Indigenous Allied Health Australia (IAHA) Submission to the Senate inquiry into the prevalence of different types of speech, language and communication disorders and speech pathology services in Australia.

Thank you for the opportunity to contribute to the Senate inquiry into the prevalence of different types of speech, language and communication disorders and speech pathology services in Australia.

There are many organisations and individuals who will make submissions that address the breadth of topics within the Terms of Reference for this Inquiry. The unique point of difference between this submission and many others is that Indigenous Allied Health Australia (IAHA) members have chosen to highlight speech, language and communication issues that pertain specifically to Aboriginal and Torres Strait Islander peoples, and to also highlight the unique considerations for the delivery of Speech Pathology services to this group.

The ability to communicate effectively can impact upon a person’s health, education and life outcomes and aspirations. There is no one size fits all approach to meeting the speech, language and communication needs of Aboriginal and Torres Strait Islander peoples – hence the need for culturally responsive speech pathology services to meet the specific needs of individuals, families and communities. In order for generational change to occur, the most economically sustainable approach contributing to Closing the Gap, is investment in evidence based, equitable and culturally responsive access to speech pathology and other allied health services.

The recommendations within this submission aim to ensure that speech pathology services are accessible and responsive to the cultural, speech, language and communication needs of Aboriginal and Torres Strait Islander individuals, families and communities within the context of a holistic view of health and wellbeing.

Consultation Process

The Aboriginal and Torres Strait Islander speech pathology members have driven the development of this submission. Indigenous Allied Health Australia Ltd. (IAHA), the national peak organisation representing Aboriginal and Torres Strait Islander allied health professionals and students sought input from its speech pathology membership (full and associate). IAHA currently has 38 speech pathologist members (full and associate). A working group of 12 members have collaborated to develop this submission.

Aboriginal and Torres Strait Islander speech pathology graduates and students view their profession through a unique cultural lens and can provide insight into the cultural, speech, language and communication needs of Aboriginal and Torres Strait Islander peoples. IAHA associate members are primarily non-Indigenous speech pathologists with expertise, interest
and commitment to improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

Through the drafting of this submission, IAHA members have provided valuable insight, evidence and specific case study examples that will assist the Senate to make changes to speech pathology service delivery that can improve the health and wellbeing of Aboriginal and Torres Strait islander peoples.

IAHA and its members would welcome the opportunity to work further with the Senate and other key partners on the implementation of these recommendations.

**Background – About IAHA**

Indigenous Allied Health Australia Ltd. (IAHA) is the national Aboriginal and Torres Strait Islander allied health peak body. IAHA was established in 2009, from a network of committed allied health professionals and transitioned into a Company Limited by Guarantee in 2013. IAHA currently has 462 members, including full and associate members across a number of allied health professions.

All Aboriginal and Torres Strait Islander allied health professionals who have graduated from an allied health course with a recognised qualification and Aboriginal and Torres Strait Islander students who are enrolled in an allied health course are eligible for Full Membership of IAHA.

IAHA welcomes non-Indigenous allied health professionals, all allied health assistants and Aboriginal and Torres Strait Islander people studying or working in other health related fields as Associate Members.

**IAHA Vision**

IAHA appreciates all people working in Indigenous health and values the holistic approach to health care and education, in respect of Aboriginal and Torres Strait Islander people, their culture, spirituality, traditional healing, inspiring us to work collegiately in following our vision:

*For Indigenous Australians to have access to professionally and culturally competent allied health services delivered by Indigenous allied health professionals who are recognised and acknowledged as an essential part of a holistic approach to Indigenous Health.*

**IAHA Purpose**

*To advance the health status of Indigenous Australians through IAHA’s contribution to the national health agenda, facilitation of improved education opportunities for and representation of Indigenous allied health professionals.*
Summary of IAHA Recommendations

IAHA urges the Senate to make recommendations that will lead to:

1. Acknowledgement of the fact that speech pathologists work across a range of settings and sectors, including health, community, education and justice and are in a position to address multiple determinants of health and work with other health professionals within a holistic context, to improve the wellbeing of Aboriginal and Torres Strait Islander individuals, families and communities.

2. Investment into research to identify the prevalence of speech, language and communication disorders in Aboriginal and Torres Strait Islander peoples across the lifespan.

3. Research and development of culturally valid assessment tools and guidelines for culturally responsive assessment approaches for Aboriginal and Torres Strait Islander peoples.

4. Provision of additional resources in schools to ensure appropriate development of Standard Australian English as a second dialect or language; similar to additional resourcing provided to migrant populations acquiring English as a second language.

5. Development of culturally responsive speech pathology based resources to support the implementation of the Health Workforce Australia (HWA) Aboriginal and Torres Strait Islander health curriculum framework currently under development for implementation into all university speech pathology programs.

6. Facilitation of culturally responsive speech pathology education by advocating for changes to speech pathology professional accreditation standards as outlined within this submission for all allied health Accreditation Standards.

7. Funding of research around the skill mix, health professions and service delivery models required to best meet the speech pathology needs of Aboriginal and Torres Strait Islander people across urban, rural, remote and very remote areas.

8. Review and revision of incentive structures that drive health service delivery (such as Medicare), to ensure that Aboriginal and Torres Strait Islander people have equitable access (available, appropriate, acceptable and affordable) to speech pathology services.

9. Development and resourcing of evidence based strategies aimed at recruitment, retention, education and support of Aboriginal and Torres Strait Islander speech pathology students and graduates.
Rationale for Recommendations

An Aboriginal and Torres Strait Islander view of health and wellbeing and cultural constructs of disability and difference.

IAHA endorses the definition that Aboriginal and Torres Strait Islander health means “not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and thus bring about the total well-being of their community.”

Taking into consideration this widely accepted Aboriginal definition of health it is clear that good health is not just the absence of disease. An interdisciplinary, holistic approach to healthcare delivery is necessary in order to positively influence speech / language / communication development for Aboriginal and Torres Strait Islander peoples.

If Aboriginal and Torres Strait Islander people are to achieve the highest attainable standard of physical and mental health as stated in United Nations Declaration on the Rights of Indigenous Peoples, then they must have the right to equitably access allied health services. Optimal health is a basic human right and also a right as the recognised first peoples of Australia, and equitable access to culturally responsive speech pathology services can help achieve this.

The Aboriginal and Torres Strait Islander view of health and wellbeing, and also of disorder and disability, may differ from that of the Australian dominant non-Indigenous culture. This may result in a different view of impairments (which will impact on identification and thereby, prevalence) and also influence the perceived impact that the impairment has upon an individual’s activity and participation and also upon their family and community environment.

Many speech pathologists working with Aboriginal and Torres Strait Islander peoples are interested in expanding their scope of practice and looking to ways that speech pathology can be integrated into primary health care and preventative health programs. They are also interested in looking to new ways of delivering speech pathology services that are informed by communities and based on an Aboriginal conceptualisation of speech/language and communication disorders. This motivation comes from the premise that without knowing how Aboriginal and Torres Strait Islander people define the ‘problem’ of speech/language/communication disorders, together we will be unable to develop a solution to service delivery. IAHA speech pathology members realise and value the need to work holistically within Aboriginal and Torres Strait Islander communities. What this actually means for speech pathologists on the ground requires further definition and research and is likely to be best informed by communities themselves.
Culturally Responsive Speech Pathology Workforce and Approaches to service delivery

IAHA asserts that a culturally responsive speech pathology workforce is imperative in order to ensure Aboriginal and Torres Strait Islander people receive the speech, language and communication services required to significantly improve health and wellbeing outcomes.

Culture can be defined as complex beliefs and behaviours acquired as part of relationships within particular families and other social groups and can predispose people to view and experience health and illness in ways that can influence decisions, attitudes and beliefs around access and engagement in healthcare. This may include acceptance or rejection of treatment options, commitment to treatment and follow up, success of prevention and health promotion strategies, perceptions of the quality of care and views about the facility and its staff.

The key concern for the person, family or community at the centre of care is how the speech pathologist responds to any particular encounter. Speech pathologists must demonstrate their ability to respond appropriately and ‘walk the talk’.

IAHA has determined that in the context of holistic and person centred therapeutic relationships with Aboriginal and Torres Strait Islander people, speech pathologists must be culturally responsive, a construct that entails life-long self-reflection and new learning as opposed to the notion of finality that other terms such as cultural competency may imply.

Culturally responsive care can be defined as an extension of patient centered-care that includes paying particular attention to social and cultural factors in managing therapeutic encounters with patients from different cultural and social backgrounds. IAHA views it as a cyclical and ongoing process, requiring speech pathologists to continuously self-reflect and proactively respond to the person, family or community with whom they interact.

There are multiple layers of responsibility to ensure that Aboriginal and Torres Strait Islander people receive culturally responsive speech pathology services.

Culturally Responsive Speech Pathology Education

It is the responsibility of the health education providers to ensure their speech pathology graduates attain the necessary skills, knowledge and attitudes that will enable them to deliver culturally responsive care. This includes providing clinical experiences that expose them to the unique needs of Aboriginal and Torres Strait Islander populations.

IAHA successfully argued for the development of a culturally inclusive, interdisciplinary Aboriginal and Torres Strait Islander Health Curriculum Framework to be integrated into tertiary entry level health profession training. Health Workforce Australia (HWA) has funded Curtin University to develop this framework. It will be essential that culturally responsive speech pathology education resources are developed to support the implementation of this framework.

However in order for any Aboriginal and Torres Strait Islander curricula framework and resources to be implemented within health profession training it is important that it be supported by and embedded within health profession course accreditation. In 2013 IAHA
developed a comprehensive submission for the Review of the OT Accreditation standards. In line with the recommendations contained within that submission, IAHA believes that Speech Pathology accreditation standards could also be improved by requiring education providers to be accountable for how they:

1. Address Aboriginal and Torres Strait Islander peoples in their health program philosophy and purpose

2. Embed comprehensive curriculum coverage of Aboriginal and Torres Strait Islander Health (studies of the history, culture and health of Aboriginal and Torres Strait Islander people) across the program.

3. Engage in education strategies that involve partnerships with relevant local Aboriginal and Torres Strait Islander communities, organisations and individuals.

4. Outline strategies used to ensure that students have the requisite knowledge and skill in delivering culturally responsive care.

5. Provide clinical learning environments that provide students with experience in the provision of culturally responsive health care to Aboriginal and Torres Strait Islander peoples living in urban, rural and remote locations.

6. Use educational expertise, including that of Aboriginal and Torres Strait Islander people, in the development and management of the program.

7. Articulate how the educational facilities and resources are consistent with and support the program’s Aboriginal and Torres Strait Islander philosophy and purpose.

8. Ensure staff recruitment strategies are culturally inclusive and reflect population diversity and take affirmative action to encourage participation from Aboriginal and Torres Strait Islander people.

9. Collaborate with Aboriginal and Torres Strait Islander health professionals and community members to provide feedback and advice to the program.

10. Utilise strategies and admission policies that target groups under-represented in the program, highlighting initiatives for and numbers of Aboriginal and Torres Strait Islander students, to ensure student profile is reflective of the community profile.

Should these recommendations be embedded within speech pathology professional accreditation standards, they would assist speech pathology education providers to produce more culturally responsive graduates.

Culturally Responsive Workplace Environment and Support

It is the responsibility of the health service provider to demonstrate culturally responsive leadership and build governance structures and environments that ensure that speech pathologists are encouraged, expected and able to respond to the needs of Aboriginal and Torres Strait Islander people effectively. The processes and supportive structures around health service delivery are equally as important as actual health outcome measures when determining the overall effectiveness of health service delivery.
The notion of Speech Pathology is a Western one. Speech, language and communication assessment and therapy approaches are, at this time, founded in Western approaches to health and disability management. More focus on integrating speech pathology with primary health care, preventable disease and working holistically rather than on individual impairments alone is needed.

Speech pathologists recognise that it is their job to contribute to service, organisation and societal change that will remove barriers to access for speech pathology services. Many IAHA speech pathology members believe that problems such as high inattendance rates at speech pathology appointments and devastating breaks in the continuum of care for patients are symptoms of an inflexible and inappropriate system and do not reflect a lack of need for speech pathology services.

Culturally Responsive Individuals

It is the responsibility of the individual speech pathologist to deliver culturally responsive healthcare. Being culturally responsive places the onus back onto the speech pathologist to appropriately respond to the unique attributes of the person, family or community they are working with. Self-reflection and reducing power differences are central to being culturally responsive; therefore making assumptions based on generalisations about a person’s ethnic, cultural or social group is unacceptable. Part of the challenge of becoming culturally responsive speech pathologists is learning to reach beyond personal comfort zones and being able to comfortably interact and work with people, families and communities who are both similar and markedly different.

IAHA asserts that all speech pathologists need to be both clinically competent and culturally responsive to positively affect the health and wellbeing of Aboriginal and Torres Strait Islander people.

Case Study 1

The Institute for Urban Indigenous Health in Queensland have developed an Allied Health practice model that demonstrates the culturally responsiveness of the workplace. All Allied Health staff are orientated to this model and given supervision and clinical leadership to support their culturally responsive practice. The model details four components; cultural safety and responsiveness, strengths based practice, family and client centred approach and purposeful approach. Cultural safety and responsiveness ensure the speech pathologist is aware of the client’s culture and needs as well as considers their own culture and how that may affect the treatment given to the child. Strength based and family and client centred practice ensure the speech pathologist is looking at the client’s strengths rather than deficits and considers the importance of family and how to manage therapy that considers the client's story. The purposeful approach is related to both assessment and treatment of the client. This component ensures Aboriginal ways of communicating are identified as well as use of a dynamic assessment approach and joint client management to assist the client with accessing the Allied Health Services.

Case Study 2

The example used here is a not-for-profit community health organisation that provides vital health and support services that respond to the needs of people in an urban environment.
They believe that community health care is an effective way of providing accessible local medical care and support that is tailored to people’s needs and circumstances. The service states that they are explicitly committed to partnership with individuals and communities and passionately believe in addressing the issues and environments that lead to illness. Community health care ensures that the services offered are the best value, most effective, and meet the needs of the people using them.

Each week the service runs a weekly event for their local Aboriginal community. During the event, staff and other service providers such as the speech pathologist (on arrangement with the Aboriginal Health team) can work with the Aboriginal community in an informal setting to conduct appointments, assessments and focus groups. This allows the interaction to occur in a relaxed environment whilst the community members are actually already in attendance; rather than setting up a formal consultation at the community health centre or a home visit which the client may cancel or just not comply with due to a number of reasons.

Some of the ways that the service demonstrates its culturally responsiveness is by providing:

- An Aboriginal and Torres Strait Islander health team including an Aboriginal Team Leader, Registered Nurse, Aboriginal Community Development Worker and an Aboriginal Health Promotion and Chronic Care Worker;
- A dedicated room for Aboriginal and Torres Strait Islander individuals and families;
- A guide to acknowledging traditional owners on intranet;
- Guidelines for respecting Aboriginal and Torres Strait Islander communities;
- Cultural awareness training available for all staff;
- Aboriginal and Torres Strait Islander identified employment opportunities across the organisation;
- Weekly Aboriginal and Torres Strait Islander specific event for community members; and
- Aboriginal Artwork and signage in reception area and information displayed about voluntary identification of Aboriginal and Torres Strait Islander status.

**Building the Aboriginal and Torres Strait Islander Allied Health Workforce**

IAHA is funded to support and build the Aboriginal and Torres Strait Islander allied health professional workforce. Further investment is required in order to attract and retain Aboriginal and Torres Strait Islander people into the health workforce, at all levels and in all professions. This includes speech pathology. The Australian Bureau of Statistics does not collect data on the number of speech pathologists in Australia in its census, but rather combines this workforce with audiologists. In 2011 ABS data states that of 6799 speech pathologists or audiologists, only 18 of those recorded identified as being Aboriginal and/or Torres Strait Islander – a mere 0.26%.

In order to grow the Aboriginal and Torres Strait Islander allied health workforce, better data collection and research into the implications of this data is required – particularly in relation to allied health professions. Health Workforce Australia has begun this process, with the development of the Health Workforce 2025 report which provides medium to long-term national workforce planning projections for doctors, nurses and midwives. It is essential that
the data around Aboriginal and Torres Strait Islander workforce participation is strengthened and that the report is expanded to include speech pathology.

A flexible education pipeline and increased linkages/partnerships between the VET sector and higher education sector must be developed in order to create authentic career pathways into speech pathology for Aboriginal and Torres Strait Islander people. There needs to be financial incentives to ensure that partnerships are developed which will meet the education needs of Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander people of all ages must be exposed to and encouraged to explore careers in speech pathology and other allied health careers. Not only is there a need to attract more Aboriginal and Torres Strait Islander people into tertiary health courses, but also a need to retain them through appropriate support measures.

Lifelong education opportunities for Aboriginal and Torres Strait Islander health professionals must be available, including higher education and professional development opportunities. In order for this to occur, communities and workplaces must be supported to facilitate ongoing learning opportunities for Aboriginal and Torres Strait Islander people working in health, at all levels.

Previous work gives guidance around what may work to increase numbers of Aboriginal and Torres Strait Islander people working in health. It is worth revisiting the 2008 National Aboriginal and Torres Strait Islander Health Council’s A blueprint for action – Pathways into the health workforce for Aboriginal and Torres Strait Islander people. This document outlined clear ways forward to increase Aboriginal and Torres Strait Islander participation in the health workforce.

It is also essential that the government reviews and implements the recommendations found within the Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People Final Report, July 2012. This review outlines the enablers and barriers to improving recruitment and retention of Aboriginal and Torres Strait Islander people into University studies and provides recommendations on the way forward.

In line with our core business, IAHA seeks further investigation into what constitutes best practice in the delivery of speech pathology education to Aboriginal and Torres Strait Islander people. Flexible delivery and community driven innovation, particularly in remote communities, is essential. In order to increase the number of Aboriginal and Torres Strait Islander people choosing to be a speech pathologist it will be essential to research, develop, resource and implement new models of speech pathology education delivery and support. This may include block release study options and intersectoral partnerships between education providers and/or workplaces.

**Equitable Access to Speech Pathology Services**

Aboriginal and Torres Strait Islander peoples have an inherent human right, in additional to their rights as Indigenous peoples of Australia, to access high quality and culturally responsive speech pathology services.
Access is more than just physical or geographical access, also including cultural, economic and social factors which all impact on whether Aboriginal peoples and Torres Strait Islander people use speech pathology services.

Availability

Speech pathology services must be available. Speech pathology service availability can depend on the geographic location of the speech pathologist or service, a barrier to access particularly for Aboriginal peoples and Torres Strait Islanders living in rural, remote and very remote areas. There is a maldistribution of the speech pathology workforce and many areas of rural and remote Australia find it difficult to attract speech pathologists. However even in urban areas where speech pathology services may be more geographically available and speech pathologist numbers are higher, Aboriginal and Torres Strait Islander people can find that health services are not available when needed, or waiting times are long.

Case study

A 52 year old man who lived in a small remote community was referred to Speech Pathology for assistance with speech and communication by a nurse from the Aboriginal Medical Service. Robert experienced a severe Acquired Brain Injury (ABI) whilst aged in his twenties as a result of a car accident. His lasting communication impairments included moderate-severe dysarthria (slurred speech) and cognitive communication disorder. Robert wanted therapy to improve his social activity and to reduce his social isolation. He would have benefitted from Speech Pathology intervention aimed at attempting to reduce his impairments and also to increase his activity and participation.

Key issues impacting on his health and wellbeing:

Access, appropriateness and acceptability of Speech Pathology (SP) service:

- Visits to the community by the Speech Pathologist were every six weeks (as a minimum with fewer visits during the Wet Season)
- The visits were for 5 days maximum and the SP was required to also service paediatric clients (pre-school and school age clients) in that time.
- The SP also had responsibilities during each visit to follow up OT/PT/Soc Work clients and perform Aged Care Assessments. Responsibilities also included regular liaison with the community council, the health centre and other aged care and disability service providers.
- Very limited access to male interpreters
- No community-based therapy assistants to perform therapy programs with Robert between SP visits.
- Lack of linguistically and culturally appropriate assessment and therapy tools.

The complexity of his other health issues:

- Robert went on to experience diabetes and renal disease. His communication difficulties (along with physical impairments) meant it was difficult for him to manage his chronic disease independently and to access the local health service.
- His chronic disease often left him feeling tired and unwell. He required urgent
medical attention on many occasions due to barriers around access to preventable chronic disease programs, exacerbated by his communication disability.

- Complex individual and social situation
- Robert lived with elderly and unwell parents who had difficulty caring for him. As such, he would rarely eat well or regularly; he had difficulty maintaining his personal hygiene and he had limited support around things such as remembering to take medications.
- Social isolation and exclusion in large part due to his communication disability. Robert was excluded from participating in ceremony leading to a loss of role and respect in the community. He had few family members or friends who would interact with him and was considered to be ‘crazy’ and ‘dumb’ when he was neither. There was little community awareness about his communication disability.
- Living in a remote Aboriginal community, Robert experienced many of the same disadvantages as the other community members (poverty; poor housing and overcrowded homes; limited access to fresh and healthy foods; limited access to primary health care).

**Positive contributions to health and wellbeing:**
The following are the ways in which Robert was able to remain living in his home community and with his family. They also present opportunities where SP services could have worked successfully if resources were greater.

- Service providers in the community were proactive in his health and social care and ‘kept an eye out’ for him. This included some transport around the community; assistance with money management; assistance with employment; prompting personal care and collecting washing (clothes and bedding); ensuring he was picked up from home and taken to the health centre 1-2 times a week for a checkup and medications.
- The gentleman has respite breaks during the year in the town where the SP was based. This was an opportunity for the SP to see the client. However he was often using his time ‘in town’ for other activities and the SP was also busy with her ‘urban’ caseload (schools, early intervention; hospital and aged care facilitates).
- The small community and family networks offered him security and support.

**Acceptability**
Speech pathology services must be acceptable to Aboriginal and Torres Strait Islander people. The acceptability of speech pathology services to Aboriginal and Torres Strait Islander people is related to the notion of cultural safety. Aboriginal and Torres Strait Islander people need to know that they will receive allied health care from a culturally responsive workforce. The availability of Aboriginal and Torres Strait Islander staff is another important factor in whether or not Aboriginal and Torres Strait Islander people are able to effectively access health services. 
IAHA members have acknowledged the value of having co-worker/s who can assist with cultural brokerage to facilitate acceptable and accessible services, especially when the speech pathologist is non-Indigenous. To work successfully in Aboriginal and Torres Strait Islander communities, speech pathologists cannot work in isolation. They may work alongside other allied health professionals, Interpreters, Linguists, Therapy Assistants, nurses and doctors and people in roles (paid and unpaid) who are cultural brokers. In order to facilitate improved cultural responsiveness of speech pathologists it is important they have an opportunity to work with speakers of traditional Aboriginal languages as well as Aboriginal English, depending on the needs of the Aboriginal and/or Torres Strait Islander communities they work with.

**Appropriateness**

Speech pathology services must be appropriate to meet the complex health needs of Aboriginal and Torres Strait Islander people. Speech pathology services must consider the Aboriginal and Torres Strait Islander holistic view of health and use an interdisciplinary approach to deliver comprehensive care that addresses the whole of the person. Many clients rely on referral to speech pathology services by their local GP. Clear referral pathways and strong interprofessional relationships are required to ensure Aboriginal and Torres Strait Islander people are referred and can access appropriate speech pathology services.

**Affordability**

Speech pathology services must be affordable. The majority of allied health professionals are private practitioners and current Medicare rebates and other funding sources for allied health service delivery are inadequate and often fail to reimburse for reports, consultation with other service providers and coordinated care for clients with more complex needs. The gap payment that is required to meet the cost of high quality allied health service provision can often be a barrier in access for Aboriginal and Torres Strait Islander people.

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**Case Study**

Blake is a 5 year old Aboriginal boy whose teacher has recommended to his mother that he sees a speech pathologist for an assessment of his expressive and receptive language abilities. The waiting list to see a speech pathologist through the public system is current 6 months in that area so Blake’s mum took him to see the GP. The GP did a health assessment (Medicare item 715) and decided to refer Blake to a speech pathologist and an audiologist. Under the ‘Follow-up Allied Health Services for People of Aboriginal or Torres Strait Islander Descent’ scheme Blake is entitled to 5 allied health visits per calendar year through Medicare. The GP wrote a referral and his Mum takes him home. When Blake’s Mum called the local private speech pathologist to make an appointment, she was told that the Medicare rebate only covered $52.95 and that an Initial Assessment Session (60 mins) costs $220. This means that she would have to pay a gap of $167.05. The next sessions would ‘only’ be $120 so she would be out of pocket by $67.10. These out of pocket expenses were too much for Blake’s family and therefore he did not access the speech pathology services he required.
Delivery of speech pathology services for Aboriginal and Torres Strait Islander people will only be improved when incentives adequately match service delivery and workforce needs.

Workforce planning and models of service delivery are driven by financial incentives such as Medicare and program specific funding. Top down approaches to changes in models of service delivery will not work unless the service is appropriately incentivised to make those changes. Revised incentives may achieve better integration, coordination and interdisciplinary collaboration to improve Aboriginal and Torres Strait Islander health outcomes.

IAHA asserts that in order for Aboriginal and Torres Strait Islander people to equitably access allied health services, we must work collaboratively to ensure that the services are high quality, available, affordable, acceptable and appropriate.

**Prevalence of speech, language and communication disorders in Aboriginal and Torres Strait Islander populations across the lifespan.**

There is no existing research that can verify the prevalence of speech, language and communication disorders among Aboriginal and Torres Strait Islander populations. However the prevalence of other health conditions that have been closely linked to the need for speech pathology services may provide insight as may available statistical information about the prevalence of speech, language and communication disorders in the non-Aboriginal and Torres Strait Islander population.

In addition, it must be noted that identifying Aboriginal and Torres Strait Islander people who are experiencing speech, language and communication disorders is a complex task. Some of the contributing influences to this complexity are listed below and on reading, it becomes obvious that the issues of identification impact upon the availability of accurate data on prevalence.

Identification of Aboriginal and Torres Strait Islander people with speech, language and communication disorders is limited by:

- The complexity of medical histories and presentations. For example it can be difficult to identify a specific acquired communication disorder in a patient who has experienced multiple events or conditions that can lead to speech, language or cognitive change e.g. stroke, kidney disease, conductive hearing loss.
- Language, speech and communication differences between clinicians and Aboriginal and Torres Strait Islander clients.
- Cross cultural communication difficulties with health professionals and cultural differences around the appropriateness of assessment and assessment practices.
- Differences in the construct of disability and difference between Aboriginal and Torres Strait Islander clients and non-Indigenous service providers.
- Possible shame and embarrassment of Aboriginal and Torres Strait Islander clients may act as a barrier to accessing services that could identify and provide assistance.
• Overlap between some features of Aboriginal English and the clinical features of speech and language disorders that many speech pathologists and educators are familiar with, can make accurate diagnosis challenging and create a high risk of misdiagnosis.

• Institutions and centres where many speech pathology services are based and where patients may be identified with speech, language and communication difficulties are not welcoming for Aboriginal clients.

• There is a lack of culturally and linguistically responsive tools available to assist in the identification of speech, language and communication difficulties in Aboriginal and Torres Strait Islander peoples.

When considering the possible prevalence of speech, language and communication disorders in Aboriginal and Torres Strait Islander communities, the influence of other health and social problems must be taken into account. The overwhelming statistics of these problems are well known and almost certainly gave rise to the adage ‘Aboriginal people are over-represented in suffering and underrepresented in health and education services’. Such social and health problems may directly and indirectly contribute to both the prevalence of speech, language and communication disorders and to the personal experience of the disorders on Aboriginal and Torres Strait Islander individuals and families.

Examples of Health Conditions that impact on Speech, Language and Communication

This section will look at important causative factors that may provide insight into the prevalence of speech, language and communication disorders an Aboriginal and Torres Strait Islander person across the lifespan.

Ear Health

The ‘Development of a National Aboriginal and Torres Strait Islander Health Plan Discussion Paper’ (2012) highlighted chronic ear disease as a key area of concern, with Indigenous children 3 times more likely to be diagnosed with ear or hearing problems, which can lead to hearing loss and in turn affect language and social development.

Aboriginal and Torres Strait Islander children endure high rates of otitis media, the disease manifests early in life, and it may continue to occur in adolescence and beyond. However these high rates of otitis media have been found in Aboriginal children living in rural, remote and urban areas.

Williams & Jacobs (2009) state that the areas of cognition perceived as most likely to be affected by the hearing loss associated with otitis media are auditory processing skills, attention, behaviour, speech and language. Their research highlighted the factors that are likely to increase the risk of sustaining long-term speech and language deficits as a consequence of otitis media are early onset of otitis media (under 12 months of age); more than one episode of otitis media before 12 months of age; long periods of infection; poor or no access to medical management; compromised environment (passive smoking, overcrowding, poor nutrition, non-compliance with medical management); pre-existing cognitive or language deficit; disrupted attachment and the degree of hearing loss.
Otitis media causes conductive hearing loss which can range from being very mild to a severe hearing loss. The hearing loss also tends to fluctuate depending on the health of the middle ear and is generally thought of as a temporary condition, however the hearing loss becomes a chronic problem in chronically diseased ears. In addition, sensorineural hearing loss can occur secondary to long-term chronic otitis media. Hearing loss affects verbal and written communication. It is associated with impaired first language acquisition, impaired second (and later) language acquisition and the inability to follow complex verbal instructions and understand complex verbal information.

A 2006 review of the economic impact and cost of hearing loss in Australia highlighted the significant effects of hearing loss on the capacity to communicate, and in turn to participate in education, gain competitive skills, and form relationships. It identified the need for further research in a range of areas, including Indigenous hearing health.

**Acquired Communication disorders after stroke and traumatic brain injury**

There appears to be no specific prevalence data available on how many Indigenous Australians have an acquired communication disorder (ACD) following stroke or brain injury. This is likely to be difficult to estimate, particularly with the high rates of co-morbidities which might impact on communication. However, it is possible to gain a general estimate because it is known that approximately 21-38% of people are known to experience ACD after stroke and acquired cognitive communication problems are common following traumatic brain injury.

According to the Australian Institute of Health and Welfare, basing their figures on the 2004-5 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the estimated prevalence of stroke was 1.7 times higher than that of non-Indigenous Australians. It also reported that in 2009-10, their hospitalisation rate for stroke was twice that of non-Indigenous Australians and their death rate 1.6 times as high. Between the ages of 35 and 64, hospitalisation rates for stroke were 3-4 times higher. A study that examined both the incidence and burden of stroke in Indigenous and non-Indigenous Western Australians found that the incidence of stroke in Indigenous men was 2.6 times greater than for non-Indigenous men and that it was 3 times that for women. Traumatic brain injury is also more common in Indigenous populations with an incidence rate of 2.3% compared to 0.7% in the non-Indigenous population. The rate of head injury following assault is 21 times that of the non-Indigenous population.

In light of these statistics that suggest that Indigenous people are experiencing higher rates of stroke and traumatic brain injury than non-Indigenous people and at a younger age, it can be inferred that there are many who are experiencing acquired communication disorders. This then points to a need for speech pathology services that is proportionately higher for Aboriginal and Torres Strait Islander than non-Indigenous populations.

**Aboriginal English and Culturally Valid Assessment Tools and Approaches.**

“The home language of very many Aboriginal children throughout Australia is some kind of Aboriginal English (AE). It is not ‘bad English’ or ‘pidgin English’ and it is in no way inferior to Standard [Australian] English (SE). Children who speak AE are fluent, articulate and creative users of language, just like children who speak SE. Furthermore, although the differences between AE and SE may not seem great in many areas, there are subtle differences,
especially in the way that language is used, which are important to the identity of Aboriginal children. Respecting, valuing and understanding Aboriginal ways of using English is a significant step in respecting, valuing and understanding the identity and self-esteem of these children. Differences between AE and SE are found in all aspects of language: i.e. phonology (or accent and pronunciation), morpho-syntax (or grammar), lexico-semantics (or words and their meaning), and pragmatics (or the way that language is used in socio-cultural contexts).

Respecting, valuing and understanding Aboriginal ways of using English is a significant step in respecting, valuing and understanding the identity and self-esteem of these children. A monocultural classroom will not provide the opportunity for many Aboriginal children to use and develop their language skills.

Speech pathology assessment processes used for non-Indigenous children are not necessarily appropriate for all Aboriginal and Torres Strait Islander children due to the cultural nature of the testing context, test scoring designed for standard forms of English as spoken by the dominant non-Indigenous culture and a lack of normative data for Aboriginal and Torres Strait Islander children. There are also very few culturally safe, linguistically appropriate and valid assessment tools for the assessments of adults with acquired communication disorders.

Speech Pathologists often use standardised assessments to evaluate the communication abilities of Aboriginal and Torres Strait Islander children. If these assessments are not norm-referenced for Aboriginal and Torres Strait Islander children and do not consider cultural difference nor Home Language, misdiagnosis can often occur. Whilst speech pathologists may be aware that standardised assessments seldom provide accurate and reliable results, they continue to be used as there are very few, if any, culturally responsive and valid speech pathology assessments to guide their practice. In doing this, Aboriginal and Torres Strait Islander children are often misdiagnosed with speech language impairment and verified through the education system as having a language disorder without any consideration of a language difference.

Speech Pathologists are considered speech, language and communication experts in the field of allied health and within the education system. Speech pathology assessments need to consider not just language difference but communication differences of Aboriginal and Torres Strait Islander children. Assessments must ensure the cultural safety of Aboriginal and Torres Strait Islander children by acknowledging and valuing Home Language, taking a dynamic method to assessment and incorporating Aboriginal ways of communicating through a yarning (conversational) approach.

Case Study

An eight year old Aboriginal girl was referred for a speech pathology assessment by her teacher with concerns regarding expressing herself and following directions. A dynamic culturally safe assessment was used and compared to the CELF-4 (a well-known standardised assessment with no norms for Australian Aboriginal children). The culturally safe and dynamic assessment revealed spoken language in Aboriginal English and moderate difficulties with following directions. The CELF-4 revealed severely delayed abilities to follow 1-3 step directions and severely delayed spoken language. This child would have been misdiagnosed with speech, language impairment.
within the education system costing the department a significant amount of resources. With the use of the dynamic culturally safe assessment the Aboriginal girl was given the opportunity to demonstrate her strengths and abilities and be giving appropriate support at school.

**Speech Pathology Services Across Sectors**

Aboriginal and Torres Strait Islander communication outcomes are strongly influenced by complex and interrelated factors including social, historical, political and cultural determinants. Allied health professionals, including speech pathologists, are ideally placed to impact on these determinants as they operate within widely diverse settings, from clinics, hospitals, rehabilitation centres, schools, long-term care facilities, Aboriginal Medical/Health Services, community health centres to home healthcare agencies. A multi-faceted approach that includes speech pathologists as key players across health, education and community sectors will be essential to improve the speech, language and communication capacity of Aboriginal and Torres Strait Islander peoples.

**The Justice Sector**

Communication disorders are more prevalent among juveniles in detentionxxv. Incarceration of Aboriginal and Torres Strait Islander people is also high. It is therefore possible that the prevalence of communication disorders is higher among Aboriginal and Torres Strait Islander juveniles in detention. Failure to treat communication disorders in Aboriginal and Torres Strait Islander children may contribute to higher rates of crime and incarceration. Difficulties with cognitive communication functions negatively impact on an individual’s capacity to reason and problem solve; as well as limiting access to education and employment. As a result Aboriginal and Torres Strait Islander communities with high prevalence of communication disorders may have lowered capacity to support themselves and higher dependence on welfare.

An evidence base for Speech Language Pathology (SLP) interventions with marginalised young people is emerging but requires further research with regards to Aboriginal and Torres Strait Islander peoples. The risks facing Aboriginal and Torres Strait Islander children with respect to both language and offending need to be a focus of multidisciplinary research and targeted in linguistically sensitive population-based education and intervention effortsxxvi.

That greater speech pathology support is needed for vulnerable young people is clear however further progress is needed to translate this evidence into policy and everyday practice, particularly in relation to Aboriginal and Torres Strait Islander peoples. From an economic perspective, the cost of speech language pathology services is modest compared with the cost of supporting a young person who might require state benefits, prison placement, public housing and mental health services over many decadesxxvii.

**Education Sector**

As previously discussed, children who speak a variety of Aboriginal English may be disadvantaged within the educational system, particularly if teachers are not familiar with the nature and cultural validity of Aboriginal English and therefore perceive it to be a substandard form of English. The majority of Australian Aboriginal people speak some form
of Aboriginal English and it is often the first language of many Australian Aboriginal children. Many Aboriginal people speak a variety of Aboriginal English where some varieties sound closer to standard Australian English than a traditional Aboriginal language. This may pose a problem for many Aboriginal children entering the school system if teachers and speech pathologists are not be aware of this difference and consider the Aboriginal child’s communication abilities as a deficit or inferior to the norm. Teachers who are unaware of Aboriginal ways of using English often wrongly stereotype Aboriginal children’s language use as ‘bad English’.

The Australian Early Development Index (AEDI) and National Assessment Program Literacy and Numeracy (NAPLAN) results show lower levels of communication skills for Indigenous Australian children and higher rates of ‘vulnerability’. The Australian Early Development Index (AEDI) indicates that 19.8 per cent of Indigenous children speak languages other than English in the home, with 109 different languages spoken. Indigenous children are more than twice as likely to be developmentally vulnerable than non-indigenous children. 43.2 per cent of the 15,490 Indigenous children are developmentally vulnerable on one or more of the AEDI domains.

The 2013 NAPLAN, a snapshot of Achievement in Reading, Persuasive Writing, Language Conventions and Numeracy, indicates that in each year level tested (year 3, 5, 7 and 9) and in all achievement domains and for all jurisdictions, the mean scale scores for Aboriginal and Torres Strait Islander students are substantially lower than the mean scale scores for non-Indigenous students.

It is unknown whether the Aboriginal and Torres Strait Islander AEDI and NAPLAN data is consistent with prevalence in non-Indigenous communities of similar socioeconomic backgrounds. Some studies suggest lower levels of literacy and communication skills among children from lower socioeconomic backgrounds, particularly lower maternal education, however further exploration is required.

Standard Australian English is the most prevalent form of English spoken in Australia. To promote success at school and later in life, Aboriginal and Torres Strait Islander children must be enabled to harness Standard Australian English and use it to their social and economic advantage. This does not devalue their Home Language or Aboriginal English – it is essential that these are valued and acknowledged as valid languages. However educational and developmental outcomes may be improved if there were provision of additional resources in schools to ensure the appropriate development of Standard Australian English as a second dialect or language; similar to additional resourcing provided to migrant populations acquiring English as a second language.

Apart from broader prevention programs that strengthen whole communities, the best and most cost-efficient universal intervention is early identification in educational settings of children who are not meeting developmental targets and the use of evidence-based instruction methods in early literacy, to ensure that at-risk children are not ‘left behind’ at a time when they could truly benefit from services.
Insight from Speech Pathologists working with Aboriginal and Torres Strait Islander peoples

A number of associate members of IAHA are currently leading ‘The Missing Voices: Communication difficulties after stroke and traumatic brain injury in Indigenous Australians’ project. This is a research project funded by the National Health and Medical Research Council and the project is currently in its data collection phase. This includes interviewing Speech Pathologists (SPs), General Practitioners (GPs), Aboriginal Health Workers and Aboriginal and Torres Strait Islander people who are living with an acquired communication disorder (ACD) in communities across Western Australia.

Early data collection via in-depth interviews with speech pathologists in rural and metropolitan areas have revealed a number of broad themes about working with Aboriginal and Torres Strait Islander people with an ACD. The themes identified below – some of which have been discussed in more detail within this submission – do appear to be influenced by geographical location, with some themes (such as that of limited resources) being more prevalent for speech pathologists providing services to Aboriginal and Torres Strait Islander communities in rural and remote areas. It should be noted that a number of the points identified may easily fit into more than one theme.

Theme: Limited resources

- Small numbers of speech pathologists in rural and remote areas are often required to cover large caseloads (children as well as adults) across a variety of settings (early intervention; schools; hospitals; aged care facilities; outpatient clinics) and across large geographical areas.

- Home visiting services are often limited and/or visits to small communities surrounding the regional centre where the speech pathologist is based are restricted to a small number each year (e.g. once per school term). In order to maximize the limited speech pathology resource, services are often consultative in nature rather than being able to deliver 1:1 therapy with clients and their families. While a consultative service may be appropriate for some settings (e.g. the classroom setting when Education/Therapy Assistants are employed to deliver therapy programs) the decision to deliver a consultative service is more often based upon the speech pathology resources that are available, rather than the appropriateness of the model itself.

- In the acute setting, the limited speech pathology resources available are often directed towards assessment and management of dysphagia (a swallowing disorder) rather than towards acquired communication disorders which can be perceived by services to be of a lower priority.

- Speech pathology positions dedicated to sub-acute services (such as post stroke rehabilitation) are limited, funded for short trial periods only and are often based in a hospital environment. The positions are also usually required to provide service for non-Indigenous patients. These factors can limit access and acceptability of the service for Aboriginal and Torres Strait Islander clients.
- High turnover of speech pathologists in rural and remote areas can lead to long periods of no or extremely limited services in some areas and a repeated need for the development of trust and relationship with Aboriginal and Torres Strait Islander communities. This impacts upon the continuity of services for Aboriginal and Torres Strait Islander clients.

**Theme: Service models and Organisational structures**

- In teams with a small number of speech pathology positions required to service a caseload that covers the lifespan, caseload management systems give a higher priority and more resources to paediatric clients than to adults in sub-acute care (patients in need of rehabilitation).

- There is felt to be incongruence between the service delivery models available and the perceived need by speech pathologists that a holistic approach to service provision is required for Aboriginal and Torres Strait Islander clients.

- The model of services that employ speech pathologists is often dependent on activity and patient contact. This does not support the flexibility and time needed to develop trust and relationships with the Aboriginal community nor support a holistic approach to input.

- Speech pathologists have limited access to human resources that could enhance the cultural responsiveness of their practice such as Interpreters; Aboriginal Liaison Officers, Aboriginal Therapy Assistants and Aboriginal Health Workers.

- Discharge policies (formal and informal) can lead to Aboriginal clients being discharged from a service despite an ongoing need. Contacting patients can be difficult and failure to make contact can lead to discharge from the service.

- Service models and availability of resources may contribute to the many reasons (currently being explored) as to why very few Aboriginal people access speech pathology services outside of the acute setting.

**Theme: Skills, knowledge and tools**

- The small numbers of Aboriginal people accessing speech pathology services leaves speech pathologists feeling under-skilled for working with this group.

- Cultural awareness training is limited, often non-compulsory, can be web-based and a one-off requirement by the workplace i.e. does not support ongoing/life-long reflective skills or other skills required for culturally responsive practice.

- There are few if any reliable assessment tools and therapy materials that are linguistically and culturally appropriate for Aboriginal and Torres Strait Islander clients of speech pathology services.

- Referral sources for speech pathology typically used for non-Aboriginal patients (GPs, inpatient medical teams, community based support services) may lack the awareness, skills and knowledge and tools to identify an Aboriginal and/or Torres Strait Islander person in need of speech pathology services.
The role of a speech pathologist for adults with ACD is not well understood in the Aboriginal community nor the Australian community as a whole.

There is a paucity (lack) of research to support clinical speech pathology practice.

Conclusion

Indigenous Allied Health Australia commends the Senate for seeking information about the prevalence of different types of speech, language and communication disorders and speech pathology services in Australia. IAHA is confident that this submission will provide the impetus for the Senate to recognise the importance of culturally responsive speech pathology services for Aboriginal and Torres Strait Islander peoples, within the context of a holistic view of health and wellbeing.

The ability to communicate effectively can impact upon every aspect of the life of an Aboriginal and Torres Strait Islander person, not just their health but education and life outcomes and aspirations. There is no one size fits all approach to meeting the speech, language and communication needs of Aboriginal and Torres Strait Islander peoples – hence the need for culturally responsive speech pathology services to meet the specific needs of individuals, families and communities.

For generational change to occur, the most economically sustainable approach to positively impacting the broader ongoing health and wellbeing of Aboriginal and Torres Strait Islander peoples, thereby contributing to Closing the Gap, is investment in evidence based, equitable and culturally responsive access to speech pathology and other allied health services NOW.

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1 National Aboriginal Health Strategy, 1989
Accessed March 2013