Level 1 / 114 William St
Melbourne Victoria 3000

T 61 3 9642 4899
F 61 3 9642 4922

office@speechpathologyaustralia.org.au
www.speechpathologyaustralia.org.au

Speech Pathology Australia

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

16 April 2020

The Speech Pathology Association of Australia Limited
ABN 17 008 393 440

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 into the NDIS workforce. As you are aware, Speech Pathology Australia is the national peak body for speech pathologists in Australia, representing more than 10,000 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 relevant terms of reference 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 or by emailing

Yours sincerely

Tim Kittel
National President

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Introduction

Speech Pathology Australia welcomes the opportunity to provide 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 terms of reference we believe are relevant to speech pathology and make recommendations that we hope the Commission 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 10,000 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

[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

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 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 Inquiry's terms of reference:

a. the current size and composition of the NDIS workforce and projections at full scheme

Speech Pathology Australia's membership database shows that a total of 4,055 members indicate they use NDIS as a source of funding, however only 763 members report that they are a NDIS registered provider, with 26 per cent of these living in geographically regional and remote communities. It must be noted however, that this information is self-reported by our members so any use of it as representative of the actual speech pathologist workforce currently providing services in the NDIS should be suitably caveated.

Speech pathologists working in the NDIS include a mix of those working in early intervention (zero to seven years of age), school aged services, adult community and home-based services, and in aged care homes.

b. challenges in attracting and retaining the NDIS workforce, particularly in regional and remote communities

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. 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. These include:

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 visit. Travel fatigue is also an issue, as therapists often need to drive long distances between participants, and participants often need to be seen on particular days, making combining travel difficult. We are aware of some participants being encouraged to move closer to services, rather than have additional funds provided for travel.

What can be done?

Firstly, 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. tube weaning program.

Telepractice

It has been pleasing to see the NDIA respond to feedback about participants needing to use funds to purchase equipment for telehealth in response to the COVID-19 pandemic, and allowing telehealth to be used where appropriate and with the agreement from the participant to reduce risk of exposure to COVID-19. Telephone meetings are also being offered to all current and potential NDIS participants as a safer way to continue service delivery, including for new plans and plan reviews, during the current outbreak.

It is hoped that the work done to set up these systems during this time will pave the way for innovative service delivery in rural and remote areas in future, particularly when a participant needs an expert consultation such as an assessment for Augmentative or Alternative Communication. Indeed, we note the NDIA's commitment to further consultation regarding the use of telehealth beyond the current pandemic:

'The ongoing use of video technology and telehealth, as an option in a suite of approaches to provide disability supports under the NDIS, continues to be explored and will be the subject of formal consultation processes and policy development with all stakeholders at a later date.'[2]

What can be done?

Feedback from our members working in rural and remote communities has indicated that many Indigenous families would prefer telehealth rather than face-to-face visits. Similarly, there are many participants who may choose to access telehealth services due to the long wait for services in their geographical area, or lack of expertise in disability. However, access to devices and a fast internet connection are not consistent for many families. Increasing funding for rural and remote participants to access telehealth equipment would be an equitable solution.

Thin markets

Rural and remote areas have thin markets for speech pathology, but this is also becoming an increasing issue in metropolitan areas including Sydney and Melbourne, the ACT and Tasmania. The Association 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 some private providers in metropolitan locations have already closed their waiting lists for 2020.

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, those able to work with participants with behaviours of concern, or with complex disability.

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.

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[2] https://www.ndis.gov.au/coronavirus/providers-coronavirus-covid-19/connecting-and-helping-participants - accessed 14 April 2020.

With the high cost of auditing, some providers are choosing to drop registration groups, particularly behaviour supports and early childhood.

What can be done?

Firstly, it is essential to have in place mechanisms to monitor and identify thin markets. 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.

Other recommendations:

- Collecting workforce data to assist with workforce planning by identifying gaps in service in geographical areas as well as specialised services.
- Including travel to service providers in a participant's travel allowance as a basic and essential service.
- Paying 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 to "high risk".
- 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. This would need to include an extra budget for travel for these providers with expertise - particularly if they are travelling to remote areas or need to conduct a joint visit to the participant's home with the primary therapist to do an assessment for equipment.
- Providing incentives for providers working in the disability sector to employ early career practitioners.
- Facilitating mentoring and supervision schemes for early career practitioners in order to attract more providers to both the disability sector, and to increase the number of providers working in rural and remote areas. Often, new graduates do not feel confident to take roles in rural and remote areas due to the lack of supervision available and the necessity to see participants with a wide range of communication and swallowing difficulties.

c. the role of Commonwealth Government policy in influencing the remuneration, conditions, working environment (including Workplace Health and Safety), career mobility and training needs of the NDIS workforce

In terms of private practice, speech pathology services can be purchased through a range of funding mechanisms including fee-for-service (both individual and through contracts with organisations such as schools), private health insurance rebates, Medicare Benefits Scheme, accident insurance schemes (such as TAC and Worksafe) and Commonwealth Home Support Programme. 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.

As a female-dominated workforce, speech pathologists tend to work part time hours (across the profession, not just within the disability sector). There is the potential for service delivery models to alter the employment trends of speech pathologists within the NDIS provider market (e.g. service delivery occurring outside traditional business hours and telepractice etc) but this will require the necessary changes to current reimbursement protocols.

Indeed, to increase the speech pathology workforce supply within the NDIS, initiatives are needed to first and foremost, address the systemic and structural issues to ensure that being an NDIS registered provider is financially viable for small and sole trader private practices. If the sole trader and smaller sized providers were lost to the market then this would result in the dominance of larger organisations and potential monopolies, which would be in direct conflict with the NDIS principle of choice.

Long-term initiatives would also need to focus on areas such as clinical education and training and work 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.

d. the role of State, Territory, Commonwealth Governments in providing and implementing a coordinated strategic workforce development plan for the NDIS workforce

With regards to individuals requiring specialised supports and the level of expertise required by speech pathologists to provide that, it is the view of Speech Pathology Australia that a market approach to disability service provision will not provide the environment that will be able to retain or further develop such a specialised workforce. NDIS participants will therefore not have choice nor control over the speech pathology services they wish to purchase with their NDIS funds if those services are not in existence within the accessible provider market. Specific, targeted workforce initiatives are needed to ensure that this component of the provider market of speech pathology services is available to meet the needs of NDIS participants who require specialised supports.

e. the interaction of NDIS workforce needs with employment in adjacent sectors including health and aged care

In terms of the supply of speech pathology service providers, there is significant competition from other sectors that will have considerable impact (now and in the future) on the supply of a speech pathology workforce to the NDIS provider market. The speech pathology workforce is spread across a number of

sectors including health (hospitals and private practice in primary care), education (significant numbers employed by Departments of Education), aged care (often through sub-contracting of private practitioners) and fewer numbers in child and adolescent mental health, and youth and adult justice settings.

g. any other matters

Billing

- GST needs to be clarified with the Australian Taxation Office (ATO). We have been advised that NDIS reports count as third-party reports and therefore attract GST, but there is a common misconception that everything under NDIS is GST free.

Solution: consultation between NDIA and the ATO is required to clarify the GST issue. Once clarified, there needs to be clear communication to providers and plan managers regarding invoicing requirements and GST payments.

- There are ongoing issues with plan gaps, often as a result of a plan being closed early. This can result in providers losing money as they have no way to claim for their service and it can take years to resolve.

Solution: If a plan review is called early, then it is essential to allow service bookings to remain open and funds not removed until all claims have been made.

Group service delivery

- Group service delivery can be very effective but the cap on what can be charged makes it financially unviable.

Solution: Need to remove the cap completely, or at least allow 1:1 price to be charged.

- No item for providers to provide group training for capacity building for families, carers etc. For example:

"I rarely run feeding groups, while research demonstrates its effectiveness it is not financially viable when it comes to feeding groups, there is a lot of prep with food pre and post. I also struggle because parent training needs to form the bigger part of groups and when funds are limited, parents want sessions for the child, building capacity for the parent needs to be factored in and funds allocated for this in plans. It's the only way I can see that parents can break the cycle of feeding difficulties and move forward – they need time (and money allocated in their plans) to be trained and supported." Speech Pathology Australia member feedback

Solution: introduce a separate line item for capacity building for parents/families/carers in group settings (which can be a more cost effective and evidence-based solution to 1:1 training) for example evidence-based parent training programs such as Hanen, which can also be considered as an effective waiting list and early intervention strategy.

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 on or by emailing