primary Health Care at the Broken Hill University Department of Rural Health, commented in her evidence to the committee on the extent of demand in rural and remote areas of Australia for speech pathology services. She began by noting the difficulty of tracking latent demand:

> Traditionally, where you do not have a service, it is very hard to map who is not accessing a service—if there has not traditionally been one there. One of the other interesting things about identifying unmet need is that a lot of

17 *Committee Hansard*, 27 June 2014, p. 24.

18 *Submission 192*, p. 3.

> public health facilities will have referral based systems. When clients or families do not present for referral, they are classified as 'failed to attend' or 'did not attend' and then can be removed or discharged from service without actually being engaged in service. So the concept of having a waiting list can be quite skewed…
>
> I think what was also interesting was that because there was this culture of not expecting there to be a service, what would you refer to then? Parents were typically giving up on trying to actually access a service. Getting very distinct numbers is a real challenge, especially where families feel really disillusioned by lack of access, challenges in access or lack of responsiveness of access. The language of 'failed to attend' or 'did not attend' is really concerning language for me. That is because typically it means that we have failed to be able to respond in appropriate ways to communities and especially our more remote communities. That language opens up some really interesting philosophies on practice and how we provide services, especially around speech, language and communication.[19]

4.19 Ms Jones gave the committee an overview of the challenges that people living in regional and remote areas face in accessing speech pathology services. In the first instance, she noted, there is a reliance on 'fly-in fly-out' general practitioners to diagnose a speech or language communication need. Once the need is diagnosed, there is often difficulty getting to the service 'especially when you are talking about travelling up to two and a half hours, one way, to a larger regional centre to access those services'. Private speech pathologists' services are often beyond the financial means of her patients.[20] Where a public speech pathologist does offer a service in town, it is often on a short-term basis. As Ms Jones told the committee:

> …prior to 2008–09, when we started thinking about working up our service learning speech pathology model, our conversations with our public health colleagues were very much around huge unmet need, huge waiting lists and lots of tension and frustration in communities. That was about not being able to access a service. There was also turnover and fragmentation in staffing. We were in a cycle where we would have speech pathologists come, but for very short periods of time. We were seeing a cycle of assessment, but limited therapy intervention. There was assessment, re-assessment, assessment, re-assessment, referral, re-referral and referral for service access.[21]

4.20 Ms Sarah Verdon, Dr Linda Wilson, Dr Michelle Smith-Tamaray and Dr Lindy McAllister argued in their submission that there was a distance for people living in Victoria and New South Wales beyond which they were unwilling to travel to access speech pathology services. The researchers noted that nearly a third of health

19 *Committee Hansard*, 12 June 2014, p. 41.

20 *Committee Hansard*, 12 June 2014, p. 41.

21 *Committee Hansard*, 12 June 2014, p. 41.

services in their sample of 13 237 rural localities in NSW and Victoria were outside this distance:

> Using the recommended service frequency of weekly and the recommended maximum travel time for a weekly service of 30 minutes a Critical Maximum Distance of 50kms was calculated for rural NSW and Victoria…
>
> 29.3% of localities were outside of the critical maximum distance for accessing speech pathology services.[22]

Mapping demand for speech pathology services

4.21 One of the challenges for service providers is to gather reliable information on the extent of demand for speech pathology services in particular areas. Ms Elizabeth Forsyth of Northcott told the committee that her organisation would like to be able to offer speech therapy services in areas of regional New South Wales. When asked to comment on the need for speech pathology services in these areas, she responded:

> [A]necdotally, we encounter families that tell us that they require a range of allied health therapy services. Whether that is speech pathology specific I probably cannot say, but certainly families identify the need for those services. Clinically whether they need them or not, again, I cannot say because we do not have that detailed analysis. I think part of the problem broadly in the disability sector is being able to get accurate data on the unmet need. There is no mechanism to capture that, and that makes it hard for planning and for rollout of services.[23]

4.22 Speech Pathology Australia (SPA) argued in its submission that there needs to be more detailed information on the demand for speech pathology services so that providers can plan to meet these needs. It noted:

> [T]he current lack of a detailed profile of the needs of people with communication or swallowing disability limits the planning for and provision of services to ensure the needs of individuals can be met and long term outcomes optimised.
>
> Detailed service needs analysis and demand mapping is required to ensure those with communication or swallowing disability can access vital intervention and supports to optimise their future educational, health and social outcomes.[24]

4.23 SPA recommended that Health Workforce Australia and/or the Australian Institute of Health and Welfare (AIHW) undertake a comprehensive analysis of the speech pathology workforce, including the availability (taking into account part time

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22 Ms Sarah Verdon, Dr Linda Wilson, Dr Michelle Smith-Tamaray and Professor Lindy McAllister, *Submission 186*, p. 2.

23 Ms Elizabeth Forsyth, *Committee Hansard*, 12 June 2014, p. 4.

24 *Submission 224*, p. 1.

working), demand (current and future) and geographic spread of speech pathologists in Australia.[25] Chapter 5 of this report addresses this recommendation.

4.24 The committee was impressed by the level of detail on projected demand provided in a submission from the South Australian branch of Speech Pathology Australia. The submission made the following observations about the demand for paediatric and early intervention services in the Adelaide metropolitan area:

> Adelaide metropolitan growth is occurring at the extreme ends of the metropolitan area. Services are not being relocated to these areas as the population increases. An example of this is the growth in the Playford Council area in the Northern end of Adelaide:
>
> - Children 0 to 4 years increased by 1 440 from 2006 to 2011 with no increase in the Primary Health speech pathology positions.
> - In the Playford Council area the Australian Early Development Index identified 18.1% of children as being vulnerable in the Communication and General Knowledge domain.
> - This means that since 2006 there are approximately 260 extra children requiring access to speech pathology services (18% of 1 440).
>
> The increasing demand in disadvantaged communities like Playford Council area may be more efficiently serviced should speech pathology staff be employed to build capacity amongst teachers and child care staff so they understood how best to support speech and language development.
>
> Further, 50% of three year old children in Australia are in formal child care and an increasing proportion of children aged 0–4 years attend out of home care. Building the capacity of these environments to support the development of children's communication abilities would help address communication and developmental needs at a population level and also help support children who are not able to access speech pathology services for a range of reasons.[26]

4.25 The committee believes that this type of analysis should be conducted in a thorough and methodical way across metropolitan, regional and remote areas of Australia. Chapter 3 of this report made recommendations to support this research.

Projected demand for speech pathology services

4.26 The terms of reference for this inquiry direct the committee to examine the projected demand for speech pathology services in Australia. The committee gathered various perspectives on this issue, but the differences related mainly to the quantum of the expected increase (rather than whether there will be an increase).

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25 *Submission 224*, p. 14.

26 Speech Pathology Australia, South Australia Branch, *Submission 226*, pp 6–7.

4.27 This section considers some of the reasons why submitters believe that demand for speech pathology services in Australia will increase in future years. SPA identified the following drivers:

- the effects of an ageing population;
- improved survival rates of premature, chronically ill and infants with disability;
- an increase in the detection of early speech and language disorders; and
- the increase in opportunities to provide support to participants of the National Disability Insurance Scheme.[27]

The National Disability Insurance Scheme

4.28 The table below shows the speech pathology services and speech pathology equipment that is currently being offered in the National Disability Insurance Scheme (NDIS) trial sites.

Table 4.1: Speech pathology services and speech pathology equipment supports offered by National Disability Insurance Scheme, 12 May 2014[28]

Support	Description	Price*
Speech and Language pathology with an individual	Optimise ability to understand information and communicate thoughts and needs. Assistance to ensure safe and effective mealtime support for participants with difficulty feeding / swallowing	$168.26 per hour
Speech and language pathology in a group	Optimise ability to understand information and communicate thoughts and needs. Assistance to ensure safe and effective mealtime support for participants with difficulty feeding / swallowing	$56.09 per hour
Speech and language pathology distance travel	Travel to participant to and from either providers work location where travel is more than 10kms	$168.26 per hour
Voice generators	Device held to neck which picks up vibrations and amplifies as speech	$650 each
Voice amplifiers for personal use	Device to amplify voice	$400 each

* Prices are the same in each of the trial sites

4.29 Many submitters identified the NDIS as a driver of increased demand for speech pathology services. Exactly how much extra demand the Scheme will create is not clear at this stage. As the Queensland Government stated: 'there is insufficient

27 *Submission 224*, p. 82.

28 National Disability Insurance Agency, *Support clusters definitions and pricing*, 12 May 2014 http://www.ndis.gov.au/document/875 (accessed 1 August 2014).

information to make an analysis of how much additional funding might be required, or how many additional speech–language pathologists might be needed'.[29]

4.30 National Disability Services foresaw an increase in demand for speech pathology services arising from the NDIS but did not comment on specifics:

> Increased demand for speech pathology will also arise from the NDIS improving the access that adults with disability have to therapy services. In the case of speech pathology, it is expected that some adults with long-term disability will have improved access to communication services and equipment, and to services such as the treatment of swallowing disorders (dysphagia). Assessing and treating communication disorders improves a person's quality of life and improves their ability to participate in the community and to work; diagnosing and treating dysphagia reduces the incidence of chest infections and pneumonia. Appropriate access to speech pathology services will, therefore, improve people's lives and reduce acute health care costs.[30]

4.31 Northcott envisaged that the increase in demand for NDIS speech pathology services will require more speech pathologists and will challenge the profession to devise new models of practice and service provision:

> The expansion of the NDIS to cohorts of people who have previously missed out on speech pathology services (e.g. adults), and the sheer increase in funding in the sector under the NDIS, is likely to significantly increase the demand for speech pathology services in Australia. The increase in demand for speech pathology services under the NDIS also highlights a major workforce issue within the disability sector, where the current challenges in the supply of speech pathologists available will only be compounded. Significant workforce development investment, flexibility in contractual and industrial arrangements, and exploration of new models of practice and service provision, must be considered for the sustainability of speech pathology (and arguably all allied health professional) services under the NDIS.[31]

4.32 Early Childhood Intervention Australia (ECIA) argued in its submission that the need for—and the shortage of—speech pathology services for very young children is evident from the federal government's decision to introduce the *Better Start* and *Helping Children with Autism* initiatives (see chapter 4). However, it argued that tight eligibility for these programs has meant there is still unmet demand which needs to be addressed prior to the full introduction of the NDIS (in 2018–19). ECIA anticipated a

29 *Submission 268*, p. 4.

30 *Submission 180*, p. 2.

31 *Submission 190*, p. 8.

significant increase in demand for speech pathology services for children from the broader eligibility requirements of the NDIS.[32]

4.33 Down Syndrome Australia (DSA) foresaw that the advent of the NDIS will 'substantially' increase the demand for speech therapy services among people with Down syndrome. It noted the higher demand will result from the Scheme's closer targeting of service provision to need. Currently, there is a clear lack of services provided to:

- children over the age of 7 who have no access to Better Start funding;
- children at independent and private schools in some states and territories;
- teenagers and adults with Down syndrome who would benefit from speech therapy but currently have little or no access to services; and
- toddlers and babies in some states or territories where access to early intervention, particularly for children under the age of 2 is lacking.[33]

4.34 To some extent, the NDIS may stimulate demand by raising awareness of speech and language disorders. The Association for Childhood Language and Related Disorders (CHI.L.D.) noted that this trend may already be occurring:

> While evidence suggests that the incidence of primary language disorder has not increased over time, it is possible that increasing awareness of the condition at earlier developmental stages in conjunction with increasing awareness of other developmental disabilities (such as autism spectrum disorder) has increased the demand for services and specific intervention before and during school.[34]

Public awareness and research breakthroughs

4.35 Professor Mark Onslow from the Australian Stuttering Research Centre commented that Australian clinical research into the treatment of stuttering among 7–17 year olds will place pressures on the public waiting lists for speech pathologists. By his estimates, the fruits of this research are 'inevitable' with 'convincing randomised controlled trials to be completed 'within this decade'.[35]

4.36 In its submission, Autism Queensland did not identify what was driving the significant higher level of diagnosis of autism spectrum disorder, but it did highlight the likelihood of growing demand for speech pathology services. It put the following view:

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32 *Submission 256*, p. 2.

33 *Submission 260*, p. 16.

34 *Submission 170*, p. 3.

35 *Submission 188*, p. 5.

> The prevalence of children diagnosed with ASD has increased dramatically in the past two decades. Where a prevalence rate of around one in 2000–2500 was widely accepted until the 1990s (Baird et al., 2006), a recent American study revealed a prevalence rate of 1 in 88 (Centers for Disease Control and Prevention, 2012). Given this escalating prevalence rate, and the fact that speech pathology is the most widely used service in this field, the demand for speech language pathologist for individual (sic) with ASD and their families is likely to continue to grow.[36]

An ageing population

4.37 Several witnesses and submitters identified the ageing of the Australian population as a key driver of increased demand for speech pathology services. The Queensland Government was one of these submitters:

> With a growing ageing population, the demand for speech–language pathology services from conditions such as stroke or dementia will likely increase. Specifically, the population of people with a disability are also living longer and thus there is a need for specialisation in speech–language pathology for older adults for speech and swallowing difficulties.[37]

4.38 The National Stroke Foundation identified significant prospective demand for speech pathology services among Australian stroke survivors. It noted that in 2012, there were around 420 000 Australians living with the effects of stroke, which is expected to increase to 709 000 by 2032. The Stroke Foundation estimated that if the rate of need remains static, by 2032 there will be:

- 280 000 stroke survivors with swallowing needs;
- 370 000 stroke survivors with speech needs; and
- 270 000 stroke survivors with reading needs.[38]

4.39 The President of SPA, Professor Deborah Theodoros, identified a need for the speech pathology profession to make greater use of telehealth delivered services to cope with the demands of an ageing population. She explained this need as follows:

> Population ageing will have a significant impact on the demand for speech pathology services. By 2030, persons over 80 years of age in Australia will increase by 140% (ABS, 2006). With increasing age, people will live longer with chronic diseases and conditions that may be associated with communication and swallowing disorders e.g., Parkinson's disease and stroke (Morris et al., 2010). It is likely that older people will remain living in their own homes and communities, even though transport issues will arise as their capacity to drive decreases (Morris et al., 2010). Speech

36 *Submission 165*, p. 4.

37 *Submission 268*, p. 4.

38 *Submission 233*, p. 5.

> pathology services will need to evolve in order to accommodate these societal changes.
>
> Alternative means of service delivery are also needed to meet the demand for equitable access to speech pathology services. In Australia, 68.7% of the population lives in major cities with the remainder (30%) living in regional and rural/remote areas (ABS, 2011). Previous studies have identified disparities in speech pathology services in rural and regional areas with residents in these areas having access to significantly fewer speech pathologists per head of population than counterparts in urban areas (Lambier & Atherton, 2003; Wilson et al., 2002).[39]

Other factors

4.40 Worryingly, the committee also received evidence that demand for speech pathologists services was likely to increase as the rate of child abuse and neglect and the number of children in out-of-home care continues to rise. The Benevolent Society stated in its submission that 'it is anticipated that demand from this group will increase in coming years'.[40] It recommended that all programs targeting disadvantaged and vulnerable children, whether funded by the federal or state governments, include provision for the employment or engagement of speech pathologists.[41]

4.41 Dr Jennifer Oates of La Trobe University commented on the projected demand for speech pathology services among transgender individuals:

> At the recent World Professional Association for Transgender Health conference in Bangkok (February 2104), nearly all providers reported an increase in demand for their services, in particular an increase in the number of children and adolescents seeking help. This trend has been experienced in Victoria. The Victorian Gender Clinic has reported a significant increase in the number of new referrals in recent years (there have been 250 new referrals between October 2012 and October 2013). The Royal Children's Hospital has also reported a 10-fold increase in referrals over the past year (38 referrals from September 2012 to September 2013). If 85% of these transgender individuals would benefit from speech pathology services (see above), it is clear that currently available services through the La Trobe Voice Clinic and other speech pathologists in the private and public health system will be unable to meet the projected demand.[42]

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39 Professor Deborah Theodoros, *Submission 234*, pp 2–3.

40 *Submission 216*, p. 3.

41 *Submission 216*, p. 3.

42 *Submission 160*, p. 3.

Models of care

4.42 A final and very important determinant of the future demand for speech pathology services in Australia relates to the model of care that is implemented. It is crucial that in projecting future workforce and service demands, careful thought is given to the most efficient model for introducing best practice care.[43] Chapter 6 of this report gives consideration to the most efficient models for delivering paediatric, education and aged care speech pathology services.

Committee view

4.43 This chapter has presented a range of evidence indicating the current and future demand for speech pathology services in Australia. Following from the evidence presented in chapter 3, its starting point was the lack of reliable data on the demand for speech pathology services. In the absence of this data, the committee has relied on anecdotal evidence from people with speech and language disorders, the parents of those with these conditions, and many practicing speech pathologists. This evidence was unequivocal:

- waiting lists (a proxy for demand) for public speech pathology services are lengthy;
- these lists understate actual demand given services are unavailable in some regional and remote areas, while the length of waiting lists will deter some from seeking a service;
- there are a number of factors that will further increase the demand for speech pathology services in coming years.

In light of all these factors, the committee reiterates recommendation 2 (see chapter 3) that the federal Department of Health consider the data that is necessary to identify the areas of current and prospective need for speech pathology services.

43 See Queensland Government, *Submission 268*, p. 4; Speech Pathology Australia, *Submission 224*, pp 38–39.

Chapter 5

The availability and adequacy of speech pathology services in Australia

5.1 The previous chapter provided considerable anecdotal evidence of long waiting lists for speech pathology services in Australia. The committee received many accounts of people with speech and language disorders and their carers wanting to access a speech pathology service but being unable to do so. The problem appears particularly acute in regional and regions areas of Australia where in some cases services simply do not exist.

5.2 This chapter's key theme is the logical extension of these problems: the supply of speech pathology services—particularly in the public system—has been unable to keep pace with demand. A recurrent theme in the submissions from adults, the parents of children with speech and language disorders, speech pathologists and peak bodies, has been the lack of adequate speech pathology services in Australia. In many cases, this has meant long waiting lists to see a speech pathologist in the public system, long travelling distances for people living in regional and remote regions, and the expense of private services for those who can afford it. The cost for a visit to a private speech pathologist generally exceeds $150 for an hour's consultation.

5.3 The chapter looks at the following issues:

- data on the number of speech pathologists in Australia;
- the gaps in speech pathology services in Australia including;
    - the waiting lists for children to access services;
    - the supply shortages in regional and remote areas;
    - the service delivery model in residential aged-care homes;
- the provision and adequacy of private speech pathology services; and
- the committee's recommendations to investigate these supply shortages.

5.4 The committee does note that despite widespread concerns with the long waiting lists for public services and the cost of private clinicians, there was very little disquiet about the quality of these services. Indeed, many submitters to this inquiry made a point of commending the quality of the services that they or their child received.

The number of speech pathologists in Australia

5.5 The demand for speech pathology services in Australia clearly outstrips supply of these services. However, the exact number of practising speech pathologists in Australia is not known. Speech Pathology Australia (SPA) explained that the data

gathered through the Australian Bureau of Statistics (ABS) Census groups speech pathologists with audiologists. The Australian Health Practitioner Regulation Agency (AHPRA) does not gather numbers either because speech pathology is not a registered profession.[1]

5.6 SPA currently has 'just over 6000 members'.[2] SPA estimates that this is 'approximately 70 percent of the total number of speech pathologists in Australia as members'. If this is accurate, there are around 8,500 speech pathologists in Australia.[3]

5.7 The 2011 ABS Census found that there were 5,295 speech pathologists in Australia. This number had increased from 2,322 in 1996, 2,984 in 2011 and 3,867 in 2006. The increase in the five years from 2006 to 2011 represented a 37 per cent increase.[4]

Numbers by state and territory

5.8 Table 5.1 shows the distribution of speech pathologists by state and territory and by 100 000 of population. As a proportion of the population, the two territories have significantly fewer speech pathologists.

Table 5.1: Number of speech pathologists

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust.
Number	1,630	1,445	1,043	411	538	130	30	68	5,295
No. per 100 000 of population	22.6	26.1	23.3	25.1	22.9	25.4	13.0	18.5	23.7

Source: Health Workforce Australia, 'Australia's Health Workforce Series, Speech Pathologists in focus', July 2014, p. 14. Data drawn from 2011 Australian Bureau of Statistics National Census.

Sector of employment

5.9 SPA found that as of July 2014, 52.5 per cent of its members were in private practice, 33 per cent were in public practice and the remainder were employed in a

1 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 2.

2 In its submission to the inquiry, SPA stated that it had 4,972 practising members as of December 2013. *Submission 224*, p. 84. It added: 'If we surmise that Speech Pathology Australia members make up approximately 60-70 % of the total workforce then there were approximately 1,500-2,000 speech pathologists working in Australia in 2013 who were not members of Speech Pathology Australia. This indicates a total workforce of approximately 6,500–7,000.' *Submission 224*.

3 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 2.

4 See Health Workforce Australia, 'Australia's Health Workforce Series, Speech Pathologists in focus', July 2014, p. 6.

combination of both public and private practice (see Table 5.2).[5] In NSW, Victoria and Western Australia, more SPA members reported working in private practice than in public practice.[6] Interestingly, two-thirds of SPA's New South Wales members were employed only in private practice. In Queensland, South Australia, Tasmania and the territories, more SPA members reported being in public practice than in private practice.

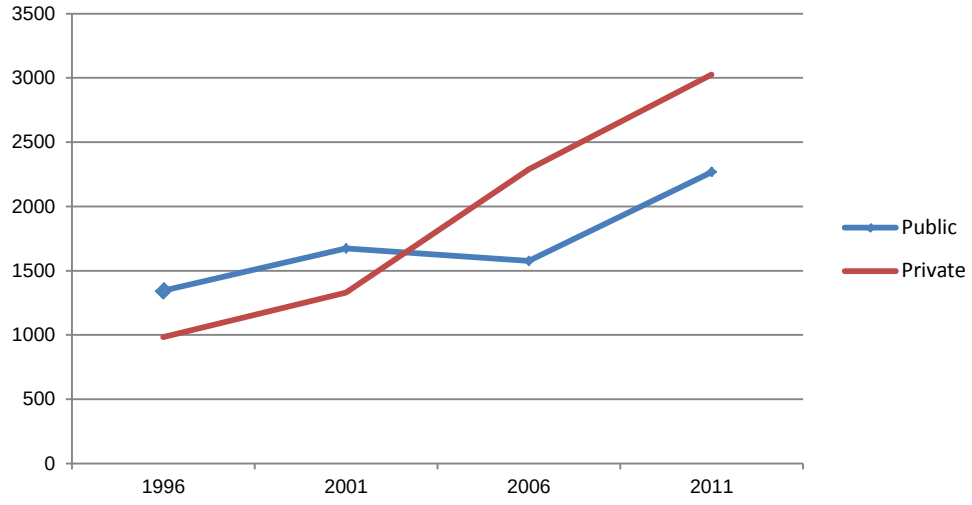
Table 5.2: Public and private speech pathologists by state and territory

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust.
Private practice only	885	578	438	140	259	24	12	12	2364
Public practice only	310	456	470	141	159	66	21	21	1648
Public and private practice	127	164	101	49	33	5	2	2	486

Source: Health Workforce Australia, 'Australia's Health Workforce Series, Speech Pathologists in focus', July 2014, p. 17. Data drawn from Speech Pathology Australia data.

5.10 The 2011 ABS Census found that 43 per cent of speech pathologists worked in the public sector, and 57 per cent in private practices. In the 2006 Census, the ratio was 41 per cent public to 59 per cent private. However, in the 1996 and 2001 Censuses, there were more speech pathologists employed in the public system than in the private sector (see Graph 5.1).

Graph 5.1: Number of speech pathologists—public and private sectors



Source: Health Workforce Australia, 'Australia's Health Workforce Series, Speech Pathologists in focus', July 2014, p. 6. Data drawn from 1996, 2001, 2006 and 2011 Australian Bureau of Statistics National Censuses.

5 This only includes SPA members who reported their practice type.

6 Health Workforce Australia, 'Australia's Health Workforce Series, Speech Pathologists in focus', July 2014, p. 17.

Numbers in remote areas

5.11 This chapter presents the committee's evidence on the shortage of speech pathologists in regional and remote areas of the country. Table 5.3 shows that the ratio of speech pathologists to population falls in areas with less density of population.

Table 5.3: Speech pathologists in Australia by region

	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Number	4,055	842	343	40	12	5,295
No. per 100 000 of population	25.9	20.5	16.9	12.7	5.9	23.7

Source: Workforce Australia, 'Australia's Health Workforce Series, Speech Pathologists in focus', July 2014, p. 15. Data drawn from 2011 Australian Bureau of Statistics National Census.

A female-dominated profession

5.12 Speech pathology is a female dominated profession. Ninety-eight per cent of SPA's members are female. There is a relatively high attrition rate for speech pathologists—13 per cent. The contraction of the full-time workforce peaks at 10 years post-graduation when many speech pathologists move from full time to part time work due to family commitments.[7]

Gaps in speech pathology services in Australia

5.13 There are significant gaps in speech pathology services that are available in the Australian community. In its submission, SPA noted the following gaps:

- it is not standard to have a speech pathologist within the care team for special care of infants in nurseries;[8]
- New South Wales, the Northern Territory, the ACT and Western Australia either have no speech pathology services in their public school systems or very limited provision;[9] and
- there are very few specialist speech pathology services for adults;[10]
- only 4.5 per cent of speech pathology practitioners provide services to rural communities which constitute 30 per cent of the total Australian population;[11] and

7 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 2.

8 *Submission 224*, p. 22.

9 *Submission 224*, p. 34.

10 *Submission 224*, p. 46.

- the lack of speech pathologists in the residential aged care setting.

5.14 This chapter presents the committee's evidence on the extent, nature and impact of these gaps. The particular focus is on the evidence of long waiting lists for children and the need for a more effective system of early intervention.

Long waiting lists for children to access speech pathology services

5.15 Chapter 2 of this report noted the importance of early diagnosis and treatment of speech and language disorders. For young children with speech and language disorders, early intervention is crucial to the long-term well-being of the child. The long-term benefits to children from early and effective diagnosis are significant. Where there is no intervention, or delayed intervention, the costs to the child and to society can be significant.

5.16 Many submitters and witnesses to this inquiry emphasised that long waiting lists for children to access speech pathology services compromises the benefits that could be gained from therapy and treatment. Further, some argued that even when a child does access a service, the pressure on the system often leads to limits on the service.

5.17 In the public system, the basic issue is inadequate resources and too few speech pathologists to cater for the demand for early intervention services. This is a problem nationwide. A submission from Associate Professor Patricia McCabe, Associate Professor Kirrie Ballard and Dr Natalie Munro, reported on the results of a 2010–11 Australia wide survey of parents of children who require speech pathology services. The submission stated:

> Parents reported being on long waiting lists with 25% waiting more than 6 months and 15% waiting more than 1 year for assessment and 18% waiting more than 1 year after assessment for treatment. Qualitative responses revealed concerns such as; a lack of available, frequent, or local services, long waiting times, cutoff ages for eligibility, discharge processes, and an inability to afford private services. Overwhelmingly they were happy with their treating speech pathologist and unhappy with the frequency, length and total number of treatment sessions received. Parents in regional centres, and rural and remote locations were more likely to have difficulty accessing any services including private practitioners.[12]

5.18 Associate Professor Michael McDowell from the Neurodevelopment and Behavioural Paediatric Society of Australasia emphasised in his submission that early intervention 'works'. However, their doctors are frustrated because speech pathology services in the public systems are 'completely inadequate'.[13] The resources are

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11 *Submission 105*, p. 9. The report of Health Workforce Australia titled 'Australia's Health Workforce Series, Speech Pathologists in focus', July 2014, p. 6.

12 *Submission 85*, p. 1.

13 *Submission 118*, p. 1.

distributed across multiple government departments (health, education, disability services) both state and federally. He argued that no department takes responsibility for the problem at a community level and the resources devoted to screening, assessment and treatment services are inadequate. As a consequence, Associate Professor McDowell argued that:

> There exists currently a sad 'Catch 22' that results from this situation. Waiting lists for therapy assessment and particularly therapy intervention services are so long that by the time children get to the top of the list, they are no longer eligible as they are too old.[14]

The availability of speech pathology services for children in Victoria

5.19 The committee received several oral and written submissions from Victorian submitters about the availability of speech pathology services in the state. At the public hearing in Melbourne on 11 June 2014, Professor Sheena Reilly from the Murdoch Children's Research Institute at the Royal Children's Hospital commented on work that the Institute in currently undertaking to map the location of speech pathologists against areas of socio-economic disadvantage and developmental vulnerability. Professor Reilly told the committee with reference to one of these maps[15]:

> This is some mapping work we have been doing on services in Victoria, and this could be repeated over every state in the country. This is done in collaboration with Megan Harper from the Department of Education and Early Childhood. What it shows you is services mapped across the Melbourne area. The blue dots are private speech services, the green dots are public services and the pink dots are early childhood intervention services. You can see that there is a chronic inequitable distribution of those services and it mirrors what Gail [Mulcair from Speech Pathology Australia] was talking about earlier, the explosion in private services but also where those services are. They are in our very rich south-east corridor of Melbourne where people can afford private services. These services have been mapped onto disadvantage across the Melbourne area. The most disadvantaged areas are the red and orange, and that is not where our services are...[16]

5.20 Professor Reilly referred to a second map (which was also provided in MCRI's submission and is reproduced as Map 5.1, below) which shows where children are most developmentally vulnerable according to their language and their cognitive skills. Professor Reilly explained that:

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14 *Submission 118*, p. 2.

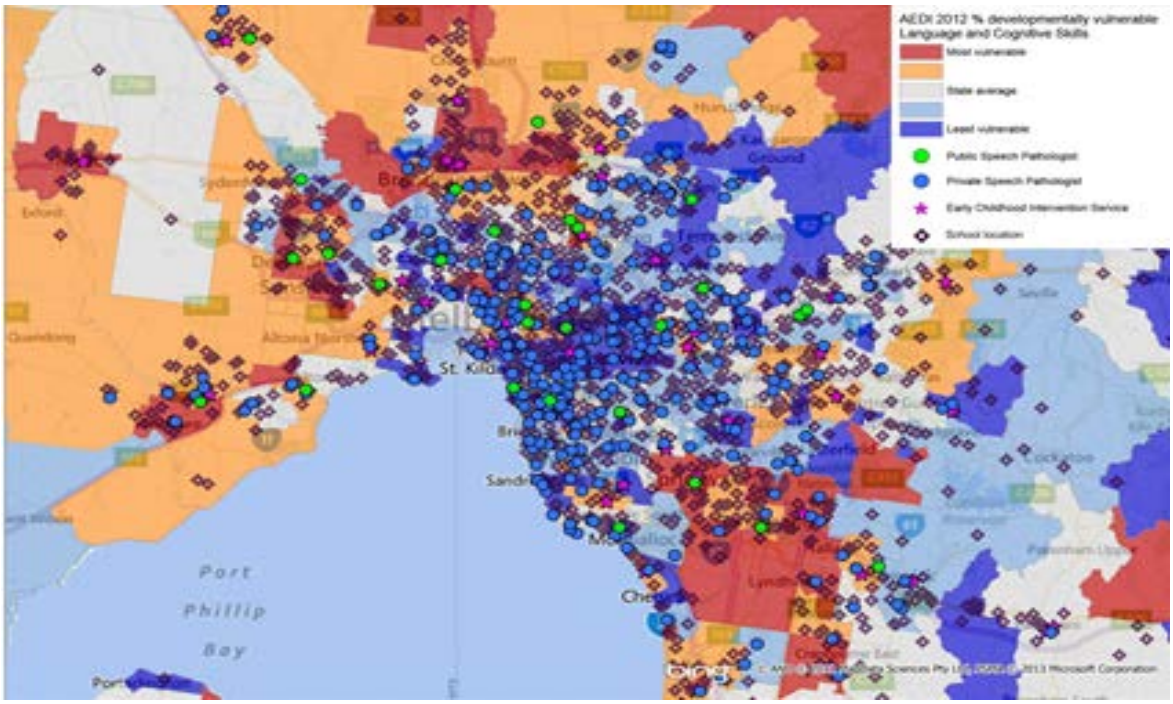
15 This map was presented at the public hearing in a Powerpoint presentation. However, the Institute has requested that the map not be reproduced in this report as it appears in research that is awaiting publication.

16 *Committee Hansard*, 11 June 2014, p. 18.

the red and the orange again are the vulnerable areas and you can see that that is not necessarily where our services are…

That tells you something about services—and that is something we have got a lot of information about and should be doing across Australia. That information about children exists; it is not something that we have to go out and create.[17]

Map 5.1: Location of speech pathologists, Melbourne: developmental vulnerability



Source, Submission 161, p. 10

5.21 The committee received evidence from other submitters that corroborated the findings indicated in this analysis. A Melbourne-based speech pathologist employed in both the not-for-profit and private sectors wrote in his submission:

I believe that there are inadequate speech therapy services for children up to the ages of 6 that are funded by the Commonwealth, state, and local governments. This is especially the case in the Western Metropolitan Region of Melbourne where there are many families who fall within the lower socio-economic bracket. There are many children who will be waiting on lists for service for extended periods. By the time it is their turn, they may be going to school, thus missing out on earlier intervention.

It is important that children are able to access early intervention-specifically for speech therapy (I am not confusing it with early intervention where children have multiple areas of delays) as it can impact

17 *Committee Hansard*, 11 June 2014, p. 19.

> on future development. This in turn can also have a negative impact on their education and self esteem.[18]

5.22 The committee asked Professor Reilly whether she had plotted these services for other Australian cities and regional centres. She responded:

> No, we have only done it for Melbourne and parts of Victoria so far. It could very easily be done; we have geographers across the country who could do that for us.[19]

5.23 The committee believes that as a visual representation and as a guide for policy-makers, this mapping exercise is very useful and should be conducted across the country (see recommendation 4, below). It would also be useful to accompany the location of public speech pathologists with information on the length of waiting lists for each public speech pathology centre.

5.24 The maps show that there is very little by way of public speech pathology services in the Frankston area in the city's south-east. There is an Early Childhood Intervention Service in Frankston. The Peninsula Model for Primary Health Planning—Children's Health Alliance and Frankston–Mornington Peninsula Medicare Local noted in its submission that Early Childhood Intervention Services (ECIS) typically have a 6–9 month waitlist. In the Frankston–Mornington Peninsula catchment, the key ECIS providers are Biala and Noah's Ark. The Peninsula Model noted that for Biala 'waiting times tend to run at 12 months'.[20]

5.25 Peninsula Health (PH) is the public provider of hospital based and community health Speech Pathology services in the Mornington Peninsula. These services are delivered through Frankston Hospital and the Frankston, Hastings and Rosebud Community Health Services.

5.26 The Peninsula Model stated that the waiting time for Speech Pathology at Frankston Hospital is 2 months for an initial screening assessment up to a maximum wait time of 12 months. It added that two-thirds of children are offered group therapy while they wait for individual therapy. In terms of Peninsula Community Health:

> [T]he waiting times…are…currently running at 14 months. Long waiting times significantly impact on the ability of families to put measures in place that will enhance the child's ability to develop and learn. Developmental delay is not usually identified until 2-3 years of age offering only a small window of opportunity to provide early and effective intervention that will enhance school readiness and improve a child's learning experience.[21]

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18 Name withheld, *Submission 91*, p. 1.

19 *Committee Hansard*, 11 June 2014, p. 19.

20 *Submission 275*, p. 11.

21 *Submission 275*, p. 11.

5.27 The Peninsula Model submission noted a number of other challenges associated with the lack of speech pathology services in the catchment area. These included:

> Many children from vulnerable communities are referred for therapy mid-way through their preschool year when their delays are identified by a preschool teacher. They receive some but limited speech pathology support prior to school entry. Follow up support for these children at school is essential to assist them to succeed academically. However the service system for school aged children is different and requires children to transition to a new system with different eligibility and priority criteria. This can be difficult for parents and carers to understand and to navigate, and disrupts continuity of care…
>
> Public services experience long waiting lists for Specialist and diagnostic services that assist Speech Pathologists plan and deliver appropriate interventions, such as specialists services that diagnose Autism Spectrum Disorder or similar…
>
> High demand on public services reduces their capacity to provide best practice care in the child's natural environments by outreach. Centre-based services are the norm; outreach to natural environments is strictly limited in an effort to stretch resources.[22]

5.28 The Peninsula Model's submission also stated that the recommended ratio of qualified speech pathologists to students in Victoria is one for every 733 students. On this basis, it noted the need for:

> …a further 744 Speech Pathologists within Victorian Government schools (DEECD) alone. In 2012 there were 140 full time positions in Victorian Government schools, funded by DEECD. This represents a significant unmet need. By way of example, the current ratio of Speech Pathologists is 1:4512, or six times less than the recommended norm.[23]

The availability of speech pathology services for children in New South Wales

5.29 A submission from NSW Health identified some of the key features of the availability of speech pathology services in New South Wales. These are as follows:

- as at June 2013, 527 full time equivalent Speech Pathologists were employed in the NSW Public Health workforce representing six per cent of the total allied health workforce employed;
- the average age of Speech Pathologists in NSW Health is 35.4 years and the speech pathology workforce is dominated by female practitioners;
- the speech pathology workforce is predominantly part time with the average number of working hours being 24.7 hours;

22 *Submission 275*, p. 12.

23 *Submission 275*, p. 12.

- speech pathologists are often sole or lone practitioners in a facility or service (particularly in rural and regional districts). As a result arranging coverage for leave is often difficult although allied health locum schemes go some way to assisting with leave relief; and
- 'due to the large proportion of part-time, temporary and locum Speech Pathology staff, managers' report challenges in ensuring there is an appropriately skilled workforce to cover all clinical areas'.[24]

5.30 Interestingly, NSW Health commented that its own modelling indicates that available supply of speech pathologists:

> …is adequate to meet projected demand based on the assumption that there is no initial workforce shortage, no inward migration, and new graduates, re-entry and wastage/loss percentages remain constant.[25]

However, the assumption of no initial workforce shortage in the State is clearly not accurate, as the following evidence attests.

5.31 A speech pathologist working in community health in western Sydney made the following comment on waiting lists in her submission:

> At the centre I work all waiting lists are between 8-12 months long. This is an unacceptable time for a child with a communication impairment to have to wait to receive a service. This is particularly so for those children who are in the year before school. Research has shown that these children are at a significantly increased risk of continuing academic, social and attention difficulties throughout their years of schooling (McCormack et al, 2009). Our waiting lists mean that even if a child is referred in the year before they commence school, it is very likely they won't receive an assessment appointment until they start Kindergarten. Lengthy waiting lists are also detrimental to staff job satisfaction. Although working extremely hard and trialling various strategies to address wait list times, minimal success has been achieved in this area. As a result there is a constant feeling that despite working hard, an effective and timely service is not being provided.[26]

5.32 Unlike most other Australian States, New South Wales does not have speech pathologists attached to government schools. This was a source of both surprise and frustration for many parents of school-aged children in New South Wales needing speech pathology services. The father of a young son with developmental delay who is attending a Sydney kindergarten. He wrote in his submission:

> I was very disappointed to learn that his current school only supplies a support teacher, not a speech therapist. His kindergarten teacher recognised his developmental delay without our mentioning of it.

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24 *Submission 271*, p. 2.

25 *Submission 271*, p. 2.

26 *Submission 144*, p. 1

> As school is in the northern beaches Sydney area, I enquired as to whether we could transfer his public hospital speech therapy from Sydney's Eastern suburbs where we live to his Northern Sydney school area so that there would be less disruption with his school attendance.
>
> The head of speech therapy for the Northern Area Health kindly returned my call and apologetically explained that they could not provide public hospital speech therapy services to children whose residence it outside the Area Health Service despite being schooled within the Area.
>
> She also explained that once children turn five years of age in her own Area Health jurisdiction and commence school, speech therapy is discontinued unless desperately needed. The reason for this sudden cut-off, as she explained, was because of limited funding resources from the State and Federal Governments. She respectfully declined to offer speech therapy services. I can't remember how many times she apologised for declining my request.
>
> What alarmed and puzzled me was that this head of a government department informed me that NSW was the only state/territory that did not have a speech therapist attached to each school.[27]

5.33 Professor Mark Onslow from the Australian Stuttering Research Centre highlighted the inadequacy of services for children with stuttering difficulties. In many cases, he noted, the pressure of needing to address the backlog in demand led to shortcuts in treatment. As he wrote in his submission:

> Clearly, then, the speech pathology profession is under resourced to manage the public health problem of early stuttering. At present there is evidence that speech pathologists and managers of speech pathology health care services, by necessity, respond to the shortcomings of treatment services in unproductive ways.
>
> The latter report was a survey of 277 Australian speech pathologists, around half of whom said that they responded to waiting list pressures by taking shortcuts with proven, treatments for early stuttering. Those shortcuts involve providing treatment "blocks" of 12 weeks per child rather than the complete treatment, treating in groups of children rather than individually, and giving treatment sessions less regularly than each week. Such compromises will likely damage the educational, occupational and psychological wellbeing of children who consequently stutter later in life.
>
> In short, current knowledge is that early stuttering is a prevalent condition with possible lifetime consequences, with proven treatment methods but without adequate treatment services. Planning and implementing reform of public health care speech pathology services for stuttering is necessary.[28]

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27 Name withheld, *Submission 189*, p. 3.

28 *Submission 188*, p. 5.

5.34 Mr Roger Blackmore, a developmental paediatrician working in the public system in Sydney, argued that the prioritisation of young children has meant that waiting lists can be longer for older children:

> Whilst local community allied health speech pathologists are available they have to prioritise younger preschool children for intervention. Waiting times can be extensive for older children however who may have presented late or missed intervention when younger due to their vulnerabilities such as out of home care and social disadvantage.[29]

5.35 Ms Kirsten Wright, a speech pathologist at the Mount Druitt Community Health Centre, also drew the committee's attention to the deleterious effect of waiting lists on a child's development. As she explained:

> …waiting times for publicly funded services are often compounding the children's initial speech and language difficulties. If a child is not referred for an assessment until they begin school, at the age of 5 years, and the waiting list is two years long (which is not uncommon in my local health district and surrounds), the child may have missed that crucial period for developing their sounds and language in order to support the development of their reading skills (a foundational skill for education). Even if they could be re-referred for another block of therapy sessions, by then they are likely to be over the age of 8 years and would no longer be eligible for the service. The one short block of sessions is not an adequate service to address all the issues that are present for children with moderate or more severe speech and language disorders, in my experience. There is often only time for one set of goals, especially where the parents are not able to adequately engage in providing support for these goals in the home environment due to the many stressors that are associated with being in a low socio-economic area (low education overall, single parenting is common, financial pressures, higher than average numbers of children in the family and other social pressures). I have observed many of these factors in the client group I have worked with.[30]

5.36 Ms Wendy Yarrow, a Sydney-based speech pathologist, put a similar view in her submission. She noted the difficulty for school aged children to receive community-based speech pathology services:

> In most hospital and Community Health Centres priority is allocated to children aged 0 to 5 years, that is prior to school entry. I fundamentally support providing Speech Pathology services to support Early Intervention and agree it should be a priority. Unfortunately, due to the limited funding for Speech Pathology services, early Intervention is provided at the expense of Speech Pathology service provision for school-age children. In some instances, school aged children are not offered any Speech Pathology assessment or therapy services and the most some children are offered an assessment only or an assessment and one block of 6 to 8 weeks of therapy

29 *Submission 168*, p. 1.

30 *Submission 208*, pp 1–2.

> in total. Consequently, if parents want their school aged child/children to receive Speech Pathology services they must be able to pay for services from Private Speech Pathologists or other fee for service Speech pathology providers, such as, non for profit organisations.[31]

5.37 Mr Robert Ieroianna, the principal of Parramatta East Public School in Sydney, argued that in his experience, delays in treating children for speech disorders affected their learning development relative to their peers. As he wrote in his submission:

> Currently in our school, which is a medium sized primary school in metropolitan Sydney, we have a number of students in need of speech support. Most are waiting on a long public health waiting list for assistance to obtain speech services. I am told that in Western Sydney, the wait for speech support through the public health service is approximately one year. For private speech therapy, costs can be very prohibitive for many families living in our school community. Without exception, the evidence in our school indicates that the greater the delay from referral to actually receiving speech therapy support, the greater the learning gap between that child and others at the same stage of learning.[32]

5.38 Mrs Susan Gardner of the New South Wales Department of Education and Communities also emphasised the opportunity cost for a child having to wait for an extended period of time to receive therapy:

> Families who are on a low income place their child's name on a waiting list for Government assisted services. The current wait on these lists is about eighteen months to two years. This support stops at age eight. This means that even if a child's name is placed on the list by the parent, GP or school on day one in Kindergarten, it could take until Year 2 for the child to come to the top of the list to be offered the services. That means that there are two years of 'nothing'. Schools and parents are left to do the best that they can for the child or children. There are six Medicare assisted sessions that can also be accessed for these children.[33]

The availability of speech pathology services for children in Queensland

5.39 The committee received several submissions from parents and speech pathologists in Queensland about the state's shortage of speech pathology services for children. The mother of a five year old boy living in south-west Brisbane expressed her frustration at the long waiting lists to access the public system.

> My son is 5 years old and has childhood apraxia of speech resulting in significant speech and expressive language difficulties. At the age of 2 I was aware of his lack of speech, and sought a referral from my GP to see a

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31 *Submission 182*, p. 1.

32 *Submission 178*, p. 1.

33 *Submission 171*, p. 2.

> Paediatrician. This was followed by several hearing tests to determine if this was the problem, but all was clear. Then we started Speech Therapy. The waiting list in my local area for the Child Development Service in suburban Brisbane was a year, in fact I waited 18 months. I received 6 sessions, and then the speech therapist contract was not renewed. We were informed it was another 6 month wait!!! We transferred to another Centre again waiting, and in all received 14 sessions until my son was no longer eligible since he was starting school. So in the course of 3 years we received 20 free 30 minute sessions with the Child Development service. During that time both centres always operated below capacity. Numerous consulting rooms were vacant. No staff appeared to work fulltime. In view of the fact that the waiting lists showed there is a significant demand for their services, it is appalling that the Queensland health service operates their Children's Developmental centres like this. The amount of therapy received was inadequate for my son leaving him not equipped to attend Prep. at the age of 5.[34]

5.40 The short supply of speech pathology services was also reported in rapidly growing regional areas of the State. Ms Katherine Osborne from Gold Coast Speech Pathologists lodged a submission to the inquiry, co-signed with ten speech pathologists from various Gold Coast practices. In it, she estimated that there are 71 960 people needing speech pathology on the Gold Coast (14 per cent of the population) and only 100 or so speech pathologists (50 private and 50 public), leaving 'only one speech pathologist to support 719 people'. She added: 'This is an impossible task'.[35]

5.41 The Gold Coast Speech pathologists' submission provided data indicating that the Gold Coast is the worst region in Queensland in terms of access to speech pathologists. It has only 19 speech pathologists per 100 000 compared with an average of 27 in other areas of the State. It argued that as a consequence:

> …the impact on young families is significant. Critical development periods are before 5 years of age, yet wait lists for this age group treated by Community Health speech pathologists, is up to 12 months. For families who can not afford private services, this wait can have devastating effects on a child's speech development, access to and ability to participate in a prep or pre-prep curriculum, and their ability to interact and form relationships with peers. Even private speech pathology services on the Gold Coast have been placing children on waiting lists for some years now, especially for access to government funding for early intervention autism and disability services. This funding is designed for early intervention up to 7 years of age, yet some children can not access private speech pathology within the time frame due to lack of workforce.
>
> A similar situation exists for children attending primary and secondary school. Due to prioritisation procedures, often only the most severe of cases

34 Name withheld, *Submission 237*, p. 1.

35 Gold Coast Speech Pathologists, *Submission* 176, p. 1.

> receive direct speech pathology services. Children with mild or moderate speech and / or language disorders usually miss out, and must seek out private services.[36]

5.42 The committee is interested in whether the Queensland average of 27 speech pathologists per 100 000 people is low on a national basis. Again, the committee makes a recommendation (below) to map language support services across Australia in a way that will provide information on the number of speech pathologists per number of people by region.

5.43 The committee received a submission from another Gold Coast based speech pathologist, which gave the following example of the problem of waiting lists:

> This child 'E' was first referred to Community Health speech pathology at the age of 2 ½ years. His own parents had difficulty understanding more than approx 50% of his speech. This is a very low rate of intelligibility by any measure. As time wore on without an appointment being offered, they went to a centre for dyspraxic children (Max's House) in Brisbane which is at least an hour from the Coast by car. The fact that he was treated there is an indication of the severity of his speech difficulties. Eventually, the parents couldn't continue to make the journey and they sought local therapy. I was able to take him on & I treated him over approx 2 years. I discharged him from therapy late last year after he'd made excellent progress, not just in speech but in early aspects of literacy which were targeted simultaneously.
>
> As for his referral for a Govt service with Community Health, his name came to the top of the list 21 months after it had first been placed there. 'E' was already experiencing psychological difficulties when he first started with me and his parents attributed this mostly to his intense embarrassment & frustration at not being understood. These difficulties faded as he made progress with his speech & had disappeared a long time before his therapy ended but after he became easier to understand.[37]

The Glenleighden School

5.44 Despite the many frustrations of parents and clinicians in Queensland with lengthy waiting lists and the impact that this wait was having on children's development, there were positive stories. One in particular is the Glenleighden School in Fig Tree Pocket in Brisbane.

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36 Gold Coast Speech Pathologists, *Submission 176*, pp 1–2.

37 Name withheld, *Submission 101*, p. 2.

Box 5.1: Parents on the Glenleighden School

I was made redundant at work and I happened to come across an online job at The Glenleighden School in Fig Tree Pocket, when I started reading up on the school and that they specialised in Primary Language disorder I sat there and cried. I was amazed that here was a school on my doorstep that could help my daughter, I knew instantly, but why had I not heard about it from my doctor, the speech pathologist, kindy? …My daughter was accepted and started at Glenleighden in April 2010 and has come on leaps and bounds since joining this magnificent school.
Submission 156, Name withheld

*Finding Glenleighden was like finding an oasis in a desert of confusion, uncertainty and grief. Here at last was a place and a group of people who "got" her – an organisation which recognised her hidden disability and was able to offer an adapted, multidisciplinary program that was tailored to her individual needs. The absolute key to the improvement we saw in once she started at the school was that the speech pathologists, occupational therapists, physiotherapists and special education teachers all worked together implementing a joint plan based on their combined assessment of requirements. Apart from hands on therapy, Glenleighden also offered information, care and support for us as parents – a port in the storm of emotion and fear arising from years of investigations and hypotheses. We were only just beginning to comprehend the extent and the complexity of the challenges that lay ahead – not just for but also her brother as well as my husband and I. I can't tell you the number of times over the years during which **** has attended Glenleighden that I have seen the same look of absolute relief on the faces of new parents when they realise the gem they have found in this unique school. Their gratitude, like ours, is palpable.* **Submission 215, Name withheld**

*We went through the process of applying to The Glenleighden School and gathered the information required. We will never forget when the phone rang and the beautiful voice on the other end said that he was accepted into the school for 2012. Quickly we put our new house on the market and sold it for peanuts to just offload it in the bid to start our new life in Brisbane. We said goodbye to our family and friends, took a deep breath and hoped that our decision was the right one. **** started school like any other little one on their first day. He seemed nervous and excited. From the first week we felt reassured that The Glenleighden School was the best choice for our child. ****'s progress is exceptionally slow however there is progress.*

*Despite The Glenleighden School being the best option for **** it all comes at a cost. School fee's come in at over $10,000 a year and additional private therapy has also been required. Most years' we spend approximately $20,000 on helping ****. We also lost about $135,000 between the sale and purchase of our house in Townsville to our new home in Brisbane. Financially we are starting over however we also feel fortunate that we were able to make the move in the first place and despite many sacrifices to keep **** at the school, we are privileged that we can still manage to pay the fees to keep him there.* **Submission 14, Name withheld**

5.45 The Glenleighden School caters specifically for children with severe and specific childhood language, communication and related disorders. It is the only facility of its kind in Australia.[38] It was established in 1979 and is operated by the Association for Childhood Language and Related Disorders (CHI.L.D). CHI.L.D also operates an outreach program and a clinic in Woolloongabba in Brisbane.

38 The Glenleigen School, *About us*, http://www.glenleighden.org.au/history.html (accessed 15 May 2014).

5.46 The committee had the opportunity to visit the Glenleighden School on 27 June 2014. It was impressed by the school's facilities and the commitment of the staff to their challenging roles. Following a tour of the school, the committee had the opportunity to discuss issues relating to the inquiry with a group of parents of children attending Glenleighden. Most of these parents had made written submissions to the inquiry. The committee extends its sincere thanks to these parents for giving so generously of their time. It also thanks the school principal, Ms Cae Ashton, for facilitating this opportunity.

5.47 Parents were clearly impressed with the quality of care and teaching offered by the Glenleighden School. Box 5.1 (above) provides a sample of comments made in submissions by the parents of children attending Glenleighden.

The availability of speech pathology services for children in South Australia

5.48 There were also concerns about the availability of speech pathology services in South Australia, particularly for school-aged children. The South Australian School Principals' Association stated in its submission:

> The hardest thing to face is that unless these students are from families who are able to access private support these students are simply not getting the type of support that would make a positive difference to not just their education outcomes but their life chances. And our regional and rural school leaders report that even this private option, if affordable to the family is usually not accessible or available.[39]

5.49 The committee received a submission from the South Australian branch of SPA on some of the gaps in the State's provision of speech pathology services. These are:

- waiting times for treatment of stuttering in South Australia can be up to a year. At about 4 years of age, children with communication disorders will generally transfer to speech pathologists working in kindergartens and school. However, speech pathologists working within these settings do not currently provide specialised assessment and treatment for stuttering;
- the South Australian Department for Education and Child Development (DECD) employs 75.2 full time equivalent speech pathologists to provide services for students attending government funded preschools and schools. The Association of Independent Schools of South Australia (AISSA) and Catholic Education Office (CEO) of South Australia does not employ speech pathologists directly, but has some capacity to engage with private providers through sources including the federally funded 'More Support for Students with Disabilities' Initiative; and

39 *Submission 177*, p. 1.

- the majority of services target preschool aged children and students in their first few years of schooling. There is limited capacity for direct speech pathology intervention for children and students from the age of 7 upwards.[40]

5.50 In 2013, South Australia commenced an integrated single service system for paediatric speech pathology services. This model is intended to allow equitable access to speech pathology services, improve service coordination, consistency in service delivery and continuity of care for children and families. Specifically, it addresses a gap in services for children aged 3–3½ to 4 years due to SA Health services often ceasing to provide a service once a child commences at a state preschool. Due to waiting lists, referrals for children in this age bracket were not always accepted before they were eligible for a service through the education system.[41]

5.51 Under the single service model, SA Health and the Department of Education and Child Development are sharing responsibility for services for children aged three years to school entry.[42]

The availability of speech pathology services for children in Western Australia

5.52 Western Australia is another state that does not employ speech pathologists within schools. Instead, the State Education Department funds the work of Language and Development Centres (LDCs) who are also responsible for running school outreach programs. There are five LDCs: the West Coast, South East Metropolitan, North East Metropolitan Districts, North West Metropolitan and Fremantle Language Development Centres. All five Centres:

- provide a full time educational placement for children in Kindergarten and year 1 who have primary language disorders or difficulties. Some Centres provide placement for children in years 2 and 3;
- provide specialised language and academic intervention on an individual and small group basis;
- operate from a number of sites and share facilities with local primary schools; and
- employ speech pathologists who work with parents and teachers to assess, evaluate and plan appropriate programs for students.[43]

5.53 The LDCs all operate an outreach team composed of Support Officers, Speech and Language. These Support Officers are employed by the State Department of

40 *Submission 226*, p. 5.

41 *Submission 226*, p. 4.

42 *Submission* 226, p. 4.

43 Discussion with Ms Rosemary Simpson, Principal, North East Metropolitan Districts Language Development Centre, 6 August 2014.

Education. They may or may not be speech pathologists but they do not take individual referrals. Rather, the role of these consultants is to provide high-level advice for teachers in building their oral literacy capacity.[44]

5.54 The Western Australian Primary Principals' Association noted in its submission that for children with speech and language needs, teachers need the capacity to 'differentially target and cater for' these individual needs. In contrast, the Association described the current situation in Western Australia as follows:

> Speech pathology services for school aged children in Western Australia have mostly been viewed as a separate system of support delivered externally to individual students (those without traditional disability label with speech/language needs) through Health or loosely connected to schools for students with disabilities by Therapy Focus (limited services). Services from the Department of Health Child Development Centres for students who have language disorders and difficulties are severely stretched, with up to a 2 year waiting list at some Government clinics. The wait lists are worst in our most disadvantaged areas. Getting children into finite speech pathology services once they have started school is becoming increasingly difficult. This impacts on our most disadvantaged children as their parents tend not to seek services in the 'before school' age bracket (shorter wait time).[45]

5.55 The WA Primary Principals' Association noted that there is inequitable access to Language Centres and some Education Support Centres. It explained that students remain on wait lists if their parents cannot afford private assessments that are required for referral, which advantages those who can afford to pay. The Association highlighted the rising ratio of students to speech pathologists under the State's Language Centre model:

> Within the 5 Language Centres the Education Department employs 10 speech pathologists to support the early, intensive direct service to students placed in the program (full time withdrawal in a school setting for a maximum of 3 years). The ratio of students to speech pathologists has risen from 1:70-80 in 2004 to 1:100-130 in 2014. The Outreach Service, which is focused on building teacher capacity across the broader mainstream communities, has 17 Support Officers Speech and Language (a mix of teachers and speech pathologists). These officers are available to provide support to any number of the 630 schools eligible for the service.[46]

5.56 Ms Jodi Lipscombe, the Head of the Speech Pathology Department at the Princess Margaret Hospital in Perth, also noted that families currently have very

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44 Discussion with Ms Polly Prior, Speech Pathologist, West Coast Language Development Centre, 6 August 2014. Discussion with Ms Rosemary Simpson, Principal, North East Metropolitan Districts Language Development Centre, 6 August 2014.

45 *Submission 228*, p. 8.

46 *Submission* 228, p. 8.

restricted access to government funded speech pathology services. She observed that for many families, there is a waiting list of 12 months or longer for services to commence for their preschool children.[47]

5.57 Telethon Speech and Hearing is a non-profit organisation that provides a range of diagnostic, therapy, education and support services for children and adults with hearing loss and speech and language delays. Its submission noted that:

> Families convey experiencing significant wait times for speech pathologist services at the Western Australian State Government Child Development Centres. Some families are waiting up to eight months to see a speech pathologist. Currently the Child Development Centres provide support for children in the early years but this does not necessarily extend to ages six, seven and eight.[48]

5.58 *Next Challenge* is a WA-based organisation that has provided private speech pathology services to both metropolitan and rural primary schools in the State over the past decade. As such, the organisation fills a key service gap, particularly through its support for schools with children from lower socio-economic backgrounds. Speech pathologists working for *Next Challenge* provide screening and assessment for school children, particularly for those entering kindergarten and pre-primary. This initiates referrals to government funded services and private services where possible.

5.59 Ms Victoria Bishop, a speech pathologist with *Next Challenge*, noted that:

> …our schools have asked for assistance in supporting those students with delayed or disordered language, speech and literacy skills. The schools have requested this because the waitlist for government funded services are so long, with their children in Kindergarten to Year 2 often waiting 12 to 18 months to receive even one block of therapy services. One block is usually not sufficient to remediate such difficulties. This wait time is a significant amount of time in a young child's development, and these children fall further behind in school achievement, resulting in poorer long term educational and socio-emotional outcomes. In addition, families often have significant barriers preventing access to attending government funded clinic services.[49]

5.60 Ms Bishop emphasised that services within the school setting maximises the child's chances of receiving therapy.[50]

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47 *Submission 212*, p. 1.

48 *Submission 276*, p. 7.

49 *Submission 245*, p. 2.

50 *Submission 245*, p. 2.

The availability of speech pathology services for children in Tasmania

5.61 The committee received little evidence on the availability of speech pathology services in Tasmania. The Tasmanian Department of Health and Human Services (DHHS) did note in its submission that the State Government employs approximately 39.7 full-time equivalent speech pathologists. These employees work in the following locations:

- Tasmanian Health Organisation (THO) North West—North West Regional Hospital, Mersey Community Hospital and Devonport Community and Health Services Centre. Outreach services are provided to King Island, Smithton and the West Coast.
- THO North—Launceston General Hospital, outpatient clinics (paediatric and adult) and outreach.
- THO South—Royal Hobart Hospitals, Transitional Care Unit, Community Rehabilitation Unit, Community Therapy Services, Specialist clinics (Holman Clinic (cancer), cleft palate, cochlear implant, paediatric feeding), outpatient clinics (paediatric and adult). Outreach services are provided to Bruny Island, Clarence Integrated Care Centre, Dover, Glenorchy, Huonville, Kingston, New Norfolk, Oatlands, Sorell, Tasman Peninsular and Triabunna.
- Human Services—Disability Services, Child and Parenting Units (north and north west).[51]

5.62 DHHS identified the following gaps in the provision of speech pathology services in Tasmania:

> A significant gap is the lack of locally based services to northern half of the east coast. In areas with limited access to speech pathology services, video and teleconferencing is utilised to improve timeliness of access to services.
>
> [S]peech pathologists are not currently employed in public mental health services in Tasmania.
>
> Once children commence in the education system they become the responsibility of the Education Department speech pathologists. This may create a gap in continuity of therapy…
>
> A significant service gap also exists in the area of juvenile justice. Youth offenders are complex and challenging for policymakers and practitioners alike and face high risks for long-term disadvantage and social marginalisation…
>
> Aged care is also a significant service gap and as the population ages, demand for services will increase…
>
> Other service gaps include cancer care, aboriginal services, and community services in the north…

51 *Submission 265*, p. 4.

> Tasmania, along with the Northern Territory and ACT, does not have a tertiary training program for speech pathology. As a result Tasmania must compete for staff from other jurisdictions.[52]

The availability of speech pathology services for children in the ACT

5.63 Table 5.1 noted the finding of the 2011 Census that the ratio of speech pathologists to 100 000 of the population was higher in the ACT than in any other State. Canberra Hospital has 7.15 full-time equivalent speech pathologists. *Rehabilitation, Aged and Community Care* employs 4.8 full-time equivalent speech pathologists. *Therapy ACT* employs 29.3 full-time equivalent speech pathologists across early childhood, school aged and adult services. There are waiting lists for all these services with Therapy ACT—as of March 2014, 866 people were on the waiting list. There are approximately 16 private practices, several of which employ tree or four speech pathologists.[53]

The availability of speech pathology services for children in the Northern Territory

5.64 SPA noted in its submission that the Northern Territory has 'a demonstrably high need for support in relation to communication disorders' based on AEDI results. It also cited a letter from the then Chief Minister, the Hon. Paul Henderson to Speech Pathology Australia in August 2012 that 'there is a high demand for speech pathology, particularly for children aged 4-7 years'.[54] SPA stated that there is only one speech pathology position within the Northern Territory Department of Education. The waiting list for an assessment for a child of school age in Alice Springs is approximately 12 months and even then, it will only be provided with indirect support (such as through a teacher).[55]

Supply shortages in regional and remote areas of Australia

5.65 Table 5.2 (above) noted the finding of the 2011 Census that the number of speech pathologists per 100 000 of population declines as population density falls. Very remote areas have only six speech pathologists to 100 000 of the population compared with 26 speech pathologists per 100 000 in major cities. Several submitters and witnesses to this inquiry commented on the difficulty of accessing speech pathology services in rural and regional Australia. They also expressed concern that services that were once provided have now been withdrawn.

5.66 The President of SPA, Ms Deborah Theodoros, told the committee that 'access to speech pathology services is a postcode lottery in Australia'. She added: 'it is almost

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52 *Submission 265*, p. 5.

53 The Hon. Katy Gallagher MLA, *Submission 273*, p. 1.

54 *Submission 224*, pp 35–36.

55 *Submission 224*, p. 36.

impossible to access adequate services if you live in rural and remote Australia or if you are socioeconomically disadvantaged'.[56]

5.67 The National Rural Health Alliance gave examples of the following two remote regions of the country where there have not been adequate paediatric speech services:

> For example, until recently there were no paediatric speech services (and other early intervention services) on Kangaroo Island in South Australia, until the child reached school age. At that time, he or she would be placed on a waiting list for up to eight years for a visiting service team, who only attended twice during a school term. Children with severe difficulties (such as feeding difficulties) were directed to the mainland. The consequence of this delay is that problems are not picked up early enough, leading to poor educational and health outcomes. Similarly, demand for speech therapy in the midwest of Western Australia is reported to be significant, with a large number of children missing out altogether or very limited services.[57]

5.68 Coolah is a country town in New South Wales with a population of around 1000 residents. It is 100 kilometres north of Mudgee and 136 kilometres north-east of Dubbo. Ms Kirsty Arnott, a director at the Coolah Preschool and Kindergarten, wrote in her submission that she is 'devastated and confused' as to why the speech pathologist from Mudgee Community Health will no longer travel to service Coolah and the surrounding area. She noted that her son had used the outreach speech pathology service for eight weeks in 2013. Ms Arnott described the financial and time benefits of this service for her family as 'immeasurable'.[58] She asked:

> With the cancellation of this speech pathology service I wonder who is going to provide this service for our community in the future. Does this simply mean that our children will not receive this service? Are rural families expected to incur the expense, both financially and in time, to travel up to 300km for an hour of private therapy sessions? Who will identify those children who require speech therapy prior to formal schooling?[59]

5.69 The Western Australian and Tasmanian organisations of the Independent Living Centre (ILC) employ speech pathologists to provide information, advice, assessment, prescription, implementation and training in augmentative and alternative communication (AAC) and assistive learning technologies. The organisations' joint submission noted that:

> Many towns experience difficulty recruiting Speech Pathology and other Allied Health staff, resulting in little and often no services in a particular

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56 Professor Deborah Theodoros, *Committee Hansard*, 11 June 2014, p. 2.

57 *Submission 266*, p. 9.

58 *Submission 250*, p. 1.

59 *Submission 250*, p. 2.

> town and surrounding areas for lengthy periods of time. The high turnover of therapy staff in country areas also significantly impacts families and the individuals progress, as they often start again with new assessments each time a new therapist commences in that role. ILC WA is able to deliver some face to face services to country WA clients. Speech Pathologists in country WA often have large caseloads and a range of client's (sic) not just clients with complex communication needs. In an eastern WA town speech pathologist turnover is extremely high and the department is often understaffed. In this town school aged children with disability are often on waitlists with no access to speech pathologists. Some clients with complex disabilities and with no means of communication had not seen a speech pathologist in over 4 years. When ILC WA visited this town we received referrals from the school and private therapists to look at AAC. Often suitable technologies are identified, however due to lack of Health Department Speech Pathologists in the town, the clients is unable to access a trial or funding for the device. This is frustrating for families and decisions for AAC are often made based on the access to funding rather than the most suitable option for the clients' communication. Families often buy their own devices without the support from a speech pathologist. Without support from a speech pathologist communication devices are often not used to their full potential or abandoned leaving the individual with no means of communicating.[60]

5.70 The Australian College of Nurses (ACN) stated in its submission that there is 'a particular paucity of speech pathology services for infants and children in regional and remote areas'.[61] It argued there is a 'significant need for improved resourcing of speech pathology services in these areas particularly to address service gaps in Aboriginal and Torres Strait Islander communities'. The ACN identified particular areas of need as:

- extreme difficulties in accessing speech pathology services for children with severe developmental delays in remote Northern Territory communities; and
- communities that have access to outreach speech pathology services, but no community-based speech pathology service. As a result, clients are often unable to access regular and/or ongoing appointments.[62]

5.71 Ms Meg Houghton, a speech pathologist with nearly 40 years' experience in various settings, argued in her submission that the challenge for catering people in remote areas could be resolved by:

- ensuring parents have cost effective access to technology to enable them to regularly access therapy with their various therapists;

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60 Independent Living Centre, *Submission 221*, p. 6.

61 *Submission 192*, p. 4.

62 *Submission 192*, p. 4.

- better funding for travel to regional centres/cities to access services (more than once or twice a year);
- the alternative is to fund speech pathologists to service remote areas (several times a year); and
- covering the cost of appropriate web based or computer based programs suggested by their therapist.[63]

5.72 Other proposals, from a speech pathologist in a central Queensland town, were reproduced in the National Rural Health Alliance's submission. These are:

- enticements to establish rural private speech pathology (SP) practice;
- internet connection speeds to support Telehealth SP services;
- financial assistance to access professional development resources such as the Speech Pathology Australia lending library in rural areas;
- establish network of specialist clinicians from whom rural clinicians can request advice and clinical guidance (eg. Fluency specialist);
- support to purchase clinical resources in rural areas. Generalist caseloads require a broad resource set that organisations seldom provide;
- improve collaboration between existing speech pathology services; and
- promote community awareness in rural and remote areas.[64]

The service delivery model in aged-care residential homes

5.73 SPA expressed particular concern with the current model for service delivery in residential aged-care homes. Its President told the committee:

> People in aged-care facilities are screened, obviously, for communication and swallowing but that is done by nursing staff with a residential aged-care facility. So we are not formally part of that funding tool, which we feel is urgently needed in the aged-care sector.[65]

5.74 SPA noted that its members consistently report that speech pathologists are rarely employed by aged care service providers as staff. The preferred model is to contract private speech pathology services for assessment and/or management advice for specific residents. However, SPA claimed that:

> …private speech pathologists working in the aged care sector consistently report that referrals for communication assessment or management are rarely received. This is despite the high prevalence of communication disorders for this population, and recognition by nursing and care staff that participation and social interaction are vital. This issue relates to the current

63 *Submission 253*, pp 2–3.

64 *Submission 266*, p. 8.

65 *Committee Hansard*, 11 June 2014, p. 8.

> Aged Care Funding Instrument that does not adequately assess communication or acknowledge the profound impact that communication and sensory impairments have on the total care needs of residents. Even though untreated communication difficulties increase the time, complexity and burden of care there is inadequate provision of funding or resources for care staff to identify or meet residents' communication abilities or needs (Potkins et al., 2005). This fails to comply with aged care Accreditation Standards (e.g. Standard 2.6 Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences) and best-practice guidelines. Furthermore, this means that a large number of older Australians with a range of medical conditions (i.e. stroke, dementia, Parkinson's disease) are denied access to an effective mode of communication and provision of best-practice care that is tailored to meet their specific communication needs.[66]

5.75 Professor Theodoros told the committee that:

> It is very important that speech pathology is recognised and involved in aged-care reform and policy. One way of doing that, of course, is for us to be a part of the aged care and accreditation standards funding…[67]

5.76 The committee is concerned by this evidence, although there it has not been provided with data to confirm these practices. The committee recommends that the federal government in collaboration with state governments inquire into the practices used by residential aged-care centres to screen for speech and language disorders and employ speech pathologists.

Recommendation 2

5.77 The committee recommends that the federal government, in collaboration with state and territory governments and other key stakeholders, investigate the current service delivery model for speech pathology services in aged care residential homes in Australia. The federal government should seek information on:

- **the capacity—in terms of both skills and resources—of nursing staff within a residential aged-care facility to screen for communication and swallowing disorders;**
- **the number of speech pathologists directly employed by an aged care residential centre; and**
- **the number of residential aged care facilities that opt to contract out private speech pathology services, and of these, the number of cases—in a calendar or financial year—where a private speech pathologist has been contracted.**

66 *Submission 224*, p. 65.

67 *Committee Hansard*, 11 June 2014, p. 8.

5.78 On the basis of this evidence, the committee recommends that the federal government form a view as to whether these practices are compliant with aged care Accreditation Standards. The findings should be considered as part of the federal government's ongoing aged care reforms.

The provision and adequacy of private speech pathology services

5.79 Those who are unable to access speech pathology services in the public system often seek private speech pathology services. The committee received several submissions from speech pathologists operating private clinics and private patients who have noted that the public system's waiting lists have forced people to access the private system. Ms Julie Carey, the owner of a private speech pathology practice in Blacktown in western Sydney, made the following observations in her submission:

> Over the past 24 years I have become increasingly concerned about the lack of quality, affordable speech pathology services available to the people in western Sydney. The community health centres in the area are understaffed and currently have long waiting lists. In addition they are required to limit their service to specific age groups and offer a very limited number of sessions. These restrictions force families to seek private therapy. This is an expensive option.[68]

5.80 While some submitters were happy with the quality and the availability of private speech pathology services, there was criticism of the lack of appropriate private speech pathology services in regional and remote areas.[69] One submitter, whose four year old son has Menkes disease, commented:

> We live in the regional town of Bowral, located in the Southern Highlands of NSW. We have found access to many therapies difficult, and have relied on a few exemplarily young therapists who have gone out of their way to meet the needs of **** and our family. Until recently there have been very few options for to participate in speech therapy locally. There is a private paediatric speech therapy service in the area, but we have found that the staff are not experienced with the challenges faced by a child with such severe disabilities as our son. This limited experience has also hampered the speech therapy services offered at our local hospital. The experience and expertise of these therapists is generally limited to oral communication, and they lack knowledge of alternative communication strategies and technologies that requires.[70]

5.81 The biggest concern with private speech pathology services appears to be the high out-of-pocket cost for these services. As chapter 1 noted, a patient can claim the Medicare rebate (currently $52 for a consultation) or claim through a private health

68 *Submission 64*, p. 1.

69 See Name withheld, *Submission 113*

70 Name withheld, *Submission 113*, p. 1.

fund (roughly 65 per cent of the cost), but they cannot do both. The committee has received evidence that a private speech pathologist charges around $180 per session, leaving the patient around $130 out of pocket.[71] Patients can only claim once per session through Medicare and private health funds typically have an annual cap on the dollar amount claimed in a financial year.

5.82 The high cost of private speech pathology services was recognised not only by patients and the parents of patients who made a submission to this inquiry, but also by private practitioners themselves. Ms Carey wrote in her submission:

> Speech Pathologists have a university degree and are paid accordingly. Therefore the cost of the service must be kept at a level sufficient to pay professional wages. Medicare provides 5 sessions annually under the Chronic Disease Management Plan. Currently the rebate is about $50 per session. This does not even begin to cover the cost of an assessment ($180) and barely covers half of the treatment session ($90). In addition speech pathology intervention is a long term intervention and clients often require at least 2 years of therapy to achieve goals. Many families cannot afford expensive private health cover and are therefore not able to access essential speech pathology services. In addition many families have more than one child in the family who requires therapy and are simply unable to afford the cost of ongoing therapy.[72]

Five private treatment sessions through Medicare per year

5.83 In terms of claiming a Medicare rebate for a private consultation, the Department of Health's Chronic Disease Management program allows five treatment sessions per calendar year. Many submitters to this inquiry have commented that this number of visits is inadequate to treat disorders such as stuttering, and the associated Social Anxiety Disorder. The Australian Easy Speak Association wrote in its submission:

> The amount of financial support required can depend on the type of treatment used and when the intervention is applied. Appropriate intervention involves regular sessions with a speech pathologist. Sessions (face to face or telehealth) of 30-60 minutes in duration for 15-50 sessions usually achieve good levels of fluency. Intensive group treatments of a week in duration, in combination with attendance at regular maintenance sessions, can also achieve good levels of fluency.[73]

5.84 Similarly, Ms Carey wrote:

> Those families who are able to avail themselves of the 5 subsidised sessions quickly see the value of therapy but come to the realisation that in order for

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71 See *submission 64*, p. 1. Interestingly, private speech pathologists are not allowed under Australian competition law to publicise their fee schedules.

72 *Submission 64*, p. 1.

73 *Submission 100*, p. 5.

> therapy to be effective it must be consistent and long term. Five sessions per year do very little to address severe speech and language disorders.[74]

The cost of private speech pathology services

5.85 A recurrent concern of submitters to this inquiry was the cost of private speech pathology services. Those who did access these services emphasised the financial burden it had placed on them, while those who did not use a private therapist highlighted cost as the key prohibiting factor. One submitter, who asked for her name to be withheld, provided the following evidence:

> Through our entire journey with *** the thing that I really wish I could change would be the financial burden that it has placed on us. The countless hours spent in the car and in appointments and waiting around, the loss of my career don't bother me at all compared to the shame and guilt I feel at not being able to provide him with the support he needs, simply because we can't afford it. To a slightly lesser extent access to services has had an impact as well, as there is simply not enough therapists or funding to go around. However I really do consider myself one of the lucky ones due to the amount of services we were able to access, particularly the wonderful Early Intervention Services provided by Therapy ACT, The Act Department of Education and The Glenleighden School.[75]

Committee view on the shortage of speech pathology services for children

5.86 The committee has gathered considerable evidence in the course of this inquiry that the supply of speech pathology services has fallen well below demand, leading to considerable waiting times. These delays for public and community-based services are evident in all states and territories. There is some evidence that services are inadequate in socio-economically disadvantaged areas while in many remote areas, the services are simply not there.

5.87 The committee is concerned with the evidence presented in this chapter indicating significant gaps in the supply of services for children with speech and language disorders in the various States and Territories. It appears that many children are missing out on timely services at a cost to their development and to the community. Governments at all levels have a responsibility to ensure that these delays are properly identified and avoided.

Mapping the supply of speech pathology services

5.88 The committee believes that in terms of identifying the need for public and private speech pathology services by location, there is real value in conducting nationwide the type of research commenced by the Murdoch Children's Research Institute in Victoria. Mapping a range of language support services against the AEDI

74 *Submission 64*, p. 1.

75 *Submission 150*, p. 6.

information about vulnerable communities would identify potential areas of mismatch between the need for services and their availability. This exercise could also potentially capture data about the quality of existing services. The data would:

- give service providers with a basis from which to refine existing services and develop new services; and
- help to reduce speech pathology waiting lists.

Recommendation 3

5.89 The committee recommends that the federal Department of Health work with the most relevant stakeholders to make an assessment of the financial cost, timeframe and research benefits of a project that maps language support services across Australia against the Australian Early Development Index information about vulnerable communities.

5.90 Pending an assessment of this proposal, the committee recommends that the federal government consider funding a project along the lines proposed. The findings of this research should inform future policy decisions to fund public speech pathology services in Australia. The findings should also guide private practitioners as to those locations where their services are most likely to be needed.

An audit of children's speech, language and communication needs

5.91 The committee has gathered considerable evidence about these shortages from across the country. What it has not done is conduct a thorough and systematic analysis of the adequacy, strengths and limitations of existing speech and language services for children. The committee agrees with the Murdoch Children's Research Institute (MCRI) that there needs to be an audit of the state of children's speech, language and communication needs in Australia. A similar project led to important policy changes in the United Kingdom.

5.92 MCRI proposed that this audit would perform the following tasks:

(a) consult extensively with individuals, families and communities from a variety of demographic subsets that are directly affected by speech, language and communication needs, including but not limited to culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities;

(b) consult extensively with a range of children’s health and education providers, including but not limited to early childhood education and care centres, primary schools, secondary schools, speech and language therapists and special needs coordinators; and

(c) commission research by leading academics in the field of speech, language and communication needs into specific areas of interest to

ensure that policies, programs and services are evidence-based and as equitable, effective and efficient as possible.[76]

Recommendation 4

5.93 The committee recommends that the federal government provide funding and/or support for an appropriate research institute to conduct a thorough and systematic audit of the adequacy, strengths and limitations of existing speech and language services for children in Australia. The audit should consult with children's health and education providers, including but not limited to early childhood education and care centres, primary schools, secondary schools, speech and language therapists and special needs coordinators.

5.94 The committee recommends that this research proceed as soon as possible. The research would provide a foundation for the federal Department of Health to conduct its work into paediatric speech and language disorders.

76 *Submission 161*, p. 11.

Chapter 6

The factors affecting the supply of speech pathologists in Australia and some options to address shortages

6.1 This report has focused on the inability of people with a range of speech and language disorders, at all stages of life, to access adequate speech pathology services when they most need these treatments. This chapter considers various options to address this issue commencing with discussion of the factors that determine access to speech pathology services in Australia:

- the level of funding for public speech pathology positions;
    - public funding that is flexible, able to be accessed early in a person's condition, and able to facilitate developmental outcomes;
- the level of funding for individuals to access private speech pathology services;
- funding for initiatives that promote community awareness and support for speech pathology services;
- the number and quality of speech pathology graduates from Australian universities;
- the system in place to train speech pathologists, including options for clinical placements;
- the ability of graduates to find work and secure meaningful professional development opportunities, particularly in the community health sector;
- the deployment of new graduates (where they find work; public or private, geographic location)
- the level of funding for clinical research to support the case for, and method of intervention and the standing of the profession; and
- the way in which speech pathologists are employed within the education, health, the aged care system and the correctional services system.

6.2 Submitters and witnesses to this inquiry put views and recommendations to the committee on all these issues. There was general consensus that greater funding is needed, particularly for public speech pathology services. The central argument is that this funding is important not only to meet the growing demand for these services in a fair and equitable way; it is also crucial to provide training opportunities for students and a career structure and professional development opportunities for graduates.

Publicly funded speech pathology positions

6.3 Several submitters identified the supply problem—and its solution—in terms of the shortfall in the number of publicly funded speech pathology positions. As the President of Speech Pathology Australia, Professor Deborah Theodoros, told the committee:

> There is really no delicate way to say it: there are just not enough public funded speech pathology positions. We do have an established private speech pathology sector but this should not be the only option for the Australian people, and most of the time it is. For those who cannot pay for private services they go without or they languish on long public waiting lists, to find that by the time their name comes up their condition has worsened or their child no longer meets the age eligibility.[1]

6.4 Several witnesses drew attention to the consequences of the current shortfall in funding public speech pathology positions. Professor Elizabeth Cardell is the Director of a new speech pathology program at Griffith University's Gold Coast Campus. She expressed support in her submission for the increase in Commonwealth-supported places in university programs and Health Workforce Australia funding to support growth in clinical placements. However, she noted that there had been no commensurate increase in publicly-funded speech pathology positions or services. As a result, Professor Cardell argued, sourcing clinical placements for student training has been increasingly challenging and competitive, and the employment opportunities for graduates are becoming more limited. She cited a survey by the Queensland Speech Pathology Clinical Education Collaborative which indicated that the market place for clinical placements in Queensland will be saturated by 2016.[2]

6.5 Associate Professor Patricia McCabe, Associate Professor Kirrie Ballard and Dr Natalie Munro wrote of the 2010–2011 national survey of parents of children with speech and language disorders:

> …paediatric services are inadequate in many areas of Australia, primarily due to lack of funding. It appears limited funding is being rationed by service providers so that school aged children and adolescents are not receiving services and all children receive less service than their parents believe they need and far less than the research suggests they require.[3]

6.6 Ms Elizabeth Forsyth of the not-for-profit organisation, Northcott, told the committee that the model for funding speech pathology services currently appears to be the driver for accessing services, rather than an assessment of need. She added:

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1 *Committee Hansard*, 11 June 2014, p. 2.

2 *Submission 213*, p. 2.

3 *Submission 85*, p. 2.

> We also see that there is an ongoing, and will be an increasing, unmet need for speech pathology services and that the demand for services will continue across the board. We actually see that there are particular cohorts of people who currently have really limited access to funding or no access to funding. Of particular concern to us are children who have lower level communication needs and who do not necessarily have a disability diagnosis and therefore access to funding to get some assessment or some support.[4]

6.7 SPA recommended that the Commonwealth Department of Health provide access to specialist speech pathology support via the Medicare Benefits Schedule, across the lifespan, for individuals with communication and swallowing disorders (see below).[5]

6.8 In its submission to the inquiry, Carers NSW made several recommendations aimed at increasing access to speech pathology services. These included proposals:

- to increase the Medicare subsidy of speech therapy services for children with disability;
- that public speech therapy services be increased to meet demand and that a priority system be introduced for children close to school age; and
- that additional financial support be provided to remote families facing high travel costs to access speech pathology services.[6]

6.9 Many submitters to this inquiry emphasised the need for better funding of speech pathology services within the public education system. Chapter 5 of this report has highlighted the fact that in New South Wales, Western Australia, the ACT and the Northern Territory, there are no speech pathologists attached to schools. But even in states where there are, submitters expressed strong concern with the growing number of children who require speech pathology but are unable to get timely access to these services. SPA noted that:

> In Victoria some schools purchase private speech pathology input, as Department of Education and Early Childhood Development speech pathologists are often unable to give direct therapy support to the majority of students who need it. The involvement of specialist therapists may even be limited where there is a significant and obvious need for their involvement.[7]

4 *Committee Hansard*, 11 June 2014, p. 1.

5 *Submission 224*, p. 13.

6 *Submission 87*, p. 1.

7 *Submission 224*, p. 36.

The frequency and flexibility of public funding

6.10 An accompanying argument, put by several submitters, is that there needs to be funding for public speech pathology services to ensure access early in a person's condition, and at key times throughout their condition. SPA, notably, made several recommendations that emphasised the importance not only of what could be accessed and by whom, but when and how this access needed to occur. In this vein, it made the following recommendations:

> The Commonwealth Department of Health provide access to specialist speech pathology support via the Medicare Benefits Schedule, across the lifespan, for individuals with communication and swallowing disorders, allowing that:
>
> (a) the number of sessions provided be based on evidence with respect to intervention effectiveness
>
> (b) services be flexibly delivered, such as via direct (in clinic), out of clinic (e.g., home based), indirect (e.g. training of a parent or carer) or telehealth services;
>
> (c) the range of conditions not be limited to only specific disability groups (e.g. Autism or conditions under the Better Start for Children with Disability), but include recognised specific communication impairments, such as, but not limited to, severe language disorder, childhood apraxia of speech, cleft palate, stuttering, voice, aphasia.
>
> (d) medical specialists (ie paediatricians, ENT) be accorded direct referral to speech pathology rights (for all Medicare items applicable to speech pathology)
>
> (e) general practitioners be accorded referral rights to speech pathology as a single discipline under the Chronic Disease Management items, without the person requiring the services of another health professional, as currently is required.[8]
>
> The Commonwealth Department of Health provide flexible and sustained funding options which will provide support to maintain and optimise a person's functioning including communication during episodic events of heightened need at different stages, as well as providing life-long support through to end stage care.[9]
>
> The Australian Government should mandate use of a revised aged care funding tool that adequately identifies communication and/or swallowing disorders and provides funding for comprehensive assessment and management by a speech pathologist if indicated. This must ensure provision of funding for periodic review or follow-up as required.[10]

8 *Submission 224*, p. 78.

9 *Submission 224*, p. 60.

10 *Submission 224*, p. 69.

> The Department of Health provide funding based on episodes of care for evidence-based intervention programs for adults with persistent communication disorders e.g. stuttering; and adults with progressive communication disorders, eg Parkinson's disease.[11]
>
> Individuals with head and neck cancer have access to publicly funded speech pathology services at all stages of the cancer pathway.[12]

6.11 Other submitters emphasised the need for more publicly funded consultations. Speech Pathology Tasmania, for example, recommended that:

> Medicare's Chronic Disease Management Plan must be extended to 10 visits per year. Communication problems that are part of a 'chronic disease' are always more complex than can be addressed in just five sessions annually.[13]

Direct funding to support private speech pathology options

6.12 Another avenue to increase access to speech pathologists in Australia is to provide financial assistance for people with speech and language disorders to visit private speech pathologists. One example of this type of assistance is the New South Wales Government's *Better Start for Children with Disability* initiative (Better Start). Introduced on 1 July 2011, Better Start is funded by the Commonwealth Department of Social Services. It provides the families of eligible children with disability with up to $12 000 to purchase early intervention services, treatments and resources delivered and recommended by registered service providers. To be eligible for Better Start, a child must have a diagnosis of a limited range of disabilities and be registered before six years of age. Families have until the child turns seven to access the funding, and a maximum of $6,000 can be spent per financial year.[14]

6.13 Carers NSW recommended in its submission that registration for Better Start should be simplified and streamlined and more broadly promoted in the speech pathology community to increase the range and diversity of providers. It argued that:

> …given the high cost and necessary frequency of speech therapy sessions, as well as the higher fees applied to Better Start participants, the annual cap of $6 000 and total cap of $12 000 may limit the benefits that this intervention could provide to children and their families. For example, at $150 per session, a child's entire yearly allocation could be used up on weekly speech therapy services, and their total funding exhausted after two years.[15]

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11 *Submission 224*, p. 79.

12 *Submission 224*, p. 51.

13 *Submission 259*, p. 7.

14 *Submission 87*, p. 1.

15 *Submission 87*, p. 2.

6.14 Ms Rosie Martin, Senior Speech Pathologist at Speech Pathology Tasmania, expressed her support for both the Better Start and the *Helping Children with Autism* (HCWA)[16] initiatives. She argued that both these Commonwealth programs have 'greatly and respectfully improved parent-choice-driven therapy options for those children who qualify'. Indeed, Ms Martin put the case for extending the funding available through these programs:

> From a communication growth point of view, many children are just reaching the 'acceleration' phase of their intervention programme when the funding expires. These schemes need to be extended, and/or coordinated with the NDIS so that they continue for another two to three years. This would bring children through, with ongoing support, to the point at which they tend, in any case, to make their own choice to have a break from therapy in the pre-adolescent and early adolescent years. This extension of financial support to families would greatly improve the options for treatment of children with social communication problems who are having trouble making friends at school. These troubles begin to surface most painfully at about the age that the [DSS]funding currently expires.[17]

6.15 Similarly, Early Childhood Intervention Australia (ECIA) argued the need to broaden access to children's speech pathology services, such as those funded through Better Start and HCWA, prior to the introduction of the NDIS. It stated:

> The shortage of speech pathology services for very young children across the country has been clearly demonstrated through the implementation of the new funding initiatives introduced by the Australian Government five years ago. These initiatives are based on diagnosis and only a small number of disability groups are eligible. Children with other types of disabilities are excluded from this funding known as Helping Children with Autism and Better Start. It is critical that this shortage is addressed prior to the full introduction of the National Disability Insurance Scheme, which will supercede these [DSS] funded services. A significant increase in demand is expected when the diagnostic criteria will be expanded so that all children with any type of disability or developmental delay will be eligible for early childhood intervention services based on the principle of reasonable and necessary supports.[18]

6.16 Northcott's submission emphasised that funding should be based on an individual's need rather than setting funding amounts based on diagnoses within programs. It was critical of the HCWA program for failing to identify the individual's need. In contrast, Northcott strongly supports the roll-out of the National Disability

16 The HCWA program provides all children with Autism under 7 years of age access to $12 000 funding for allied health therapy services, regardless of their level of need.

17 *Submission 259*, p. 8.

18 *Submission 256*, p. 2.

Insurance Scheme (NDIS) given that the scheme will provide access to speech pathology services based on actual need.[19]

6.17 The NDIS is expected to be fully rolled out by 2018–19. As chapters 4 and 5 noted, the scheme has an individualised funding model. It will give funds to an eligible person with disability to spend on services and equipment according to their needs and life goals.

6.18 The NDIS will provide a significant injection of funding for speech pathology services. As Dr Ken Baker, the Chief Executive of National Disability Services, noted:

> Although it is difficult to predict how many additional speech pathologists will be required as a result of the NDIS, the investment in early invention services for young children with disability will certainly increase (as the scheme seeks to reduce its future liabilities). Early intervention services will be available to many more children than currently receive them and these services will be available at a higher intensity…
>
> Increased demand for speech pathology will also arise from the NDIS improving the access that adults with disability have to therapy services. In the case of speech pathology, it is expected that some adults with long-term disability will have improved access to communication services and equipment, and to services such as the treatment of swallowing disorders (dysphagia). Assessing and treating communication disorders improves a person's quality of life and improves their ability to participate in the community and to work; diagnosing and treating dysphagia reduces the incidence of chest infections and pneumonia. Appropriate access to speech pathology services will, therefore, improve people's lives and reduce acute health care costs.[20]

6.19 However, the individualised funding model of the NDIS, and the planned departure of state governments from their current disability service obligations, has raised some concerns. SPA noted:

> As states such as NSW wind up their state-based disability support systems, we are very concerned about gaps that will not be filled by NDIS, leading to further disadvantage for people with a disability. Our members have reported that there are likely to be gaps in availability of speech pathology support, particularly in rural and remote areas. There is a high administrative burden associated with coordinating supports that do not fit the direct one-to-one service approach for which the NDIS is mostly suited. For example, models of service that have been successfully implemented in the past (such as fly in-fly out services providing to a number of people in the same town) will be more difficult to implement because each participant under the NDIS has a separately developed, individual plan. Thus a

19 *Submission 190*, pp 5–6.

20 *Submission 180*, pp 1–2.

> therapist who would like to offer a satellite service to several NDIS participants in the same town would need to coordinate travel time allowances being split across each individual plan equally, in order to provide the service. This can place an administrative burden on the therapist which may compromise the provision of the service.[21]

6.20 SPA recommended that the Department of Social Services undertake a review of NDIS and state based disability services now; in 12 months; and then 24 months, to consider if people with specific communication or swallowing disabilities who are not deemed eligible for NDIS support have 'fallen between the gaps'.[22]

6.21 SPA told the committee that the advent of the NDIS will increase demand for speech pathology services in Australia. However, it argued that there are adequate numbers of speech pathologists to meet this demand. It did qualify this confidence by noting its concern with the risks to retention and recruitment to the sector as a consequence of the transition to the NDIS:

> State funding withdrawal, focus on individualised funding, shift to NGO and private provider service provision paradigms, loss of career structure, loss of clinical supervision, loss of training and professional development opportunities, erosion of clinical governance structures, loss of communication access and community capacity building programs and services. SPA believes addressing these risks to retention and recruitment of speech pathologists as providers to participants of the NDIS is of particular importance in speech pathology because health, education and the private sector are all competing employers.[23]

Recommendation 5

6.22 The committee recommends that the federal Department of Health work with the National Disability Insurance Agency to develop a position paper on the likely impact of the National Disability Insurance Scheme (NDIS) on speech pathology services in Australia. The paper should consider:

- **the possible impact of the NDIS on the demand for speech pathology services in Australia, and the likely drivers of this demand;**
- **the need for greater numbers of trained speech pathologists as a result of increased demand for speech pathologist services arising from the introduction of the NDIS;**

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21 *Submission 224*, p. 74. See also the comments of Mrs Robyn Stephen, Speech Pathology Australia, *Committee Hansard*, 11 June 2014, p. 7.

22 *Submission 224*, pp 13, 75.

23 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 5.

- **the need for the speech pathology profession to develop telehealth practices to cater for NDIS participants requiring speech pathology services; and**
- **concerns that the withdrawal of State funding for speech pathology services in anticipation of the NDIS may leave some people worse off if they are ineligible to become an NDIS participant.**

The position paper should be circulated to key stakeholders for consideration and comment and to assist in decision making.

Community capacity building

6.23 A third avenue through which to facilitate greater access to speech pathology services is to fund initiatives that promote community awareness and support of these services. This is known as 'community capacity building'. SPA, for example, recommended in its submission that:

> The Department of Social Services and the National Disability Insurance Agency (NDIA) extend funding beyond individual support for persons with disability, to include sustaining services that reduce barriers to participation and promote community awareness and support. This should include training in communication disorders for NDIS staff and those employed as NDIS Planners.[24]

6.24 Ms Forsyth of Northcott argued that while the NDIS may resolve some of the issues around equity and access to funding, there also needs to be funding for 'a community capacity building approach' for speech pathology services. As she explained:

> While there will always be a need for individuals to have access to funding to support their individual needs, we think there is a big need for adequate funding and resourcing so that there can be an approach that targets the community and community members, particularly in school and education settings. The focus of the speech pathology intervention or service would be around building the skills and the capacity of those teachers, the staff or those key community members to identify communication needs and respond on a holistic level, building a much more inclusive environment for kids, particularly for those kids with lower level communication skills who would benefit from early intervention or some assistance at the early stages in order to decrease their need for more formal or costly supports later in life.
>
> That is a gap that we see in the system. We operate some and in our submission we point to an example of our SPOT in Schools program. That is one example of a program in this space that has been effective. But we really do not see an ongoing funding source or an identified area of need

24 *Submission 224*, p. 75.

> that says speech pathology is not just going to be about an individual funding, assessment and intervention approach but should look at a skills development and community capacity building approach to provide some broader scale supports in the community.[25]

The challenge of training speech pathologists

6.25 As this chapter has discussed, a key challenge facing the speech pathology profession is to attract public funding that will ease the pressure on waiting lists and meet the significant backlog of demand for public speech pathology services. While meeting this demand is imperative, funding for public speech pathology positions is also important to provide clinical placements for students and employment and professional development opportunities for graduates. The following section looks at the number of speech pathology students in Australian universities over the past decade and the numbers graduating.

Box 6.1: Training speech pathologists

Speech pathologists complete a degree at university covering all aspects of communication including speech, writing, reading, signs, symbols and gestures. Currently, there are 15 universities offering 24 speech pathology programs.

Courses are either a **four year undergraduate bachelor's degree** or a **two year entry level Masters' degree** (where there is a bachelor's degree requirement in a related discipline). **Charles Sturt University**, for example, offers both a Bachelor of Speech and Language Pathology and a Master of Speech Pathology. Students graduating from both courses must meet the same competency standards. **Griffith University** has recently introduced a Master of Speech Pathology at its Gold Coast Campus. Pre-requisite degrees for this course include health science, linguistics, medical science, psychology, public health, education, and nursing.

There are **clinical placements** in the third and fourth years for undergraduate students and in both years for students in the two year Master's course. Speech Pathology Australia is the peak professional body that represents speech pathologists in Australia and has a role in accrediting university programs that train speech pathologists.

Source: http://www.speechpathologyaustralia.org.au/information-for-the-public/frequently-asked-questions

25 *Committee Hansard*, 12 June 2014, p. 1. See also Northcott, *Submission 190*, p. 6.

Commencements, enrolments and completions for 2005–2012

6.26 The committee requested data from the federal Department of Education on the number of students commencing, enrolled in, and actually having completed an undergraduate or postgraduate qualification in speech pathology at an Australian university between 2005 and 2012.[26] These data are shown in Tables 6.1–6.3 (below).

6.27 Table 6.1 relates to new enrolments in speech pathology courses offered in Australian universities. This is the first year intake. Table 6.2 shows enrolments—the number of students in the system in all years (including commencements). Table 6.3 shows the number of students who have completed the requirements of a speech pathology course in a given year.

6.28 The tables show that there has been a significant increase in the number of commencements (1st year students) and enrolments (students in the system) for both undergraduate and postgraduate courses in speech pathology over the period. There was a 71.6 per cent increase in commencements for bachelor courses in speech pathology from 2005 and 2012 (Table 6.1), and a 62.6 per cent increase in the number of undergraduate enrolments in these courses over the period (Table 6.2).

6.29 The bachelor's degree in speech pathology is a four year degree. With rising commencement and enrolment numbers, one would expect that the numbers graduating from undergraduate speech pathology courses would also be increasing. However, as Table 6.3 shows, the numbers graduating with a bachelor's degree in speech pathology at Australian universities has been stagnant over the period. In 2005, 401 students completed a bachelor's degree in speech pathology; in 2012, 402 students completed a bachelor's in speech pathology. The calendar year with the highest number of completions over the period was 2009, when (only) 408 students graduated.

6.30 Table 6.1 shows that in 2006, there were 523 commencements in undergraduate speech pathology courses in Australia. Assuming these students studied full time, passed their exams and progressed to the next year, one would expect that a similar number would graduate in 2010. However, Table 6.3 shows that only 380 students completed their bachelor's degree in 2010. Certainly, given the significant number of additional enrolments since 2005, and the introduction of several new undergraduate speech pathology courses since 2012, the expectation must be that completion numbers will increase sharply in coming years.

26 The committee thanks the federal Department of Education for its assistance in providing this information and permitting the publication of this data in this report.

Table 6.1: Commencements in Speech Pathology, 2005-2012*
Source: Selected Higher Education Statistics - Department of Education

			2005	2006	2007	2008	2009	2010	2011	2012	% change 2005-2012
Postgraduate	**61707**	**Speech Pathology**	120	145	123	120	161	170	218	308	156.7%
Bachelor	**61707**	**Speech Pathology**	497	523	555	548	638	684	769	853	71.6%
Total			617	668	678	668	799	854	987	1,161	88.2%

Table 6.2: Enrolments in Speech Pathology, 2005-2012*
Source: Selected Higher Education Statistics - Department of Education

			2005	2006	2007	2008	2009	2010	2011	2012	% change 2005-2012
Postgraduate	**61707**	**Speech Pathology**	321	370	401	343	383	429	510	650	102.5%
Bachelor	**61707**	**Speech Pathology**	1,631	1,721	1,814	1,830	1,977	2,106	2,355	2,652	62.6%
Total			1,952	2,091	2,215	2,173	2,360	2,535	2,865	3,302	69.2%

Table 6.3: Completions in Speech Pathology, 2005-2012
Source: Selected Higher Education Statistics - Department of Education

			2005	2006	2007	2008	2009	2010	2011	2012	% change 2005-2012
Postgraduate	**61707**	**Speech Pathology**	101	80	131	114	127	114	159	182	80.2%
Bachelor	**61707**	**Speech Pathology**	401	371	362	347	408	380	392	402	0.2%
Total			502	451	493	461	535	494	551	584	16.3%

* Commencements refer to first year students. Enrolments refer to first year and continuing students.

Commencements, enrolments and completions for 2013–2014

6.31 SPA provided the committee with data showing commencements and expected completions in 2013 and 2014 from the 15 Australian universities that offer speech pathology courses. Table 6.4 summarises these data. The number of commencements continues to grow. The number of students enrolled increased strongly from 2013 to 2014, and the number of students expected to complete and graduate in both years was significantly higher than the numbers shown for the 2005–2012 period (see Table 6.3). In 2014, five Australian university courses expected more than 50 speech pathology students to graduate: the bachelor's programs at Curtin University of Technology, Flinders University, La Trobe University, the University of Queensland and the University of Sydney.[27]

Table 6.4: Commencements and expected graduations in 2013 and 2014 [28]

	Number of students commencing	Number of students enrolled	Number of students expected to complete/graduate
2013	1,181	3,171	720
2014	1,312	3,581	719

Source: Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 7, Attachment 1.

6.32 The committee asked SPAa for its comment on the number of speech pathology courses and graduates in Australia in recent years. Ms Gail Mulcair, the Chief Executive Officer of SPA responded:

> There are 15 universities that offer 24 speech pathology programs. Some of the universities offer a bachelor's program, some offer graduate entry master's program, which is two years, as against the bachelor's being four years; and some universities offer both.[29]

6.33 Professor Deborah Theodorus, the President of SPA, told the committee that the number of Masters' programs is small compared with the number of bachelor's programs. She noted that 'the vast majority of graduates will be coming through bachelor programs'.[30] Ms Mulcair added:

> And the number of students going into those programs are larger than the intake for the graduate master's as well. We know that there were roughly 1 300 new students commencing speech pathology programs this year…across all of those programs—both bachelor's and graduate entry

27 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 7, Attachment 1.

28 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, pp 6–7, Attachment 1.

29 *Committee Hansard*, 11 June 2014, p. 5.

30 *Committee Hansard*, 11 June 2014, p. 5.

> master's—and that is more than double the figure if you go back 10 years. It has been a significant increase. Of all of those programs that I mentioned, 10 of the programs are new in the last five years. There has been a significant recent increase in terms of the number of training programs. Because of the four-year pipeline for graduates to be completing their course we are now seeing, particularly of this year and I think future years, a significant increase in the number of graduates entering the workforce. We are estimating around 730 new graduates at the end of this year. That is a 45 per cent increase since the figures in 2005.
>
> …Both [Professor] Corinne [Williams] and Deb [Thoedoros], heads of speech pathology programs, can confirm that the attrition rate for speech pathology is certainly comparable if not less than other health professions. It is around the sort of 10 per cent to 15 per cent.[31]

Clinical placements

6.34 Speech pathology students undertaking a Bachelors or Masters degree are required to undertake a clinical placement as a requisite for the completion of their university course. For students to meet the Competency-based Occupational Standards (CBOS) and graduate, they must have access to sufficient clinical experience to allow them to meet the standards.[32]

6.35 However, with the 'significant increase in the number of students training' and the funding pressures on the public system, there has been pressure on clinical placements. As Ms Mulcair told the committee:

> We are seeing that it is increasingly difficult for some of the public sector facilities—hospitals, community health, rehab facilities—to take students to the same level that they did previously, largely because of their workforce pressures and their competing demands in terms of how they are having to prioritise their services.[33]

6.36 Professor Theodoros noted that the nature of clinical placements was also changing as the types of care have changed. She gave the example of the significantly shorter period of time that a person would now stay in rehabilitation, which means there is less time for students to gain the experience and the competencies that SPA requires them to have.[34]

6.37 Associate Professor Steven Cumming, Head of Discipline in Speech Pathology at the University of Sydney, identified the lack of clinical placements for students as one of two significant 'chokepoints' in training the profession. He noted that Health Workforce Australia had addressed this issue in its 'Placement Capacity

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31 *Committee Hansard*, 11 June 2014, p. 5.

32 *Submission 224*, p. 88.

33 *Committee Hansard*, 11 June 2014, p. 5.

34 *Committee Hansard*, 11 June 2014, pp 5–6.

Growth projects', which are aimed at better managing the allocation and distribution of placements between institutions. However, he cautioned that:

> …it is not clear that this model is sustainable in the medium to long-term, and indeed it may have given universities a false sense of ongoing growth in availability of placements. The work of Health Workforce Australia, Speech Pathology Australia and the universities in exploring and developing alternate experiences on such as simulations and virtual clients may represent a more viable and sustainable approach to the increasing number of students competing for practical clinical experience.[35]

6.38 The limited number of opportunities for students to undertake a clinical placement in the public system is reflected in various trends. One of these is for health services and other organisations to require payment to have students on placement.[36] SPA informed the committee that the:

> [C]apacity to meet these costs varies between universities which results in inequities in the universities' ability to provide clinical placements opportunities. In addition this also results in inequity between clinical placement providers. The unintentional flow on effect has been an erosion of the willingness of non-paid organisations to take students.[37]

6.39 Another reflection of the limited number of clinical placements available in the public system is private speech pathologists reporting an increase in requests from universities to provide clinical placements. However, SPA notes that placements with sole practitioners provide limited exposure to or experience with:

> …how to provide clinical placements, time pressures, insurance considerations, client perceptions, potential financial burden and access to private health fund or Medicare rebates.[38]

6.40 SPA told the committee that the profession is currently looking at broader options for clinical training including simulated learning activities.[39] Professor Theodoros reflected that universities are having to be 'very innovative' to ensure that their students can gain clinical experience.[40]

6.41 In its submission, SPA argued that robust data is needed regarding the ability of the profession to meet the demand for clinical placements. It recommended that:

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35 *Submission 261*, p. 2.

36 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 3.

37 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 4.

38 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 4.

39 Ms Gail Mulcair, *Committee Hansard*, 11 June 2014, p. 5.

40 Professor Deborah Theodoros, *Committee Hansard*, 11 June 2014, p. 6.

> Health Workforce Australia continue its support to enhance access to clinical placement opportunities for speech pathologists in Australia, including Simulated Learning Environment projects and models for increasing clinical education within private practice, as part of a broader review of speech pathology workforce availability and projected need.[41]

6.42 In August 2014, Health Workforce Australia (HWA) was abolished and its functions were subsumed within the federal Department of Health. The committee supports SPA's recommendation that the work of HWA should be continued.

Recommendation 6

6.43 The committee recommends that the federal Department of Health develop a strategy aimed at broadening the opportunities for speech pathology students to undertake clinical placements that satisfy the profession's Competency-based Occupational Standards. The strategy should be developed in consultation with:

- **the relevant heads of Department from each of the 15 Australian universities offering speech pathology courses; and**
- **Speech Pathology Australia and a broad cross-section of its membership.**

The ability of graduates to find work

6.44 The committee received some submissions from speech pathologists expressing their frustration at the difficulty in finding secure, full-time work in the public system. The short-term contracts that some graduates have been forced to accept has impacted on their job satisfaction and their capacity to make major financial decisions.

6.45 SPA told the committee that new graduates are reporting difficulties finding full time positions in the public sector. It noted that in 2016 the number of graduates will peak: 'in the absence of increased growth in positions, it is likely that these new graduates will need to find employment in other sectors of the workforce'.[42] SPA also observed that many new graduates:

> …are entering the workforce as sole private practitioners potentially leading to a higher attrition rate than usual. Others are being contracted by private practitioners, or NGOs and potentially have little job security and fewer professional supports than would traditionally be offered to new graduates and early career speech pathologists.[43]

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41 *Submission 224*, p. 89.

42 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 4.

43 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 4.

6.46 The committee recognises that a possible reason for long waiting lists in the public system is the shift of both new graduates and qualified practitioners to the private system. In terms of new graduates, the problem is the lack of full-time positions in the public sector. Qualified and experienced speech pathologists leave the public system to seek the financial rewards of the private practice. The committee agrees with SPA that it is important that funding for public speech pathology positions is increased to attract and retain talented and committed staff in the public system and real options for people with speech and language disorders who are unable to afford private services.

Where graduates find work

6.47 One factor that also affects the supply of speech pathology services is the placement of new graduates in the workforce. This was not an issue that was raised with the committee in any detail, but it is clearly an important one. Associate Professor Cumming expressed his concern that graduates were gravitating to private practice in areas where the need for services may not be greatest:

> While the number of graduates entering the workforce will increase significantly over the next decade, there is also evidence of increasing geographical and demographic clustering of speech pathology services in Australia. For example, the *University of Sydney Graduate Destinations Survey* suggests that there has simultaneously been a slight drop in the employment of recent graduates, coupled with a proportional increase in the number of new graduates moving directly into private practice. At the same time, changing eligibility criteria for publicly funded rehabilitation and disability services are obliging more consumers to seek out private speech pathology services. This tendency towards increased private provision will impact upon the ability of the public health care system to ensure adequate and equitable speech pathology service delivery to geographically, demographically or financially disadvantaged populations. I note that other submissions have outlined the difficulties that currently exist in providing stable, high-quality speech pathology services to non-metropolitan communities and I will not reiterate those difficulties here. Suffice it to say that there are considerable challenges in ensuring equity, quality and access of speech pathology services throughout the country, and these challenges require a national solution together with careful consideration of the present and future speech pathology workforce.[44]

6.48 The Queensland Government noted in its submission to the inquiry that its agencies have reported some challenges in recruiting and retaining speech pathologists:

> For example, DETE [Queensland Government Department of Education, Training and Employment] reports an ongoing challenge of managing episodic vacancies, particularly in rural and remote areas of Queensland. Current DCCSDS [Queensland Government Department of Communities,

44 *Submission 261*, p. 2.

> Child Safety and Disability Services] speech–language pathology services are limited in rural and remote communities where sole speech–language pathologists may have to travel very long distances to see one client. In addition, local Hospital and Health Services have reported shortages in some rural areas related to difficulties in recruitment.[45]

6.49 The committee notes that a range of incentives have been put in place to attract medical graduates to regional and remote areas of Australia where their services are most needed. Under the Rural Health Workforce Strategy:

- doctors who relocate to regional and remote areas for the first time may be eligible for payments of up to $120 000;
- doctors already working in regional and remote locations may be able to access retention payments of up to $47 000;
- medical graduates can have a portion of their medical studies Higher Education Contribution Scheme (HECS) fees reimbursed for every year of training undertaken or service provided in rural, regional or remote Australia;
- the Bonded Medical Places (BMP) Scheme which provides funding to universities to offer 600 additional medical school places each year for students willing to commit to training and/or working in a district of workforce shortage; and
- the Medical Rural Bonded Scholarships (MRBS) is an annual scholarship payment from the Commonwealth Government paid to students who in return commit to working in a rural o remote area of Australia for 6 continuous years after completing their training as a specialist.[46]

6.50 The committee is not convinced that incentives along these lines would necessarily be appropriate for the speech pathology profession. However, it believes that there is a need for further work to be done to identify the extent of the shortage of speech pathologists in rural and remote areas of Australia, and the merit of different options and incentives to attract and retain professionals to these areas.

Recommendation 7

6.51 The committee recommends that the federal Department of Health investigate the evidence of geographical and demographic clustering of speech pathology services in Australia. This investigation should look at:

- **the number of new graduates in speech pathology moving directly into the public health care system;**

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45 *Submission 268*, p. 4.

46 Department of Health, *Rural Health Workforce Strategy Incentive Programs*, http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/RHWS_incentive_programs (accessed 16 August 2014).

- **the proportion of new graduates moving into regional and remote areas of Australia;**
- **the proportion of new graduates from regional universities (such as Charles Sturt) opting to remain in a regional area to practice; and**
- **the attitudes of those graduates who work in a regional or remote area of Australia following the completion of their studies, including:**
    - **the reason why they opted to work in a regional or remote location; and**
    - **whether they intend to remain working in that location; and**
- **the attitudes of those graduates who work in metropolitan areas following the completion of their studies as to:**
    - **the reason why they opted to work in a metropolitan location; and**
    - **the attractiveness of various financial incentives to encourage them to relocate to a regional or remote area.**

6.52 The committee recommends that this investigation should be considered in the context of:

- **the findings of the project to map language support services across Australia against the Australian Early Development Index (recommendation 3); and**
- **the findings of the proposed audit of the adequacy, strengths and limitations of existing speech and language services for children in Australia (recommendation 4).**

Funding for clinical research

6.53 A submission from Dr Adam Vogel of the University of Melbourne argued that research funding for communication and swallowing impairment is 'dramatically under-represented in Australia's two key funding bodies', the Australian Research Council (ARC) and the National Health and Medical Research Council (NHMRC). He explained:

> A recent audit of funding allocated by NHMRC and ARC over a 10 year period (2004–2013) for projects focussing on pathological communication and swallowing showed a discrepancy between research funding and disease burden and prevalence in Australia. The paper, to be published in the Medical Journal of Australia, describes a review of all funding (including people support, project, program, linkage and discovery grants) allocated to projects with a specific focus on communication or swallowing disorders. Only 154 of the 12 000 grants awarded by the NHMRC and ARC during this 10 year period met criteria. The monetary value of these grants totalled approximately AU$61 million (1.1% of all funding awarded). Funding for hearing impairment (42%) represented the bulk of grants (not including AU$32.6 million awarded to the HEARing Cooperative Research Centre since 2007), followed by stuttering (17%), language (16%), speech

> (7%), literacy (3%), swallowing (3%) and mixed focus (12%). 20% of the value of the 154 grants awarded were for people support (i.e., salaries for researchers).[47]

6.54 A similar point was made by the Centre for Research Excellence in Child Language. In its submission, the Centre noted that language impairment receives around one-fifth of the funding that the NHMRC allocates to obesity 'despite similar rates and significant, enduring consequences'.[48] It added:

> In the 2011-12 financial year alone, obesity research was awarded more than seven times the amount allocated to speech and language disorders research ($37 million compared to $5 million).[49]

The Centre for Research Excellence in Child Language recommended that language impairment should be a new National Health Priority area.[50]

6.55 The committee has not had the opportunity to examine the issue of funding for clinical research in any detail. It does note that there has been some significant funding given to understanding the science of how language develops, what goes wrong and the best way to intervene. The Murdoch Children's Research Institute, for example, was recently awarded $2.5 million to establish the Centre for Research Excellence in Child Language.[51]

Service delivery models

6.56 Chapter 4 of this report noted that an important determinant of the future demand for speech pathology services in Australia is the model of service delivery. The committee received several recommendations from submitters and witnesses aimed at improving the process through which people with speech and language disorders at different stages of life can access these services. These recommendations emphasise the need for more streamlined and targeted models of service delivery

Streamlining access to, and administration of, early intervention services

6.57 Associate Professor Michael McDowell from the Neurodevelopment and Behavioural Paediatric Society of Australasia recommended developing a single integrated government strategy for Early Intervention. He argued that this strategy would combine the NDIS, the HWCA and subsequent early intervention initiatives, and publicly funded services. Further, he put the case for a single government

47 *Submission 97,* pp 2–3.

48 *Submission 161*, p. 1.

49 *Submission 161*, p. 1.

50 *Submission 161*, p. 1.

51 *Submission 161*, p. 15.

department as the lead agency in Early Intervention (0 to school age) with all publicly funded therapy for early intervention to be provided by that department.[52]

6.58 In addition to a more efficient governance framework for early intervention, Associate Professor McDowell proposed a single point of entry for assessment and treatment services for speech pathology. He also advocated a portfolio of intervention models such as training parents to deliver services, group programs and working with early childhood educators so that they can deliver services.[53]

6.59 The Centre of Research Excellence in Child Language has argued that despite the efforts of professionals in health and education, the needs of children and families are not being met. It claimed that the current model, which consists largely of 'targeted specialist interventions' delivered by speech pathologists, is neither sustainable nor equitable. The Centre argued that:

> A shift is needed in emphasis, analogous to that in other areas of healthcare, from a specialist clinical focus to one grounded in public health principles. Testing alternative service models would ensure the use of the most equitable, efficient and effective approaches to language promotion and early intervention.
>
> In the first instance, such an approach could involve harnessing the increasing interest from Medicare Locals as place-based advocates of child health and development. The Australian Early Development Index could also be used to identify geographic areas with higher rates of developmental vulnerability in which to test alternative service approaches and programs. This would enable the generation of new evidence about what works in areas of high need and would complement the Federal Government's already considerable investment through Communities for Children. Our Centre is developing an accessible, short form method for detecting children at higher risk for Language Impairment, which may prove useful in identifying specific children that could participate in this different service paradigm.[54]

6.60 The committee believes that there is merit to this idea of using Primary Health Networks to target speech pathology services to those children most in need of these services (see recommendation 9).

The education system: a tiered approach?

6.61 The committee received proposals to streamline access to speech pathologists within the education system. SPA, notably, suggested the following model:

- Speech pathologists are trained to work within schools, alongside teachers and other educational team members and with parents to improve educational

52 *Submission 118*, p. 2.

53 *Submission 118*, p. 2.

54 *Submission 161*, p. 12

outcomes for children. A best practice model for the provision of speech pathology services in schools is the 'Response to Intervention' model which invokes multiple tiers of service provision:

- Tier 1 (all students in the school): Provision of high-quality, evidence-based teaching and learning that supports oral language development across the school;
- Tier 2 (extra support): Provision of focussed support for children or groups of children who are struggling in Tier 1;
- Tier 3 (individual support): Individual intervention and support to target skill deficits and prevent further problems; individualised classroom strategies to support access to the curriculum.[55]

6.62 The Western Australian Primary Principals Association also argued the merit of a three tiered model. It claimed that this model would align 'the instructional needs of students with increasingly intensive interventions in the context of the best evidenced based, universal curriculum and teaching and learning practices'. The Association explained the three tiers as follows:

- Tier 1 is the universal level that is preventative and proactive where data informs the design of intervention. At this level all students receive research-based high quality, engaging, general education that incorporates on going universal screening, progress monitoring, and prescriptive assessment that supports the design and implementation of instruction;
- some students require more intense focus, more time and some degree of specialisation and differentiation over the short or slightly longer term. This is tier 2. At tier 2, interventions are rapid response, targeted group interventions provided to students identified as at-risk of academic and/or social challenges and/or students identified as underachieving who require more targeted approaches. The expectation is to accelerate learning and to minimise impact of difficulties; and
- a few students may require more specialised intervention and significant intensity and time, often for the longer term. This is tier 3. This level targets students with intensive/chronic academic and/or behavioural or social needs based on ongoing progress monitoring and or diagnostic assessment.[56]

Engaging speech pathologists with aged-care residential homes

6.63 The committee noted in chapter 5 the SPA's concerns with the current model of service provision in residential aged care homes. The committee has recommended that the federal, state and territory governments inquire into the current service delivery model for speech pathology services in aged care residential homes in

55 *Submission 224*, p. 38.

56 *Submission 228*, pp 9–10.

Australia. It is particularly concerned that nursing staff have the skills to screen residents in aged care facilities for communication and swallowing disorders. The broader goal should be for residential aged-care centres to engage routinely and systematically with speech pathologists, whether employing them directly or contracting out their services.

6.64 The committee also agrees with SPA that in terms of the involvement of speech pathologists in aged-care homes, they have an important role in creating a communication-friendly environment. This means that those who work in the aged care setting are educated about how to communicate with people with speech and language disorders and how to facilitate that communication.[57]

Speech pathologists within the youth justice system

6.65 Associate Professor Pamela Snow has argued that speech pathologists need to be employed in both community-based and custodial settings within the youth justice system. She writes that:

> Young offenders represent the extreme end of developmental vulnerability. There are many young people whose circumstances do not result in youth justice involvement but who never-the-less are educationally and socially marginalised and developmentally vulnerable as a result of undiagnosed or mis-attributed communication impairments. Such young people fail to achieve their potential and will make disproportionate demands on government-funded services, such as housing, mental health, substance abuse, and vocational training programs. Although prevention and early intervention are optimal, intensive and specialist services must be made available to vulnerable young people in their still formative adolescent and early adult years. Speech Pathology has a hitherto largely overlooked, but strongly research-informed role to play in the lives of young people who are developmentally vulnerable for a range of reasons, whether as a consequence of neurodisabilities such as autism spectrum disorders, or as a consequence of socio-economic adversity in early life.[58]

6.66 The organisation, Mental Health for the Young and their Families (Victoria), argued the benefits of programs that target improved communication skills among juvenile offenders. It argued:

> Research indicates that appropriate programs can make a difference to communication skills. Improved communication skills can make a difference to social competence, emotional well-being and executive functioning. This improves the outcome for the young person in terms of quality of life and for the Juvenile Justice system in terms of reduced recidivism. This has been recognized by the Juvenile Justice authorities in Victoria through participation of all young offenders in schooling programs enhanced by specialist assessments and interventions with language

57 *Committee Hansard*, 11 June 2014, p. 8.

58 *Submission 32*, p. 4.

> development programs. This is aimed at helping the young people become more productive members of society and less likely to engage in recidivist offending. Ongoing evaluative research is being undertaken to clarify the effectiveness of various interventions. The cost of implementing such programs is believed to be small compared to the benefits of greater productivity and reduced costs of recidivist delinquent behaviour and necessary ongoing social support programs, possibly even to subsequent generations. The verification of the estimated cost effectiveness of these interventions will take some years of follow-up research. Even a cost-neutral outcome would be a program success, but the benefits are likely to be shown to be much greater. An interesting question is whether the programs can be effective with young adult offenders who have developmental language delays, which could warrant consideration of implementation in the adult forensic system.[59]

6.67 SPA proposed engaging speech pathologists more directly to treat juvenile offenders within the justice system. It recommended that:

> Appropriate screening, specialist assessment and intervention be available to children and young people who are already in the criminal justice pathway, including that:
>
> (f) speech pathology service provision in secondary schools also be extended to 'special behavioural schools' to provide targeted support to students with communication and literacy difficulties, and to provide teachers with whole of classroom strategies;
>
> (g) education centres within youth justice services involve speech pathologists in the education team to contribute to the curriculum, consult with educators and other justice staff, and provide targeted support to young offenders, to improve their language, literacy and social interaction skills, with the aim of reducing recidivism.[60]

Recommendation 8

6.68 The committee recommends that the federal Department of Health, in collaboration with state and territory governments, Speech Pathology Australia, and other key stakeholders, prepare a position paper on the most appropriate model of service provision for speech pathologists working in:

- **early childhood intervention services;**
- **the education system;**
- **the justice system;**
- **the health system; and**
- **the residential aged-care environment.**

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59 *Submission 110*, p. 1.

60 *Submission 224*, p. 13 & p. 47.

Committee view

6.69 This chapter has discussed various options to address the shortage of speech pathologists in Australia. These options relate to both the level and the type of funding to support the profession, as well as the professional opportunities for students and the placement of graduates. All these issues must be considered in the context of where resources are needed and for what purpose. As chapter 5 discussed, important preliminary work is needed to map language support services against the Australian Early Development Index, and audit the adequacy, strengths and limitations of existing speech and language services for children (see chapter 5).

6.70 The committee considers that there is a strong case for greater funding of public speech pathology positions in Australia. However, this should be better substantiated and articulated. In its submission, SPA argued the need for a 'robust cost-benefit analysis of speech pathology intervention', which could be conducted by the Productivity Commission or a consultancy such as Deloitte Access Economics.[61]

6.71 The committee believes that there has been sufficient evidence gathered during the course of this inquiry to warrant an analysis of the benefits and costs of speech pathology intervention. This inquiry should consider the costs of doing nothing (retaining current funding levels) in terms of:

- the effect of long waiting lists on the individual in need of the service;
- the difficulty of retaining high quality staff in an over-stretched public system;
- the lack of clinical placements and employment opportunities for graduates; and
- the impact on those who miss out on services altogether.

6.72 It should then consider the costs and benefits of speech pathology intervention based on the Department of Health's position paper on the most appropriate models of service provision for speech pathologists working in various settings (see recommendation 9).

Recommendation 9

6.73 The committee recommends that the federal government commission a cost-benefit analysis of:

- **the current level of funding for public speech pathology positions. This should include:**
  - **the impact on individuals of existing waiting lists;**
  - **the limited provision of speech pathologists in the education, aged care and youth justice settings;**

61 *Submission 224*, p. 13 and p. 47.

- **the impact on individuals where services are not available;**
- **the impact of limited clinical placements and job opportunities for the speech pathology profession; and**
- **the impact on the Australian community of underfunding these services.**

- **the various service delivery models proposed by the federal Department of Health (see recommendation 9).**

Chapter 7

Conclusion

7.1 This inquiry into the prevalence and incidence of speech, language and swallowing disorders in Australia, and the availability of services to treat these disorders, has been important. It is the first time that a federal parliamentary committee has focussed on the issue of the availability and adequacy of speech pathology services in Australia. As such, it has allowed many people who suffer from these conditions, as well as their parents and carers, the opportunity to have their voice heard and considered by the Parliament. This process has been valuable in itself. This report should be read in conjunction with the accounts of these submitters who experience, and care for those with, these disorders on a daily basis. The committee again thanks these submitters for their insights and their contribution to this inquiry.

7.2 The committee is also grateful to Speech Pathology Australia (SPA) for its leadership and guidance throughout the inquiry process. SPA proposed this inquiry in 2011. Once referred in late 2013, SPA was instrumental in publicising the inquiry among its members, encouraging submissions from its members and suggesting options for the committee's site visits. SPA has also provided the committee with information and advice throughout this inquiry on matters of committee interest.

7.3 As chapter 3 observed, a notable feature of this inquiry was the lack of reliable data on the prevalence of speech and language disorders as a whole, but quite substantial data on the number of people affected by particular disorders. There is no official data on the prevalence of speech and language disorders in Australia. SPA offered an estimate of 1.1 million Australians that are affected by speech, language and swallowing disorders, adding that it this figure is an under-estimate. There is, however, some excellent research data on the incidence and prevalence of specific disorders in Australia, such as stuttering and aphasia.

The need for collaboration with key stakeholders

7.4 This report has made several recommendations aimed at identifying the dimensions of the demand and the supply of speech pathology services in Australia. Most of these recommendations are addressed to the federal Department of Health. To recap, the committee has recommended that the Department:

- consider the data that is currently available through Research Centres and academic studies, and the data that is necessary to identify the areas of current and prospective need for speech pathology services. It should then consider where there are gaps, the need and the benefit of filling these gaps and how this information could best be gathered (recommendation 1);
- assess the need, the practicality and the likely cost of gathering further data through the Australian Bureau of Statistics, particularly through the National Census, the Disability Services National Minimum Data Set and the

Nationally Consistent Data Collection on School Students with Disability tool (recommendation 1);

- assess the financial cost, timeframe and research benefits of a project that maps language support services across Australia against the Australian Early Development Index information about vulnerable communities (recommendation 3);
- develop a position paper on the likely impact of the National Disability Insurance Scheme (NDIS) on speech pathology services in Australia. The paper should consider, among other matters, the need for greater numbers of trained speech pathologists as a result of increased demand for speech pathologist services arising from the introduction of the NDIS (recommendation 5);
- develop a strategy to broaden the opportunities for speech pathology students to undertake clinical placements that satisfy the profession's Competency-based Occupational Standards (recommendation 6);
- investigate the evidence of geographical and demographic clustering of speech pathology services in Australia, with particular reference to the proportion of new graduates moving into regional and remote areas of Australia and the attitude of graduates generally to working in a regional or remote location (recommendation 7); and
- prepare a position paper on the most appropriate model of service provision for speech pathologists working in early childhood intervention services, the education system, the justice system, the health system and the residential aged-care environment (recommendation 8).

7.5 In the committee's view, the recommendations made in this report are the platform that is needed to begin to address the concerns of people with speech and language disorders, their parents and carers and the concerns of the profession. They impress the need for an evidence-based, collaborative approach to identifying and addressing these needs.

7.6 The successful implementation of these recommendations will depend on a genuinely collaborative approach among a range of key stakeholders. For example, recommendation 1 on the current gaps in data and the merit of gathering further data through the ABS will require broad-based consultation among a wide range of stakeholders. This task should be informed by a range of organisations including, but not limited to:

- Speech Pathology Australia;
- the Centre for Clinical Research Excellence Aphasia Rehabilitation;
- the Centre of Clinical Research Excellence in Childhood Language;
- the Australian Stuttering Research Centre;
- the Centre for Community Child Health;

- the Telethon Institute for Child Health Research;
- the Centre for Research Excellence in improving health services for Aboriginal and Torres Strait Islander Children;
- the Heads of Discipline in Speech pathology from the Australian universities offering speech pathology courses;
- the Australian Institute of Health and Welfare;
- the State and Territory Governments;
- the Australian Bureau of Statistics;
- the Department of Social Services;
- the federal Department of Education; and
- the federal Department of Employment.

7.7 It will be important to engage a similarly broad cross-section of stakeholders to undertake the position papers on the likely impact of the NDIS on speech pathology services and the most appropriate model for service provision in different settings.

7.8 The committee is aware of some support—most notably from SPA—for a National Taskforce or a National Council for Speech Pathology. This option should not be discounted. There may be merit in the introduction of a formal platform to carry out some of the work the committee has outlined in this report and manage the task of targeting these services to areas of current and project demand. In the first instance, however, the committee believes that these tasks should be addressed by the federal government in partnership with key stakeholders from academia, the speech pathology profession and the state and territory governments.

7.9 Chapter 2 of this report focussed on why early and effective intervention in speech and language disorders is so important. In the committee's view, the key message that the federal government must convey is the significant benefits to both the individual and society from a strategy that prioritises early intervention of speech and language disorders.

7.10 This inquiry highlights the costs to the individual and to society from delays in intervention and failure to treat conditions and emphasises the significant personal benefit from access to timely, professional speech pathology services.

7.11 On both fronts—the benefits and the costs—the evidence that committee has gathered during this inquiry is compelling. What is now needed is a collaborative effort across the profession, and with the assistance of government, to research the precise dimensions of the problem and the best strategies to recognise the benefits of effective early intervention.

Recommendation 10

7.12 The committee recommends that the federal government, working with state and territory governments, consider the costs to the individual and to society of failing to intervene in a timely and effective way to address speech and language disorders in Australia and address these issues in the development of relevant policies and programs.

7.13 The committee recommends that the federal government work with state and territory governments and stakeholders to ensure that parents and carers have access to information about the significance of speech and language disorders and the services that they can access to address them.

Senator Rachel Siewert

Chair

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

1 Name Withheld
2 Ms Pam Short
3 Name Withheld
4 Name Withheld
5 Mr John Farroway
6 Ms Angela Estimoff
7 Mr Sanka Ranaweera
8 Mr Peter Whitwell
9 Mrs Deb Sandford
10 Name Withheld
11 Name Withheld
12 Dr Neil Moore (plus an attachment)
13 Name Withheld
14 Name Withheld
15 Dr Jane McCormack
16 Ms Michelle Swift
17 Name Withheld
18 Name Withheld
19 Name Withheld
20 Ms Felicity Burke
21 Mr Matthew O'Brien
22 Autism SA
23 Name Withheld
24 Name Withheld
25 Name Withheld
26 Ms Laura Caire (plus five attachments)
27 Confidential
28 Name Withheld
29 Ms Bree Hodgson
30 Name Withheld
31 Ms Catriona Gunn
32 Associate Professor Pamela Snow
33 Ms Ruth Hartman
34 Name Withheld
35 Name Withheld
36 Name Withheld
37 Name Withheld
38 Ms Sue-Ellen Woods
39 Confidential

40 Mr Hank Wyllie
41 Name Withheld
42 Mr Ron Morey
43 Name Withheld
44 Name Withheld
45 Name Withheld
46 Ms Bernadette Pringle
47 Name Withheld
48 Confidential
49 Services for Australian Rural and Remote Allied Health
50 Victorian Advocacy League for Individuals with Disability Inc (plus two attachments)
51 Mrs Clare Clarke
52 Confidential
53 Wobbly Hub Research Team, The University of Sydney
54 Ms Lorraine Parkinson
55 Ms Catherine Schiller
56 Ms Jennifer Schiller
57 Ms Susan Woolfenden
58 Mr Philip Wilkins
59 Name Withheld
60 Ms Lyne Croteau
61 Parkinson's Victoria
62 Able Australia
63 Name Withheld
64 Western Sydney Speech Pathology
65 Victorian Principals Association
66 Name Withheld
67 Name Withheld
68 Name Withheld
69 Name Withheld
70 Ms Heather Madsen
71 Port Curtis Speech-Language Pathology
72 Professor Sharynne McLeod
73 Professor Sharynne McLeod and Ms Sarah Verdon
74 Dr Roslyn Neilson
75 Flinders University
76 Ms Lynne Middleton
77 Mr Carlo Silipo
78 Confidential
79 Ms Heidi Hulspas
80 Ms Louise Bale
81 Professor Leanne Togher
82 speechBITE
83 Name Withheld
84 Dr Vanessa Sarkozy

85 Associate Professor Patricia McCabe, Associate Professor Kirrie Ballard and Dr Natalie Munro (plus an attachment)
86 Voice Care Australia
87 Carers NSW
88 Confidential
89 Name Withheld
90 Melbourne Cleft Service, The Royal Children's Hospital
91 Name Withheld
92 Name Withheld
93 Mr Johan Langfield
94 Name Withheld
95 Name Withheld
96 Confidential
97 Mr Adam Vogel
98 The University of Sydney
99 Ms Fiona Seamer
100 Australian Speak Easy Association
101 Name Withheld
102 Mr and Mrs Robert and Lyna Leo
103 Ms Tamara Stone
104 gr8 Start Alliance
105 Broken Hill University Department of Rural Health, The University of Sydney
106 Name Withheld
107 Coonabarabran Public School Parents and Citizens Association
108 Name Withheld
109 Confidential
110 Mental Health for the Young and their Families
111 Department of Education Tasmania
112 Ms Melinda Pearce
113 Name Withheld
114 Therapy Focus Inc
115 Name Withheld
116 Name Withheld
117 The Centre for Cerebral Palsy (plus an attachment)
118 Neurodevelopmental and Behavioural Paediatric Society of Australasia
119 Name Withheld
120 Alfred Child and Youth Mental Health Service
121 Murdoch Childrens Research Institute
122 The University of Melbourne
123 Reflux Infants Support Association (plus an attachment)
124 Austin Hospital, Child and Adolescent Mental Health Service
125 Ms Gwendalyn Webb
126 Apunipima Cape York Health Council
127 Department of Education and Early Childhood Developement - Central Peninsula Network
128 AGOSCI Inc

129 Queensland Facilitated Communication Training (FCT) Inc.
130 Deadly Ears Program
131 Australian Hearing
132 ISAAC Australia
133 Mr Damian Georgeff
134 Children's Health Alliance
135 Mr Christopher Coombs
136 Name Withheld
137 National Relay Service
138 Name Withheld
139 Hear and Say
140 Name Withheld
141 Ms Harriet Korner
142 Name Withheld
143 Name Withheld (plus three attachments)
144 Name Withheld
145 Name Withheld
146 Ms Monique Thompson
147 Confidential
148 Name Withheld
149 Ms Harmony Turnbull
150 Name Withheld
151 Ms Claire Salter
152 Ms Ellie Thompson
153 Name Withheld
154 Ms Francesca Eaton
155 Pharmacy Guild of Australia
156 Name Withheld
157 Confidential
158 Ms Keryn McMahon
159 Catholic Education South Australia
160 Dr Jennifer Oates and Ms Georgia Dacakis
161 Centre of Research Excellence in Child Language (plus an attachment)
162 Mr Geoff Martin
163 Confidential
164 Ms Monica Smit
165 Autism Queensland
166 Ms Karen Vella
167 Name Withheld
168 Mr Roger Blackmore
169 Centre for Clinical Research Excellence (CCRE) in Aphasia Rehabilitation
170 Association for Childhood Language and related Disorders (plus fourteen attachments)
171 Mrs Susan Gardner
172 Autism Spectrum Australia
173 Dr Judith Gould

174 Dietitians Association of Australia
175 Mr Jacob Ungaro
176 Gold Coast Speech Pathologists
177 South Australian Secondary Principals Association
178 Mr Robert Ieroianni
179 Ms Nicole Gosbell
180 National Disability Services
181 Ms Laura Overdyk
182 Ms Wendy Yarrow
183 Name Withheld
184 Name Withheld
185 National LGBTI Health Alliance
186 Ms Sarah Verdon, Dr Linda Wilson, Dr Michelle Smith-Tamaray and Professor Lindy McAllister
187 Ms Sarah Verdon and Professor Sharynne McLeod
188 Professor Mark Onslow
189 Name Withheld
190 Northcott
191 Multicultural Disability Advocacy Association of NSW Inc
192 Australian College of Nursing
193 Name Withheld
194 Dr Elise Baker
195 Dr Elise Baker, Ms Sarah Masso, Dr Kate Crowe, Professor Sharynne McLeod and Assoc. Professor Jane McCormack
196 Name Withheld
197 Learning Difficulties Australia (plus an attachment)
198 Name Withheld
199 Ms Mimi Naylor
200 Ms Garnet Smith
201 Confidential
202 Professor Sharynne McLeod, Associate Professor Jane McCormack and Dr Graham Daniel
203 Professor Sharynne McLeod, Professor Lindy McAllister, Associate Professor Jane McCormack and Professor Linda Harrison
204 Allied Health Professions Australia
205 Mr Matt Wilson
206 Ms Michelle Owens
207 Name Withheld
208 Confidential
209 Aphasia Queensland
210 Name Withheld
211 Name Withheld
212 Ms Jodi Lipscombe (plus an attachment)
213 Associate Professor Elizabeth Cardell
214 Andrew Dean Fildes Foundation
215 Name Withheld

216 The Benevolent Society
217 Associate Professor Jane McCormack, Professor Sharynne McLeod, Professor Lindy McAllister and Professor Linda Harrison
218 Ms Kathy Stoddart
219 Name Withheld
220 MND Australia
221 Independent Living Centre WA and TAS
222 Communication Rights Australia and Disability Discrimination Legal Service
223 Dr Cate Madill
224 Speech Pathology Australia
225 Associates Professors Patrica McCabe and Kirrie Ballard; Drs Angela Morgan, Elizabeth Murray and Alison Purcell; Ms Donna Thomas, Ms Jacqueline McKechnie and Ms Jacqui Lim
226 Speech Pathology Australia, South Australian Branch
227 LifeTec Queensland
228 WA Primary Principals Association Inc
229 Dr Bronwyn Hemsley (plus an attachment)
230 Confidential
231 Anne McDonald Centre Inc
232 Ms Amanda Smith
233 National Stroke Foundation
234 Professor Deborah Theodoros
235 Confidential
236 Confidential
237 Name Withheld
238 Name Withheld
239 Ms Charlene Cullen and Ms Tracey Bode
240 Name Withheld
241 Ms Deanne Nevin
242 Name Withheld
243 Ms Julie Bury
244 Confidential
245 Next Challenge
246 Mrs Jean Martin
247 Catholic Education Office Wollongong
248 Ms Jan Lowis
249 Name Withheld
250 Ms Kirsty Arnott
251 Ms Lyn Legge
252 Name Withheld
253 Ms Meg Houghton
254 Name Withheld
255 Ms Louise Bale
256 Early Childhood Intervention Australia
257 Australian Education Union
258 Ms Rosemary Hodges, Dr Natalie Munro and Dr Elise Baker

259 Speech Pathology Tasmania
260 Down Syndrome Australia
261 Associate Profressor Steven Cumming
262 Dr Julia Starling and Dr Natalie Munro
263 Cerebral Palsy Education Centre
264 Ms Natalie Albores
265 Department of Health and Human Services Tasmania
266 National Rural Health Alliance
267 Mr and Mrs Tony and Ann Rowe
268 Queensland Government
269 People with Disability Australia
270 Australian Literacy and Numeracy Foundation (plus an attachment)
271 NSW Health
272 Australian Primary Principals Association
273 Ms Katy Gallagher MLA
274 Royal Far West
275 Peninsula Model for Primary Health Planning - Children's Health Alliance, and Frankston-Mornington Peninsula Medicare Local
276 Telethon Speech and Hearing
277 CleftPALS Victoria (plus two attachments)
278 Mrs Olwen Forker
279 Name Withheld
280 Name Withheld
281 Name Withheld
282 Name Withheld
283 Name Withheld
284 Ms Kim O'Rourke
285 Ms Kellie Ace
286 Ms Kelly O'Brien
287 Name Withheld
288 Name Withheld
289 Name Withheld
290 Name Withheld
291 Name Withheld
292 Name Withheld
293 Wynnum Family Day Care
294 Name Withheld
295 Name Withheld
296 Name Withheld
297 Name Withheld
298 Name Withheld
299 Queensland Advocacy Incorporated
300 Mr Nick Safstrom OAM
301 Indigenous Allied Health Australia Ltd
302 Blue Care
303 Ms Loretta Woolston

304 Public Guardian
305 Mr and Mrs Keith and Sonya Kerslake

Additional Information

1 Information sheet on Australians with difficulty communicating and swallowing, tabled by Speech Pathology Australia, at Melbourne public hearing 11 June 2014
2 Language competence: A hidden disability in antisocial behaviour, InPsych article from June 2013, tabled by Associate Professor Pamela Snow, at Melbourne public hearing 11 June 2014
3 Oral Language Competence, Young Speakers, and the Law, LSHSS article from October 2012, tabled by Associate Professor Pamela Snow, at Melbourne public hearing 11 June 2014
4 Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence, article from November 2011, tabled by Associate Professor Pamela Snow, at Melbourne public hearing 11 June 2014
5 Model diagrams, tabled by Melbourne Cleft Service, Royal Children's Hospital, at Melbourne public hearing 11 June 2014
6 Snapshot of speech pathology in child and adolescent/youth mental health services: Victoria, tabled by Alfred Child and Youth Mental Health Service, at Melbourne public hearing 11 June 2014
7 Language and Social Exclusion, I CAN Talk series - Issue 4, tabled by Alfred Child and Youth Mental Health Service, at Melbourne public hearing 11 June 2014
8 Opening presentation, tabled by Broken Hill University, Department of Rural Health, University of Sydney, at Sydney public hearing 12 June 2014
9 Training Secondary School Teachers in Instructional Language Modification Techniques to Support Adolescents With Language Impairment: A Randomized Controlled Trail, LSHSS article from October 2012, tabled by Discipline of Speech Pathology, University of Sydney, at Sydney public hearing 12 June 2014
10 Mental Health Clinical Guidelines, from Speech Pathology Australia, received 20 June 2014
11 Mental Health Position Statement, from Speech Pathology Australia, received 20 June 2014
12 Information, from Apunipima Cape York Health Council, received 27 June 2014
13 Information sheet about Apunipima Cape York Health Council, from Apunipima Cape York Health Council, received 27 June 2014

14 Information on Apunipima's preventative early education program: the Baby One Program, from Apunipima Cape York Health Council, received 4 July 2014

Answers to Questions on Notice

1 Answers to Questions on Notice received from Speech Pathology Australia, 23 June 2014

2 Answers to Questions on Notice received from Northcott, 4 July 2014

APPENDIX 2

Public hearings

Wednesday, 11 June 2014

Parliament of Victoria, Melbourne

Witnesses

Speech Pathology Australia
ADAM, Mr Tim
DIXON, Mrs Gaenor, Vice President Communications
MULCAIR, Ms Gail, Chief Executive Officer
STEPHEN, Mrs Robyn, Vice President Operations
THEODOROS, Prof. Deborah, President
WILLIAMS, Prof. Corinne, National Advisor Evidence Based Practice and Research

SNOW, Associate Professor Pamela, Private Capacity

Murdoch Children's Research Institute, Centre of Research Excellence in Child Language
MENSAH, Dr Fiona, Biostatistician and Senior Research Officer
REILLY, Prof. Sheena, Associate Director Clinical and Public Health

CleftPals Victoria, Royal Children's Hospital
CULNANE, Ms Evelyn, Manager

Melbourne Cleft Service, Royal Children's Hospital
KILPATRICK, Associate Professor Nicky, Director

Murdoch Childrens Research Institute, Royal Children's Hospital
REILLY, Professor Sheena
VERHOEVEN, Ms Andrea, Senior Speech Pathologist, Cleft and Craniofacial Service

Alfred Child and Youth Mental Health Service
ANGER, Ms Narelle, Director Speech Pathology
FEENEY, Ms Bernadette, Speech Pathologist, SocialAbility
FLEMING, Ms Mary, Chief Speech Pathologist

Thursday, 12 June 2014

Parliament of NSW, Sydney

Witnesses

Northcott
COOK, Mrs Cassandra Brea, Senior Speech Pathologist
FORSYTH, Ms Elizabeth Mary, Sector and Business Development Manager

Telethon Kids Institute
CHRISTENSEN, Mr Daniel, Senior Analyst
TAYLOR, Professor Cate, Principal Research Fellow

Discipline of Speech Pathology, The University of Sydney
STARLING, Dr Julia, Adjunct Lecturer

Autism Spectrum Australia
KERSLAKE, Ms Rachel, Manager Early Intervention
VARDANEGA, Mrs Catherine Santangelo, Senior Speech Pathologist

Independent Living Centre New South Wales
CHAPMAN, Ms Robyn, Chief Executive Officer

CRANKO, Ms Georgia, Private capacity

KORNER, Ms Harriet, Private capacity

Broken Hill University Department of Rural Health, University of Sydney
JONES, Ms Debra, Director Primary Health Care
HALL, Mrs Maeva, Assistant Professor and Deputy Director of WA Centre for Rural Health

Western Sydney Speech Pathology
CAREY, Mrs Julie, Principal and Practice Owner
PASCUAL, Ms Celine, Speech Pathologist

Friday, 20 June 2014

Parliament House, Canberra

Witnesses

Department of Health
LEMMON, Mr Greg, Acting Assistant Secretary, Access and Incentives Branch, Health Workforce Division
WALLACE, Mr Benjamin James, Executive Director, Clinical Training Reform, Health Workforce Australia

WILLIAMS, Associate Professor Corinne, Private Capacity

Services for Australian Rural and Remote Allied Health
SALTER, Ms Claire, Speech Pathology Coordinator
WELLINGTON, Mr Rod, Chief Executive Officer

Friday, 27 June 2014

Queensland Parliament, Brisbane

Witnesses

Neurodevelopmental and Behavioural Paediatric Society of Australasia
McDOWELL, Associate Professor Michael John, Foundation President

Autism Queensland
ASHBURNER, Dr Jill, Manager, Research and Development
LAVERCOMBE, Ms Rachel, Senior Speech Pathologist; Outreach Team Leader for North Queensland

Deadly Ears Program
ANDERSON, Mrs Renae Michelle, Senior Health Promotion Officer
BROWN, Mr Matthew Jeremy, Director
MARSH, Mrs Bonny Jayne, Acting Allied Health Team Leader
SARGISON, Mrs Helen Kate, Advanced Speech Pathologist

Hear and Say
BALFOUR OGILVY, Ms Jessica, Clinical Manager, Auditory-Verbal Therapy
CONSTANTINESCU, Dr Gabriella, Lead Researcher
RUSHBROOKE, Ms Emma, Clinical Director

Association of Childhood Language and Related Disorders

ROSE GRAYDON, Ms Vikki, Chief Executive Officer
ASHTON, Ms Cae, Principal, The Glenleighden School
LANGTON, Ms Tracey-Lee, Manager, Let's Talk Developmental Hub

Lift Program – Centre for Research Excellence in Aphasia Rehabilitation

COPLAND, Associate Professor David Andrew, Principal Research Fellow, University of Queensland
WORRALL, Professor Linda Elizabeth, Co-Director, Communication Disability Centre, University of Queensland
AISTHORPE, Mrs Natasha Francesca, Private capacity
AISTHORPE, Mr Bruce Rodney, Private capacity
CORP, Mrs Wendy Ann, Deputy Chairperson, Australian Aphasia Association Inc.
CORP, Mr Paul William, Chairperson, Australian Aphasia Association Inc.

Apunipima Cape York Health Council

RUBEN, Dr Alan, Community Paediatrician
WALLIN, Mrs Kristen, Senior Audiologist
WILSON, Ms Amanda, Speech Pathologist
SCHUH, Ms Sonia Valarine, Teacher-Director, Napranum Preschool