

# What we know about: Speech pathology service access and delivery

Equitable use of limited resources is a challenge for all Speech Pathology service providers.

## Service Access:

Rates of access to Speech Pathology services by children with a known communication impairment is low. Multiple studies demonstrate that only about 35% of children with an identified need will access a Speech Pathologist.

Condition	% with a known condition seeing a Speech Pathologist
Expressive Language	34%
Receptive Language	33%
Speech	42%
Fluency	32%

Children who have a concerned parent are nine times more likely to access a Speech Pathology service, regardless of how severe the problem is. Access to services is often socially and geographically determined.

Service under and over utilisation is prevalent. According to one Australian study:

- 14% of all 4yo have an identified communication impairment (as determined by professional evaluation) but never access Speech Pathology services
- 5% of all 4yo do not have a communication impairment (following a standardised assessment by a Speech Pathologist) but are accessing services

Waiting times of 12mths or longer are more common in Queensland compared to other states and territories. Parental dissatisfaction with the quality and outcome of services increases with longer waiting times.

Families access a range of service providers: private (44%), health (30%), school (11%) and other organisations (13%). There is geographical variation in the availability of providers, particularly in regional and rural areas.

## Models of Service:

Speech Pathology interventions have generally followed a medical model of service: diagnosis and remediation of specific problems focused on the individual. This may be at the expense of understanding: the broader population perspective; social and familial factors that drive communication competence; and the raft of likely co-morbid features that contribute to a child's capacity to function across contexts.

Traditional clinical models where caseloads are defined by severity and where services are likely to be diluted in an attempt to increase reach across a population are not sustainable and are no longer feasible in the face of emerging evidence.

There is widespread support in the literature for using the World Health Organisation's (2001) International Classification of Functioning, Disability and Health (ICF) as a conceptual framework for understanding developmental disability (including communication impairment) and reducing the impact of communication impairment on a child's day to day function.

Increasingly, a tiered approach to preventative interventions is being advocated for:

<b>Primary Prevention</b>	Directed at the general population and aimed at stopping language impairment. Environmental enrichment, influencing decision makers at a policy level.
<b>Secondary Prevention</b>	Directed at populations identified as at-risk for poor communication outcomes. Support speech and language skills to develop in line with peers using evidence based models and programs.
<b>Tertiary Prevention</b>	Directed at families where a child's communication impairment is persistent and is unlikely to resolve with traditional intervention. Goal: reduce the negative effects of the communication impairment across the lifecourse.

Optimal resource allocation will only come through collaborative partnerships and clearly determined responsibilities for service provision across the care continuum.

When intervention is indicated, there are considerations that must be made in regard to the type and intensity of support:

1. *Episode of Care*: treatment occurs for a defined period and to support the acquisition of a specific skill. This is in contrast to a traditional view that a life-long condition requires continuous therapy support.
2. *Readiness for Activity and Participation*: a child's development is dynamic and skills acquisition will be optimal when they are ready across domains such as body function and structure, motivation and interest, family systems and environment.
3. *Method of Service Delivery*: 'Intervention' needs to be conceptualised broadly and incorporate assessment, diagnosis, consultation-liaison, and monitoring of skills development as well as traditional 'therapy' services.
4. *Distinction between Intensity of Therapy and Practice of Activity in Natural Environments*: skills development is most likely to occur within the environmental conditions in which it is usually performed. The time spent in 'therapy' is small in comparison to the opportunity to practice in natural environments. Intervention needs to support this.

## References:

Bloomfield, J., & Dodd, B. (2011) Is speech and language therapy effective for children with primary speech and language impairment? Report of a randomised control trial. *International Journal of Language Communication Disorders*. 46-6. 628-640

Law, J., Reilly, S., & Snow, P. (2013) Child speech, language and communication need re-examined in a public health context: a new direction for the speech and language therapy profession. *International Journal of Language and Communication Disorders*. 00-0. 1-11

Lindsay, G., Dockrell, J., Law, J., & Roulstone, S. (2010) *The Better Communication Research Programme: Improving provision for children and young people with speech, Language and communication needs*. London. DfE

Palisano, R., & Murr, S. (2009) Intensity of Therapy Services: what are the considerations? *Physical & Occupational Therapy in Practice*. 29-2

Ruggero, L., McCabe, P., Ballard, K., & Munro, N. (2012) Paediatric speech –language pathology service delivery: an exploratory survey of Australian parents. *International Journal of Speech-Language Pathology*. 14-4. 338-350

Skeat, J., Wake. W., Ukoummunne, O., Eadie, P., Bretherton, L., & Reilly, S. (2012) Who gets help for pre-school communication problems? Data from a prospective community study. *Child: care, health and development*. 40-2. 215-222