

Submission
No 44

**INQUIRY INTO SERVICES PROVIDED OR FUNDED OR
THE DEPARTMENT OF AGEING, DISABILITY AND
HOME CARE**

Name: Name suppressed

Date received: 05/08/2010

Partially Confidential

5th August 2010

The Director
Standing Committee on Social Issues
Parliament House
Maquarie St
Sydney NSW 2000

Dear Madam/Sir

Re: Inquiry into services provided or funded by the Department of Ageing, Disability
and Home Care (ADHC)

I am a speech pathologist working within NSW Health. I wanted to make an independent submission to the inquiry into ADHC services, as I have not left time to consult my colleagues or have a submission approved by management.

Speech pathologists are frequently the first point of contact for many families with children who have significant communication and feeding difficulties. Many of these children are later diagnosed with an intellectual disability. At this point, they are transferred to ADHC services. Initial speech pathology contact with ADHC is referring children and providing current clinical information. Our role often extends to advocating to ADHC on behalf of families frustrated by issues of service quantity, quality, timeliness, and transparency. Please find some of the Terms of Reference addressed below.

a) The historical and current level of funding and extent of unmet need.

Families are generally reluctant to be transferred to ADHC. Sometimes, this is because they are coming to terms with the diagnosis and have formed relationships with therapists in Health. Families also mention concerns that; they will wait years to be seen and may never receive services; that any intervention will be brief and address one problem only; that re-referral is required for each specific concern. ; and that it is difficult to speak to therapists to find out about services.

ADHC's inability to meet the needs of children and families affects the care of children across Health, Education, Disability, and non government sectors. Some families are reluctant to have a formal assessment and diagnosis that will require transfer from Health to ADHC. Families may withhold information about previous assessments and diagnosis in order to access Health therapy services. Speech pathologists working in Health receive many calls from parents and professionals asking us to see children with identified significant disability because they are not receiving adequate services via ADHC.

I do not know details of ADHC funding. However, any past and future increases in funding should be matched by increases in actual service delivery: that is, more occasions of quality therapy service, more respite places, more group home places, more service flexibility. Increases in non clinical management positions should not exceed increases in actual service delivery or patient satisfaction.

b) Variations in service delivery, waiting lists and program quality between; services provided, or funded, by ADHC; and ADHC Regional Areas.

There is a lack of transparency about ADHC service delivery. While experience demonstrates the waiting periods can be years, no one will tell you this. Instead parents and other professionals are told 'we don't have waiting lists, we see people based on need and priority', 'we can't say when he'll be seen, it depends on the priority he is assigned'. Information should be available on; about how children are prioritised; how decisions are made about therapy timing, type, and amount; how cases are allocated to therapists; and anticipated waiting times for children with particular needs.

Parents are also confused about what being a 'low priority' at ADHC means. ADHC should be explicit and transparent about the difference between; a child needing therapy, but to whom ADHC are unable to provide services; and a child who does not need therapy. In the latter case, evidence for the decision should be documented (for example, data showing the child has reached a plateau).

Most intervention evidence for communication disorders relates to provision of direct therapy, and the systematic, specific training of parents, carers, and staff. Assessment, consultation and review assessment seems to be a commonly used intervention model in ADHC. The evidence for 'consultative' models of intervention involving an assessment, written report, and one off discussion with parents/carers/staff, should be examined.

It is logical that therapists, whose primary role is clinical, should spend the majority of their time in face to face contact with clients and carers, particularly where there are already designated Case Manager positions in an organisation. One small organisation that receives ADHC funding to provide intervention requires its full-time therapists to provide 20 hours of face to face home visiting contact per week. The service is popular and produces positive outcomes for children and families.

c) Flexibility in client funding arrangements and client focused service delivery.

ADHC's Intake process is not a very client focussed service. Parents report frustration at speaking with an administrative person, rather than a therapist at their first point of contact. Although the wait for services is long, a 'needs assessment' is normally conducted reasonably quickly. Children are often referred to ADHC following already comprehensive assessments of their abilities and needs. Increased efficiency would result from using the information and recommendations for services contained within these referral reports, rather than completely re-doing a 'needs assessment'. This would also reduce parental frustration at repeating information.

f) Internal and external program evaluation, including program auditing and achievement of program performance indicators review.

Evaluation is important. However, to see more money poured into evaluation and auditing processes than to service delivery would not be ideal.

We acknowledge that there are some very talented and caring professionals working within ADHC. Thank you for the opportunity to comment on services provided or funded by ADHC.

Yours sincerely

Speech Pathologist.