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Speech Pathology Australia

Speech Pathology Australia's submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry: NDIS Workforce Plan

10 August 2021

Hon Kevin Andrews MP
Chair
Joint Standing Committee on the National Disability Insurance Scheme
PO Box 6100
Parliament House
Canberra, ACT 2600

Dear Mr Andrews

Speech Pathology Australia welcomes the opportunity to provide feedback to the Joint Standing Committee on the National Disability Insurance Scheme's Inquiry, and in particular the National Disability Insurance Scheme Workforce Plan. As you are aware, Speech Pathology Australia is the national peak body for speech pathologists in Australia, representing more than 12,000 members. Speech pathologists are university-trained allied health professionals with expertise in the assessment and treatment of communication and swallowing difficulties.

We are very pleased that the Committee has decided to glean more information regarding this important issue. We preface our response to the main points of the Workforce Plan with an update regarding the speech pathology workforce currently providing NDIS services with brief background information about communication disability, swallowing difficulties and the role of speech pathologists. As always, we would be willing to appear before the Committee to provide more detail of the problems we highlight in our submission and to discuss potential solutions, as leaders in the speech pathology profession with expertise and 'real life' experience.

In the meantime, if Speech Pathology Australia can assist in any other way or provide additional information please contact Ms Amy Fitzpatrick, Senior Advisor Disability,

Yours sincerely

Tim Kittel
National President

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Introduction

Speech Pathology Australia (the Association) welcomes the opportunity to provide further feedback to the Joint Standing Committee on the National Disability Insurance Scheme's Inquiry into the NDIS workforce. We have structured our feedback in response to the initiatives within the Workforce Plan and make recommendations that we hope the Committee will find useful. We preface our comments with some brief background information on communication and swallowing disability and the role of speech pathologists.

About Speech Pathology Australia

Speech Pathology Australia is the national peak body for speech pathologists in Australia, representing over 12,000 members. Speech pathology is a self-regulated health profession through Certified Practising Speech Pathologist (CPSP) membership of Speech Pathology Australia.

The CPSP credential is recognised as a requirement for approved provider status under a range of government funding programs including the NDIS.

As the national body regulating the quality and safety of speech pathology practice in Australia, Speech Pathology Australia is also well placed to monitor and progress workforce developments and initiatives. Speech Pathology Australia accredits the 26 university entry-level training courses for speech pathologists in Australia, evaluates requests for recognition of overseas qualifications, administers the continuing professional development (CPD) program for the profession and provides mentoring and support programs to the significant cohort of new graduate/early career speech pathologists currently within the speech pathology workforce. The Association also manages the formal complaints process for the profession and can, if necessary, place sanctions on practice for any member who is demonstrated to contravene the Association's Code of Ethics.

About people with communication disability

The Australian Bureau of Statistics' 2015 Survey of Disability, Ageing and Carers (SDAC), estimated that 1.2 million Australians had some level of communication disability, ranging from those who function without difficulty in communicating every day but who use a communication aid, to those who cannot understand or be understood at all.[1]

Some people have problems with their speech, language and communication that are permanent and impact on their functioning in everyday life.

Difficulties in speech, language, fluency, voice, and social communication can occur in isolation or the person may have difficulties in more than one area and can negatively affect an individual's academic participation and achievement, employment opportunities, mental health, social participation, ability to develop relationships, and overall quality of life.

Communication disabilities can arise from a range of conditions that may be present from birth (e.g., Down Syndrome or Autism Spectrum Disorder), emerge during early childhood (e.g., stuttering, severe speech sound disorder), or during adult years (e.g., traumatic brain injury, stroke and head/neck cancers, neurodegenerative disorders such as Motor Neurone Disease) or be present in the elderly (e.g., dementia, Alzheimer's disease, Parkinson's disease). The prevalence and complexity of these disorders increase with age as both communication and swallowing functions are vulnerable to the natural ageing

[1] Australian Bureau of Statistics (2017) Australians living with communication disability, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4430.0Main%20Features872015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view

process; therefore, with an ageing population, prevalence and subsequent demand for supports will increase.

Some people with disability have complex communication needs (CCN), which are difficulties with understanding or the expression of communication, associated with additional physical, cognitive or sensory impairments. Many people with CCN benefit from the provision of alternative or additional methods of communication, including aided Augmentative and Alternative Communication (AAC) such as communication books, boards, speech generating devices and accessible technology for phone and internet-based communication.

The role of speech pathologists

People with communication and swallowing disability span the entire age range and the nature of their difficulties impacts on most areas of life. These people frequently require interventions and supports from multiple areas of public service (including health, disability and education sectors and mental health services). Speech pathologists, as experts in the assessment, diagnosis, and treatment of communication disorders are essential members of multi-disciplinary teams providing services to people with disability.

The clinical protocols for speech pathology treatment are evidence-based and backed by strong multidisciplinary scientific evidence for efficacy. Clinical protocols for treatment (in terms of session duration, frequency of care, intensity etc.) differ depending on the clinical presentation and diagnosis – usually speech pathology care is aimed at maximising function for that person. Speech pathologists use their diagnostic capacity to provide tailored and individually targeted intervention solutions to achieve functional outcomes. Some speech pathologists working in disability focus their practice on the assessment and provision of communication aids for people with CCN. This is a specialised area of the NDIS workforce. Speech pathologists working in this specific area of clinical focus typically develop their skills over many years working with people with CCN.

Speech pathologists also provide valuable contributions to the assessment of decision-making capacity and the facilitation of supported decision making for people with communication support needs. This includes developing communication accessible health information and decision-making procedures and protocols. In addition to identification of disease/disorder, assessment and intervention, speech pathologists can also provide counselling/support to families and caregivers, education of other professionals, case management, consultation, and advocacy. Communication partner training, including staff training, is considered an essential part of a speech pathologist's work.

Speech Pathology Australia's specific comments relating to the NDIA's Workforce plan

Firstly, whilst the Association supports the tenets outlined in the vision for the NDIS workforce detailed on page 5 of the Workforce Plan, it must be noted that the Plan itself does not appear to accurately reflect or address this vision. Additionally, the plan is very much focused upon support workers, to the detriment of all other professions and workers within the sector. This is of concern, as the workforce issues within the sector very much affect allied health professions, not just support workers, and yet the plan makes very limited reference to allied health professionals or how to address these thin markets.

Priority 1: Improve community understanding of the benefits of working in the care and support sector and strengthen entry pathways for suitable workers to enter the sector.

The Association has concerns that with this first priority, the NDIA has mistaken the nature of the problem with attracting a disability workforce as simply being a lack of understanding that there are jobs available. **Initiatives 1-5**, and then **7** (under priority 2), are based upon the premise that there is a willing and capable existing workforce, but they have been prevented from connecting with a suitable employer, or are unaware of job opportunities within the sector.

Speech Pathology Australia would challenge this notion, particularly with regards to allied health providers. The Association would suggest that it is not a lack of awareness that is a barrier to expansion of the workforce, but rather other more significant issues such as the level of renumeration and working conditions. The Workforce Plan is silent on these issues, and the Department of Social Services (DSS) specifically stated in their public webinar on 29 June 2021[2] that the Workforce Plan does not include pay adjustments, as DSS feels there are already industrial instruments that decide upon and conduct this process.

This ignores the current pricing regulation that occurs by the NDIA, who set pricing caps on the majority of NDIS services. It should be noted that the price for therapy supports, for instance, has not increased since 2018. Rather than focusing so heavily on informing possible workers of potential jobs, it would be beneficial to gather data on what would make the existing vacant positions more attractive, including, but not limited to:

1. Accurate benchmarking of the cost of providing supports, as well as the general renumeration rates in the sector beyond the NDIS to ensure renumeration is competitive and an incentive to work within the sector.
2. Investigation into attrition rates within the sector, and the reasons behind this.
3. Concurrently interrogate the reasons and ways that workers are encouraged to enter and remain within the sector.

For example, a recent survey conducted by Speech Pathology Australia with early career speech pathologists indicated that they prioritise accepting roles that provide appropriate supports and supervision, continuing professional development and workload productivity levels that are manageable. Providers who are unable/unwilling to offer these supports are more likely to have issues around retention and recruitment. As a result, many experienced speech pathologists who own practices prioritise retaining their staff through attractive salaries, supervision and professional development packages, at times to the detriment of drawing their own salary.

[2] Page 10 https://www.dss.gov.au/sites/default/files/documents/07_2021/ndis-national-workforce-plan-sector-briefing-transcript-29-june-2021.pdf

These issues, whether they be the same or different within the NDIS sector must be identified and addressed as a matter of urgency. Awareness campaigns will be utterly ineffectual if potential workers are informed of jobs, but do not apply due to lack of interest as the roles themselves are not attractive.

Additionally, when addressing this priority, caution must be exercised to avoid any awareness building or job promotion being delivered in such a way as to infantilise or degrade people with disability, directly or indirectly. Any campaigns or promotions within this space should therefore be developed with and ideally co-designed by people with disability.

One aspect of 'improving community understanding' that requires discussion is ableism within the general public, and disability workforce. Ableism is an underlying current throughout Australian culture, and this affects the experiences and interactions of people with disability on a frequent basis. Ableism can be defined as the discrimination or prejudice against people who have disabilities. It can take the form of ideas and assumptions, stereotypes, attitudes and practices, physical barriers in the environment, or oppression on a more systemic level. Inherent ableism may also have an impact upon those who apply for positions within the disability sector, and their treatment of people with disability once they are working in those roles. This must be named and addressed within the sector, potentially under the scope of Priority 2.

Priority 2: Train and support the NDIS workforce

The NDIS Quality and Safeguarding Commission (the Commission), in consultation with stakeholders including people with disability themselves, has produced a mandatory module 'Quality, Safety and You', using actors and people with disabilities to demonstrate some of these concepts, however this training only obliquely refers to ableism and is only required for registered providers and their staff. Specific modules that are mandatory for disability workers to complete that address ableism may be required.

Initiatives 6. ***Develop micro-credentials and update nationally recognised training to improve the quality of supports and enhance career pathways*** and **8.** ***Work with the sector to establish a skills passport*** are both options that may be helpful for the support worker sector, but have limited relevance within the allied health sector due to the nature of university level qualifications.

When contemplating a 'skills passport' for the support workforce it should also be noted that there does need to be a suite of training resources available to be reflected in a skills passport, and the process of adding to and using this type of 'passport' would need to be easy and ideally without cost to the worker to encourage its use. The Association would also strongly encourage any training packages to be designed with people with disability and in consultation with key stakeholders and peak bodies within the sector to ensure they are fit for purpose, and targeting areas of need as a priority. For example, Speech Pathology Australia has long advocated for the need for specific, mandatory training around working with people with complex communication needs, and eating and drinking support needs. Whilst these courses have been developed, they are not mandatory, and their roll out has not yet been organised. If these courses are optional, this indicates to the sector that communication access and mealtime supports are not a priority, and do not need to be the focus of training initiatives, which is not the case.

Whilst the Workforce Plan initiatives listed above do not appear directed towards allied health professionals, supports are strongly required in this area. We have seen the loss of pre-existing networks and community knowledge hubs (particularly around complex disability and AAC provision) which has resulted in supports being siloed and individual providers not having the support mechanisms they previously used. Whilst the NDIS was designed to incorporate and work with Tier 1 (general community) and Tier 2 (people with disability who do not qualify for NDIS) supports, there is a lack of infrastructure or system in place to enable them.

The Information, Linkages and Capacity building (ILC) grants as an approach have resulted in piecemeal projects, that often have not had the structures in place to effect change or be of benefit on the larger

scale that is needed. This entire portfolio subsequently being transferred to DSS also created additional paperwork and bureaucracy, and may have significant unintended impacts upon projects that are as yet unknown.

Rather than a specific grant process, it may be beneficial for the NDIA to return to the main intent of Tier 2/ILC, particularly "Community awareness: Invests in building long-term community capacity to support people with disability, their families and carers to ultimately reduce the need for formal disability supports."[3] A clear pathway for these types of supports would be an investment in the establishment or reactivation of specialised service hubs in relevant clinical practice areas (such as the specialised equipment services, or specialist provider organisations) to support the ability of the sector to be able to develop providers who are highly skilled in certain complex areas and are able to transfer knowledge and skills, thereby building capacity, across the sector. These hubs would also build capacity of participants and providers alike to understand how and when to access these scaffolded supports.

The Association supports **Initiative 9.** ***Support the sector to grow the number of traineeships and student placements, working closely with education institutions and professional bodies*** in principle, but it is essential to first identify and address the barriers currently in place to offering clinical placements.

The current lack of clinical education placements in disability provider services has been counter-productive, in terms of supporting the development of the workforce to support the emerging market. Such training and work placements are currently the responsibility of the jurisdictions, which has resulted in a number of universities having to 'reinvent the wheel' as there is no overarching monitoring process. A national approach would correct this wasteful duplication.

Additionally, Speech Pathology Australia has heard from numerous members that the provision of student placements is simply not financially viable for many providers to undertake. This is due in part to an expectation from the NDIA that there is a financial benefit to participants in having a student involved in their session, either in the form of reduced payment, or additional session time. Restrictions on billing placed by the NDIA mean that the therapist is unable to claim for their time in addition to the student's, if they are observing the student session. Given the potential complexity of participants' needs, which would necessitate the allied health professional also attending the session, or limiting the appropriateness of a student providing service, this results in a lack of placements being offered in the NDIS space. It is therefore recommended that more financial incentives and the utmost flexibility be offered to providers to support innovation in the provision of placements within the sector.

Priority 3: Reduce red tape, facilitate new service models and innovation, and provide more market information about business opportunities in the care and support sector

A significant issue regarding this priority and the Workforce Plan in general that is clear to the Association is the lack of accurate workforce data in regard to allied health professions. At present, the NDIA only reports on the numbers of registered providers, however the Association is aware from numerous member surveys and more recent 2021 renewal data, that a significant portion of our membership (more than 70%) are not registered providers, but do provide services for self managed and plan managed NDIS clients. Additionally, some speech pathologists may be employed by registered providers, and are therefore not registered themselves, and would not be included in the NDIA's workforce data. As a result, it is currently unclear as to the true number of NDIS providers working in this sector.

[3] https://www.ndis.gov.au/about-us/operational-guidelines/overview-ndis-operational-guideline/overview-ndis-operational-guideline-support-and-assistance -accessed 2 August 2021.

This is exacerbated by the NDIA's reporting on all registered providers as an aggregate number, rather than just those that are actually 'active' (defined by putting through at least one payment request within the MyPlace portal in the previous quarter). This results in seemingly inflated numbers of providers and means that thin markets may not be as obvious. Accurate workforce data, of both registered and unregistered providers is crucial if thin markets are to be identified and addressed.

Please see the table below for the quarterly report data from the NDIA[4] that shows significantly less 'active' providers compared with registered providers, and reduced numbers of active providers in some states.

State	Total # of Registered Providers March 2020	Active Early Childhood Supports providers in March 2020	Active Therapeutic supports providers in March 2020	Total # of Registered Providers March 2021	Active Early Childhood Supports providers in March 2021	Active Therapeutic supports providers in March 2021
NSW	7058	513	1976	8007	553	1979
VIC	4826	318	1417	5571	338	1153
QLD	4848	423	1211	5772	405	1152
WA	1241	95	266	1900	149	406
SA	1716	178	397	2169	158	407
TAS	996	49	201	1198	46	199
ACT	975	42	146	1180	51	169
NT	504	30	88	665	29	92

There are several challenges in attracting and retaining the speech pathologist workforce to provide services through the NDIS and these are even more pronounced for regional and remote communities. At the beginning of the roll-out of the NDIS, the administrative burden on providers, registration and third party verification requirements, and delays to payment all had a very negative impact as these caused extreme financial stress to some small and sole providers, which in turn contributed to some providers de-registering or deciding that providing services in the NDIS would not be financially viable for them. The impact of significant registration requirements, including the recent addition of NDIS worker screening checks on subsequent attrition from the NDIS workforce is also unknown. As discussed earlier within this submission, from our data the vast majority of members working in the NDIS space are not registered. It should be noted that in a survey conducted with members prior to the transition to the NDIS Commission registration process, 49% said that they were not intending to re-register.

While some of these initial issues have now been rectified or addressed to a certain extent, there are still areas where improvement is needed to ensure an adequate number of skilled and experienced providers are attracted to, and retained in, the NDIS workforce. Speech pathology services typically delivered by a small sector of speech pathologists has now seen increased demand and movement away from a small number of disability providers and an expectation for a greater number of generalist speech pathologists, or those early in their careers, to provide these more complex services. At present the NDIS does not

[4] https://www.ndis.gov.au/about-us/publications/quarterly-reports- accessed 30 July 2021

renumerate for supervision or training of staff, therefore dis-incentivising some organisations to provide it, and leaving limited avenues for the disability workforce to be upskilled and receive appropriate supports in these more complex areas.

The process of registering as a NDIS provider is felt by speech pathologists to be overly onerous, and out of reach for many, both in terms of financial cost and time burden, to fulfil all of the requirements. For instance, the registration process for early childhood supports requires providers to undertake an external Certification audit if they are registered for 'high risk' supports. It should be noted that Early Childhood Supports (ECS), which allows providers to supply services to 0-7 year olds has been labelled as 'high risk', and that providers are fully responsible for both the cost of audit, and the cost of flights and accommodation for auditors if they do not have an audit office close by.

The majority of private speech pathology practices are small or sole trader organisations, with limited infrastructure and resources, and auditing, particularly under certification, is costly. These costs can be indirect (opportunity costs) due to the significant time required to complete the large amount of paperwork and preparation, as well as time spent during the actual auditing day when the business owner may not be able to see clients, and direct financial costs with Certification being reported by our members as between $3,000-$18,000. Given that businesses must undergo Certification every three years, these costs are simply untenable for small businesses to sustain, and mean that many speech pathologists are unwilling to be registered. Until the costs of auditing are regulated, and the process is demonstrated to be less onerous in regards to both time and financial costs, the majority of providers of NDIS supports will choose to remain unregistered.

The Association strongly supports **Initiative 10.** ***Improve alignment of provider regulation and worker screening across the care and support sector***, as currently there is extensive duplication that negatively impacts upon the workforce.

The complexity of safeguarding and governance is a reflection of the fact that frequently new safeguarding systems are introduced, seemingly without attention paid to existing systems that might serve the same or similar function. For example, many speech pathologists underwent particular screening processes in order to be registered under the Department of Social Security (DSS) Helping Children with Autism or Better Start programs, however this is not recognised by the Quality and Safeguarding Commission (the Commission). Other allied health professionals such as occupational therapists and physiotherapists are regulated through the Australian Health Practitioner Regulation Agency (AHPRA), whilst speech pathologists who are members of Speech Pathology Australia undertake a professional self-regulation program implemented through the Association, are bound by a professional code of ethics and are required to fulfil the requirements of their state regarding police or working with children checks. Speech Pathology Australia is a member of NASRHP (National Alliance of Self Regulating Health Professions) which requires the same standards as that set through the National Regulation and Accreditation Scheme in use for AHPRA.

Speech pathology is therefore already a well regulated profession through the Association and other mechanisms, and the overly onerous and expensive registration process under the Commission has meant that large numbers of speech pathologists are de-registering from the NDIS, or allowing their registration to lapse. This impacts upon participants of the NDIS by limiting the number of registered providers in the market.

Governance and safeguarding processes are also different in different states and territories. For instance, the NDIS worker screening program is meant to be a national process, however each state has its own timeline for implementing the changes and different rules for their transitional process. As an example, in Victoria workers were required to apply within 6 months, whereas in Queensland this is only required after the expiry of their existing check (which lasts for 3 years). This unnecessarily increases the complexity of the system and could disadvantage certain providers. It also means that the workers in some states may not be screened or checked for several years. Currently members are also reporting a significant backlog

in the NDIS worker screening clearances being conducted, as the system is unable to cope with demand. This has a significant impact upon workers, as many states have 'a no check no start' policy.

Furthermore, there is a lack of cross sector liaison between aged care, disability and health. There is no centralised system to flag or check workers who may have been the subject of a professional investigation, or potentially even been dismissed due to their conduct. Some states and territories may have their own system, but only for workers in a particular sector e.g., the former Victorian Disability Worker Exclusion Scheme only checked workers against their exclusion list - relying upon the worker being placed on the list in the first place.

With increased complexity, and a lack of consistency across areas, comes an increased risk of a worker who is not suitable, or has been sanctioned in one system or geographical area moving on to another and continuing to provide services. A nationally consistent system, with the same rules for each state and territory, and clear accountability pathways, may help to ameliorate these issues.

Recognition of existing processes and programs, and potential exemptions for allied health professionals who are already regulated through other mechanisms is recommended. It would be important to extend this process to not only those professions regulated through AHPRA, but also self-regulating professions (such as speech pathology) who are members of the National Alliance of Self Regulating Health Professions (NASRHP).

Initiative 11. ***Continue to improve NDIS pricing approaches to ensure effective operation of the market, including in thin markets***

Rural and remote areas have known thin markets for speech pathology, but this is also becoming an increasing issue in metropolitan areas including Sydney and Melbourne, the ACT and Tasmania. Data from Seek.com indicates that speech pathology positions are the hardest to fill roles of any profession in every state and territory except Victoria (where the profession is 5th) and Western Australia (where it is 11th), indicating that demand is far outstripping supply.

Speech Pathology Australia has received numerous calls from parents of NDIS participants and participants themselves who have been unable to find a speech pathologist, even in metropolitan areas. We are also aware that many private providers in metropolitan locations have already closed their waiting lists for 2021 and that some potential clients/participants have their names on multiple waiting lists in an effort to secure supports.

This is particularly concerning for older adolescents and adults experiencing long waitlists to access providers regarding specific areas such as those with specialist expertise in Augmentative and Alternative Communication (AAC), those providing direct mealtime supports and mealtime management planning advice and those able to work with participants with behaviours of concern, or with complex disability.

In addressing this initiative, it is essential to have in place mechanisms to monitor and identify thin markets as discussed. These are likely to not only be in geographically remote areas but also in the provision of very specialised, and therefore uncommon, services. There are a number of possible incentives that could be put in place to increase the number of NDIS providers, such as free training, paid administration time, paid time for professional development in registration groups who have less providers, and a surcharge for expertise in certain skillsets. However, for those services not provided by the market, and to ensure a full range of culturally appropriate services are available, contracting arrangements with organisations or sole traders outside the NDIS may be needed.

Funding of speech pathology services through the NDIS needs to be appropriately remunerated and administratively 'easy' in order to secure a speech pathology workforce within the disability sector. The therapy price for 'other' therapies has not increased in the last two financial years, and the NDIA's approach to operation of the market appears to be continued control through pricing caps, rather than allowing for a free market that is self regulated.

One aspect of pricing that is continuously raised by both providers and participants is travel. The lack of an additional travel budget effectively discriminates against participants in rural and remote areas in terms of service access. Participants are not able to access funding to transport themselves to therapists, and therapists may not choose to travel those distances. Indeed, most providers servicing MM6 and MM7 locations using an outreach model make a loss on this service as costs associated with travel to MM6 and MM7 locations (e.g. Cobar in NSW) such as mileage, wages, accommodation and meals are greater than what they can recoup for the outreach trip even when a number of participants are seen during the same trip.

The NDIA must recognise the need for a range of incentives to ensure an adequate supply of services in areas with currently sparse distribution of providers and geographically remote. The assumption that there will be providers accessible in all areas, or that telehealth can be used to provide services instead, is problematic in that many remote areas have poor internet connections, and also those providers who are available in the area may not be able - experienced or skilled - to provide the necessary services to meet all clients' needs.

One solution would be to allocate specific travel budgets (extra allowance to cover exorbitant costs for travel) and/or consider one-off payments to participants/families to visit provider/s to receive services e.g., a tube weaning program.

Regarding initiatives **12-** ***Provide market demand information across the care and support sector to help identify new business opportunities*** and **13.** ***Support participants to find more of the services and supports they need online***, these are considered to be superfluous, as these initiatives already exist. The NDIS demand map has been in place in a beta form for almost two years. This would indicate that the data is available to providers who wish to know where participant demand lies, but this has not had any impact upon the number of providers or programs of supports, presumably because the underlying issues regarding the infrastructure of providing these supports have not been addressed.

Similarly, there are a range of privately run online services that allow participants to link in with providers such as Mable and HireUp, in addition to the NDIA run Provider Finder, and search engines for particular allied health professions run by peak bodies (e.g., the Association's Find a Speech Pathologist search engine). The consistent feedback that is received by the Association is that participants are able to contact professionals, but not able to receive services in a timely manner due to lengthy or closed waiting lists, or a lack of professionals servicing their geographical area.

The Association would like to raise concerns regarding **Initiative 14.** ***Explore options to support allied health professionals to work alongside allied health assistants and support workers to increase capacity to respond to participants' needs.***

Speech Pathology Australia has been inundated with recent reports of funding being allocated for the exclusive use of allied health assistants (AHAs) to the exclusion of allied health providers with no rationale or understanding of whether this is clinically appropriate, or the limitations on the use of AHAs and need for consistent qualified therapist involvement in a supervisory role.

Whilst the inclusion of AHA supports in a participant's NDIS plan can increase efficiency and effectiveness of service provision in some circumstances, creating benefits for both the participant and the speech pathologist across a range of areas/goals, it should not be the remit of the NDIA to determine if the use of an AHA is clinically appropriate. This must be the responsibility of the supervising allied health professional, and funding within plans needs to be adequate to allow for appropriate supervision and program planning for the AHA.

This is directly linked to the governance of AHAs, who currently have no official code of conduct, regulatory body, or mandated training or qualification required by the NDIA. The responsibility for the conduct of the AHA remains that of the supervising professional - the NDIA specifically states this,

including that they are to be covered by the allied health professional's insurance[5]. This vastly underestimates the complexity and variation possible in the employment arrangements of AHAs, and greater clarification and governance regarding the use of AHAs is needed. This may include the remit of the Commission to be extended to also cover AHAs within their safeguarding & complaints processes.

Regarding **Initiative 15. *Enable allied health professionals in rural and remote areas to access professional support via telehealth***, the issue is similar to Initiative 9 - the current barriers experienced by allied health professionals in this space must be addressed. Namely, difficulties with fast and consistent internet access, in addition to a lack of renumeration for supervision and other professional supports.

Initiative 16. *Help build the Aboriginal and Torres Strait Islander community-controlled sector to enhance culturally safe NDIS services* is supported in principle, however this would need to involve the First Nations community and leaders directly. The Association would also highlight that approaches within this space might require different funding models to be considered by the NDIA.

Recommendations:

- Collect workforce data to assist with workforce planning by identifying gaps in service in geographical areas as well as specialised services.
- Investigate reasons for both attrition and retention of workers in the disability sector.
- Involve people with disability in the co-design of any 'awareness building' or training campaigns.
- If a skills passport is introduced, it must be easy to use and free for workers.
- Pay providers an hourly rate for travel in rural and remote areas as an incentive, rather than putting the provider in a difficult position of charging the participant a large sum for travel.
- Considering funding 'hub' areas, e.g., a regional centre that participants could travel to in order to receive services.
- Encouraging more providers to become registered providers through:
    - Regulation of audit costs and providing discounts for people in rural and remote areas who already have significant additional costs associated with the audit process.
    - Changing the classification of registration groups, particularly early childhood away from "high risk".
    - Modification of audit requirements to correspond with the size and risk of the business and reflect the safeguarding processes already in place for allied health professions.
- Improving the workforce skills and capabilities so they can meet the needs of the sector by ensuring providers have appropriate supports e.g., supervision, work shadowing, upskilling and that the providers can charge appropriately for this, optimally in a way that is not tied to participants.
- Providing incentives for providers working in the disability sector to employ early career practitioners under appropriate supervision.
- Facilitating mentoring and supervision schemes for early career practitioners in order to attract more providers to the disability sector, and to increase the number of providers working in rural and remote areas.

[5] See pages 103 & 105 of the current price guide https://www.ndis.gov.au/providers/pricing-arrangements

- Address the need for further upskilling of the incoming speech pathology workforce by providing incentives for providers, especially in rural and remote areas, or more complex clinical areas to take on student placements or provide work shadowing opportunities.
- Allow providers to charge appropriately for the provision of student placements, including the therapist's time when observing or supervising the student providing services.
- Develop or re-establish community hubs or 'centres of excellence' for providers to access additional supports and skill building in complex clinical areas.
- Review of existing safeguarding processes prior to implementing additional onerous systems.
- Consideration of exemptions or reduction in registration requirements for allied health professions that are already well regulated through NASRHP and AHPRA.
- Mandatory training (as part of registration) for all disability workers/carers working with people with mealtime support and complex communication needs.
- Include mandatory modules on ableism, communication access, informed choice and control for people with complex communication needs and dysphagia in the 'NDIS Worker Orientation Module' package, including communicating with people with intellectual disability, and using communication devices.
- Cultural sensitivity training should be provided to all non-Indigenous staff working in the disability sector to help raise their understanding and awareness of the effects of trauma, discrimination, lack of sense of belonging and identity.
- Investigation of the current AHA market and workforce, with a focus on greater governance and clear guidelines from the NDIA regarding employment arrangements and pathways.
- Concurrent training and upskilling of NDIA staff to understand the role and scope of AHAs and understanding that they are not a replacement for a qualified allied health provider.
- The scope of the Commission regarding complaints & governance to be extended beyond just therapists to AHAs.

Once again thank you for the opportunity to provide feedback on this important issue. If Speech Pathology Australia can assist in any other way or provide additional information please contact Ms Amy Fitzpatrick, Senior Advisor Disability, on 03 9642 4899 or by emailing disability@speechpathologyaustralia.org.au.