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SUBMISSION TO:

THE PRODUCTIVITY COMMISSION
INQUIRY INTO LONG TERM DISABILITY CARE AND SUPPORT

This document outlines the Speech Pathology Australia response to the Productivity Commission's Inquiry into Long Term Disability Care and Support

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PRODUCTIVITY COMMISSION'S INQUIRY INTO DISABILITY CARE AND SUPPORT

SPEECH PATHOLOGY AUSTRALIA SUBMISSION
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Preamble

The Inquiry aims to explore alternative approaches to the funding and delivery of disability services with a focus on early intervention and long term care. The scheme is intended for people in significant need of support. People with a severe communication and/or swallowing impairment are in need of significant support, often across their life span.

There is an added urgency to the inquiry and the outcomes to be produced. The increasing burden of the ageing population (including those people with a disability), the ageing workforce and the rapidly increasing fall of workforce participation rates affect and will continue to affect the capacity to deliver speech pathology services.

Increasingly, as demand for services continues to grow exponentially, there is the significant issue of a declining workforce and substantial problems around the recruitment and retention of speech pathologists (as well as other health professional groups) to be able to undertake the delivery of services. This is much more pronounced in rural, regional and remote parts of the country.

Speech Pathology Australia supports the government's commitment to ensure that people with disabilities have the same opportunities as other Australians – a quality education, appropriate health care, a job where possible and access to buildings, transport and social activities.

Speech Pathology Australia supports the premise of a social insurance model that provides necessary funding for access to care and supports that enables individuals with disability to achieve these opportunities.

Introduction

Speech Pathology Australia is the national peak body for speech pathologists in Australia representing approximately 4,500 members. Speech pathologists are university qualified health professionals who are specialists in the assessment and management of disorders of communication and swallowing that may present across a person's life span. Speech pathologists contribute significantly to the assessment, care, management, and quality of life of individuals through the provision of services that maximise communication (speech, language, voice, fluency, social skills and behaviours, literacy and numeracy, problem solving and general learning) and swallowing (eating, drinking, managing saliva) needs whether this is through direct intervention, education, consultancy, advocacy or a combination of these approaches.

Speech pathologists work with large numbers of children with disabilities prior to and during their formal education, in public and private sectors, in education, health and disability programs. Speech pathologists also work extensively with the adult population who have acquired a communication impairment/disability or who have had a disability present at birth. Many of these people have communication impairments of unknown origin and are in need of significant supports that are currently not funded.

These people may be unable to communicate through speech, have limited speech or speech that is extremely difficult to understand. Often people with communication disability are required to "make do" with suboptimal forms of communication, thereby not only limiting their potential to communicate but also their ability to participate and develop their full potential in all aspects of their lives. The profession of Speech Pathology believes that it is ideally placed to provide meaningful input into the Inquiry into the Long Term Disability Care and Support Scheme, particularly in relation to the needs of people with moderate to severe communication and/or swallowing impairment.

Speech Pathology Australia congratulates the current Government on the development of a draft National Disability Strategy and we support the vision – "for an inclusive Australian society that enables people with a disability to fulfil their potential as equal citizens" (National Disability Strategy, 2010-2020, page 8). We further commend the Government for ratifying the UN Convention on the Rights of Persons with a Disability in 2008.

By recognising that some people with disability and their carers need specialist supports and care, the commissioning of an Inquiry into a National Disability Long Term Care and Support Scheme will inform approaches to funding and service provision that importantly focus on early intervention and long term care. The Scheme and ultimately the final National Disability Strategy must explicitly include people with disabilities of communication and swallowing.

In this submission, Speech Pathology Australia makes two key points:

- The Definition of Disability must include communication and swallowing disability of unknown origin, in addition to those arising as part of a specific disorder or complex syndrome
- People with complex disabilities and associated communication and/or swallowing difficulties need funding for access to speech pathology services, and where required, augmentative and alternative communications (AAC) systems.

Speech Pathology Australia is keen to ensure that communication and / or swallowing impairment encompasses a range of communication and swallowing difficulties and/or disabilities affecting:

- Speech and Language (understanding and/or use)
- Voice and Fluency (stuttering)
- Social skills and behaviour
- Aspects of literacy, numeracy, problems solving and general learning
- Alternative forms of communication: for example, the use of communication devices by children and adults who cannot communicate using speech
- Eating, drinking and ability to meet nutritional needs

In relation to this submission, Speech Pathology Australia is referring to people with communication and/or swallowing impairments that are moderate to severe.

Context

Communication Impairment is included in the definitions of disability under various United Nations (UN) Conventions and the World Health Organisation (WHO). UN Conventions and WHO state that communication is a basic human right and is essential for participation in society (World Health Organisation 2007). Yet communication impairments are often the **"invisible"** disability in our society.

Hundreds of thousands of Australians suffer from communication disabilities. A communication disability is not dependent on age, socio-economic status, education or location. Access to speech

pathology services is variable and inconsistent across Australia and in particular those people in remote and rural areas are seriously disadvantaged. For our indigenous population the disadvantage is even greater.

Speech pathologists understand first hand that people with a disability and in particular a communication disability are impacted on daily in all the aspects of living, learning, working and socialising which prevents them from participating fully in the community. Participation in society must be supported by appropriate access to communication. The ability to communicate effectively – talk with and listen to others easily, learn, share ideas, express our needs and wants and be part of a social or work conversation – is a basic human right.

The speech pathology profession aims to partner with individuals with a communication disability so that they can participate as fully as possible in our society. This means that the profession takes up a range of different roles from therapist, advocate, lobbyist, partner, researcher, educator, academic to counsellor and support person in order to work with key agencies and groups to develop and promote key initiatives that will optimise social inclusion for those people with a communication disability.

Legislation

Communication impairment is a prevalent childhood disability. The way countries formally recognise communication impairment impacts on the provision of services and long term outcomes for these children. Currently Australia does not identify children with communication impairment in legislation and policy.

Australian legislation and policy does not adequately address the needs of children (and adults) with communication impairment, particularly those with communication impairment of unknown origin. Health professionals, educators and disability service providers are left to interpret ambiguous policies to make a case for service delivery.

Two Commonwealth Acts provide legislation for disability and health: Disability Services Act (DSA) 1986, Disability Discrimination Act (DDA) 1992. In 2005, the Federal Government formulated the Disability Standards for Education, 2005 (The Standards) to clarify the obligations of education and training service providers under the Disability Discrimination Act 1992 as well as articulate the educational rights of people with disabilities (Commonwealth of Australia Disability Standards for Education 2006). Although communication disorders are not specifically identified as a “disability” in the DDA or the Standards, such disorders could be covered by the reference to “a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction.” (Commonwealth of Australia, Disability Standards for Education, 2006. 2005 Guidance Notes.)

Access to speech pathology services is not consistent across Australia’s states and territories due to different interpretations and applications of the relevant federal legislation. Children with communication impairment of unknown origin are rarely accounted for in Commonwealth or state legislation or policies.

Prevalence and Impact of Communication Disabilities/Impairment

Severe communication impairment may affect as many as 8-10 people per 1000 population (Beukelman & Ansel,1995). At a minimum, difficulties communicating may affect 1.3% of the total population (Australian Institute of Health and Welfare, 2004) whilst difficulty swallowing (dysphagia) may affect up to 16% of Australians (Eslick & Talley, 2008).

Considering disabilities in communication alone, one in seven users of government disability services (over 5 years of age) has little or no effective communication and over 40% of users require assistance with communication (Australian Institute of Health and Welfare, 2005).

Augmentative or alternative communication devices are used by 13,000 Australians (Speech Pathology Australia 2008).

Research in Victoria showed that common underlying causes of severe communication impairment (SCI) include:

- Cerebrovascular accident (stroke) (16%)
- Cerebral Palsy (14%)
- Genetic or congenital conditions (9%)
- General Developmental delay (6%)
- Autism (4%)
- Progressive neurological diseases (4%)
- Trauma (3.2%)

For 38% of people with severe communication impairment, the underlying cause is unknown. (Bloomberg & Johnson, 1990).

Communication impairment is evident in 75% of children with autism; 69% of children with Down syndrome and 55% of children with cerebral palsy (Speech Pathology Australia, 2008). Speech and language disorders of unknown origin have a high prevelance in childhood, with one in 4 children (25%) having difficulty understanding and using language upon school entry (McLeod & Harrison, 2009).

Speech and language disorders have the potential to result in long term disabilities, not only impacting on acquiring literacy and maximising academic achievement, but also in relation to psychosocial development and community participation and integration. Australian research demonstrates that severe speech and language (communication) disorders are associated with reduced employment options, social, emotional and behavioural problems across the life span, mental health problems, and criminal behaviour leading to juvenile offending and imprisonment (Snow & Powell, 2007).

The strong link which has been established between juvenile offending and language impairment is of significant concern. An Australian study (Snow & Powell, 2008) showed that over 50% of a sample of young offenders had language impairments. This has significant long term social and economic implications for the community.

Childhood communication impairment is a risk factor in relation to long and short term outcomes. Compared to the general community, adults who had a communication impairment of unknown origin as a child typically achieved lower levels of education; had greater literacy problems, experienced significant social problems and discrimination and had decreased occupational opportunities. (Conti-Ramsden & Durkin, 2008; Felsenfeld et al, 1994; McCormack, McLeod, McAllister & Harrison, 2009).

As children with severe communication disabilities grow to adulthood and as adults acquire disabilities through a range of factors, similar pressures apply. Carers who are ageing themselves find it difficult to provide ongoing 24 hour care; there is often no appropriate residential accommodation for the adult; respite care is scarce and services to adults with disabilities are more limited than the services provided to children.

In relation to difficulties with swallowing (dysphagia), as much as 5% of the population are affected by severe swallowing problems that require non oral forms of nutrition. Children and adults with disabilities resulting in dysphagia are at risk of malnutrition and dehydration, of choking, and of food and drink entering their lungs, resulting in infection.

Dysphagia can result in significant disability, impacting on quality of life and having psychological consequences, including social isolation and depression. (Nguyen et al, 2005)

The inability to communicate effectively or to meet one's nutritional needs in the most appropriate manner is a major disability for many people, whether present in isolation or as part of another disability. These issues relate to basic human rights.

Compared to people with disabilities but no communication and/or swallowing impairment/disabilities, people with disabilities that include communication and/or swallowing impairment:

- are less likely to be employed, more likely to be restricted in the type of job, and more likely to need a disability support person or someone at work to assist them;
- have poorer social opportunities – are less likely to receive or make visits to family and friends, far less likely to communicate with family and friends over the telephone, and less likely to leave home for activities/visits;
- are more likely to be attending special schools, rather than attending normal school with a special class. (Australian Institute of Health and Welfare) (2003).

(Further statistics on communication and swallowing impairment prevalence can be found in Appendix 1).

Cost Implications

The social and economic cost of communication and swallowing impairment is significant for the person and society as a whole and places a huge financial burden on government supports and services. The deleterious consequences of communication and swallowing disability affect Australians across their life span.

A report by ICAN, a UK charity highlighted the triple cost of communication difficulties: costs to individuals, to families and to the country. There are costs to individuals such as lower educational attainment and social /emotional difficulties. Costs to families may include not only the direct costs of therapy but other costs such as travel. The costs to the country are related to the increased educational needs, higher unemployment rate and fewer employment opportunities of people with communication difficulties (ICAN 2006).

As cited in McLeod 2010, a UK study found that the cost of education provision and welfare benefits was significantly higher for a child with developmental language disorders than for their siblings.

Speech Pathology Australia's response to the Key Questions posed by the Productivity Commission

Eligibility

Who should be in the new scheme and how could they be practically and reliably identified?

- Eligibility needs to be based on a national standard set of definitions of disabilities. These standard definitions should be informed by internationally accepted classifications of disability such as the International Classification of Functioning, Disability and Health (ICF). Professional bodies, such as Speech Pathology Australia, should be consulted as to the application of such definitions to the Disability Care and Support Scheme.
- Rating of severity needs to be based on international and national standards and will require profession based specific input.
- Assessment of severity would require formal assessment and the use of accepted standards in regard to severity. One example in relation to language impairment is the use of specified test scores and accepted standards to determine severity.
- People with severe communication and/or swallowing impairment/ disabilities that require significant support across their life to access employment, recreational opportunities, independent/supported accommodation away from home.
- Speech Pathology Australia contends that people with moderate (as opposed to severe) disabilities in communication that have significant long term impacts should also be included to ensure appropriate funds are available to access specialist services. This, in turn, will have an effect to mitigate the high impact on educational and social participation opportunities.
- People with complex communication needs as part of a specific identified disorder or syndrome such as cerebral palsy, Down syndrome, autism and sensory impairments, and their carers, will be eligible recipients of care and support under this scheme.
- People with equally complex communication needs but occurring in the absence of an identified syndrome or multiple impairments, as in the case of a severe language disorder, childhood apraxia or acquired aphasia, and those of unknown origin must also be eligible due to the significant impact that communication impairment has on learning, socialisation and full participation in educational, work and community activities.
- It is recommended there be development of an appropriate assessment tool (including a dedicated communication and/or swallowing component) based on functionality. Generally, the assessment tool should be able to identify the needs of each person, considering severity, function and complexity as well as potential for improvement and future gains in communication. The tool needs to be objective and reliable so that it can be used throughout the country with a high degree of inter-rater reliability. Additionally the tool needs to have a broad degree of acceptance and be relatively easy to administer so that core and common components could be administered by one health worker. The tool needs to be able to account for multiple aspects of assessment so that people are not subjected to repeated and multiple testing.

Which groups are most in need of additional support and help?

- People with severe/profound and multiple disabilities, including communication and/or swallowing impairment.

- Parents with children who have severe/profound disabilities (often more than one child) and are providing 24 hour care in order to prevent harm or injury to the child or to others. The parents live in a constant state of anxiety worrying about the long term outcomes including care and accommodation for their children and are often physically and emotionally unwell themselves due to the care burden.
- Elderly parents with a grown child who has a severe/profound disability and are themselves ageing and finding the burden of care physically, emotionally, psychologically, socially and financially overwhelming.
- People with communication and/or swallowing impairment particularly those with communication impairment of unknown origin.
- Children and adults with severe communication impairments need access to extended speech pathology services in order to have the best chance of developing and retaining an effective communication system over their lifetime .They have access to little or no funding and their disabilities are not recognised formally at a system level.
- People who require Augmentative and Alternative Communication devices that are expensive and are not consistently or adequately or funded. Such devices may range from communication boards and pictures to more sophisticated and costly electronic voice synthesisers. These devices are expensive and funding is currently inadequate to meet the needs of users. One example of such equipment is a high technology voice output communication device, at a cost of $13,000.
- People who are “at risk” of being “in crisis” and who need support be provided flexibly and timely with adjustments as the need changes – not at the point of breakdown/ joblessness/homelessness/ill health.

What could be done about reducing unfairness, so that people with similar levels of need get similar levels of support?

- Appropriate funding to ensure services and the number of professionals are sufficient to meet the needs of people with disabilities (specifically speech pathologists to provide services to those with communication and swallowing disabilities).
- Funding on a national basis for appropriate Augmentative and Alternative Communication Systems (as above), ranging from low technology communication books to high technology speech generating systems.
- Adequate funding for the provision of aids and equipment with clear and transparent guidelines in relation to eligibility and access.
- Develop case manager style roles with experience and expertise of specific disability groups so that they understand the needs of a particular group. People with different disability types present with vastly different needs e.g. a person with a severe physical disability will have very different needs to a person with acquired hearing impairment/blindness.
- Development of a rating/ranking scale that outlines support and service needs.
- The use of the International Classification of Functioning, Disability and Health (ICF) as a framework of identifying needs.

Power/Influence

How could people with disabilities or their carers have more power to make their own decisions (and how could they appeal against decisions by others that they think are wrong)?

- Continuing support for the development of Consumer Advisory Representatives to sit at the table with agencies charged with delivering services to people with disability.
- Increase in the number of disability advocates to support people with disability
- Funding should reside with the person not the service. The development of appropriate levels of "individualised funding" or "consumer directed" funding so that the person with the disability has greater control over the choices in their life.

How should the amount of financial support and service entitlements of people be decided (and by whom?)

- Amount of funding should directly relate to the individual's needs based on assessment of need and optimal support and equipment required.

Service need and delivery

What kinds of services particularly need to be increased or created?

- The core formal services that include personal care services, respite and accommodation services, community access and community support will need to be supported by the development of new worker roles such as the community support worker and other competencies arising from changes to the Health Training Package.
- Access to appropriate diagnostic and referral mechanisms that enable a person with disability to get the multidisciplinary range of services required.
- Subsidised packages of comprehensive multidisciplinary services (including speech pathology) for those people with severe communication and/or swallowing impairment.
- The establishment of specialist Augmentative and Alternative Communication services in all States and Territories.
- Improved financial support for communication tools ranging from low technology communication books to high technology speech generating systems.
- Respite and support packages designed to keep young adults at home for as long as is practicable and in line with their wishes.
- Suitable residential facilities for young people with disabilities so that there are a range of appropriate housing options.
- Support for transport, aids, appliances and equipment.
- Advocacy services for people with communication disabilities who need assistance to "speak out" about their choices and decisions and wishes
- Respite services and carer support services
- Recreation and social groups for adults with disabilities
- Enhanced Employment Support services and supported employment options

- Development of specialist programs to facilitate the acquisition of literacy skills for adults with disabilities.
- Specialist literacy programs for children with disabilities to assist their acquisition of literacy skills.

How could the ways in which services are delivered – including their coordination, costs, timeliness and innovation – be improved?

- Multidisciplinary team management of people with disabilities who have swallowing disorders should be facilitated. Currently access to services is variable and the degree of support provided by key professionals is limited by funding and insufficient resources.
- Interprofessional training, education and practice as a means to counteract the silo approach that currently prevails in relation to service delivery.
- Development of service delivery models that meet the individual needs of those with disabilities (including access to schools, hospitals, rehabilitation, community settings, aged care settings and the home).
- Subsidised access to allied health professional services
- Flexible funding system so that the best suited multidisciplinary team works together to deliver the best services
- Person centred and family centred approach to service delivery
- Team based approach across systems (within and across services and sectors) to ensure all health professionals are accountable and responsible for delivering coordinated services
- Use of evidence based protocols and practice
- Improved training for GPs in screening and referring people with disabilities to appropriate multidisciplinary services and in particular identifying the signs of dysphagia and making appropriate and timely referrals.
- Mandatory training of carers and educators in ways to maximise language development or to ensure a functional communication system for the person.
- Training of staff in residential houses, aged care facilities, other residential facilities where residents have dysphagia or use alternative communication systems.. Regular review training is also required to be provided by Speech pathologists.
- Incorporation of disability education and training into tertiary courses relevant to that field of disability (including medicine, nursing, the health sciences, teaching and support workers)
- Increase training, consultative support and education by Speech Pathologists to teachers and teachers' aides particularly in relation to inclusive education methodologies that promote inclusion of children with disabilities.
- Increased trained staff presence at mealtimes so that they can assist and supervise at mealtimes in residential facilities.
- Development of advanced scope of practice for speech pathologists.

Are there ways of intervening early to get improved outcomes over people's lifetimes? How would this be done?

- It is the position of Speech Pathology Australia that access to timely and appropriately structured speech pathology services in early intervention settings is integral to the achievement of optimal education, communication and social outcomes for children.

- Screening the “at risk” population/those diagnosed with a disability/those with an acquired disability (for communication and/or swallowing impairment) for the need for services and access to accurate and timely information
- For those identified, provide further referral for assessment and intervention
- For those assessed with a communication/swallowing impairment, provide early intervention that is tailored to meet individual need
- For the people with complex needs, referral to specialised services and programs
- Develop services and programs that identify and provide remediation for “at risk” children in 0-4 age group.
- Develop evidence based tools for early childhood educators to accurately identify young children needing intervention (prior to starting school)
- Development of standardised screening tools for dysphagia.
- Child–carer ratios in child care centres need to be sufficient to ensure significant amounts of child-carer interaction as this drives language development.

How could the new scheme encourage the full participation by people with disability and their carers in the community and work?

- Minimise barriers to participation in all facets of life including education, employment, access to community and recreational activities and facilities, socialisation and the opportunity to express views about culture, diversity, religion. Barriers are caused by the person with a disability being unable to communicate effectively.
- Increase skills and expertise for Disability Support workers through competency training
- Increase skills and expertise for respite staff through competency training

How can a new system ensure that any good aspects of current approaches are preserved?

What should be done in rural and remote areas where it is harder to get services?

- Access to Telemedicine facilities and the use of “e” technologies.
- Developing and supporting the health professional workforce to increase and optimise capacity to respond to the needs of people with disabilities specifically communication and or swallowing impairment
- Build on skills and experience of available or emerging workforce
- Need to build sustainable approaches to respond to the needs of people with disabilities
- Provide incentives that will encourage health professionals to take jobs in hard to staff areas.

How could a new system get rid of wasteful paper burdens, overlapping assessments (the “run around”) and duplication in the system?

- Invest in supporting “e” technology readiness among health providers to support better coordination across the entire multidisciplinary team. Practical support and financial incentives are needed for allied health professionals to ensure the uptake of appropriate information technologies.
- Ensure the development of a strong interface between disability services, local hospitals and community health care including primary health organisations

Funding

How should the new scheme be financed?

- The proposal of a social insurance model funded by government (through a Medicare-type levy or taxpayers funds) is supported, however means and assets testing is not supported as this may potentially serve to create inequity and lack of consistency in accessing support and funding.

How can it be ensured that there is enough money to deliver the services that are needed and provide greater certainty about adequate care in the future?

- The Association supports an approach to funding that considers the impact of a disability and an individual's experiences of their disability, such as occurs in the World Health Organisation's International Classification of Functioning.

Organisation/Implementation

What are your views about the "nitty gritty" aspects of a scheme that will make it work practically?

How long would be needed to start a new scheme and what would happen in the interim?

- Significant and meaningful consultation with peak bodies representing the health professions (including Speech Pathology Australia).
- Professional peak body and disability representative organisations should be included in the formation of the scheme's governance and operations.

Conclusion

This submission provides the Association with the opportunity to advocate on behalf of the many individuals with complex communication and swallowing needs, their families, carers, support workers, teachers and therapists. Individuals with complex needs, particularly where their communication is impaired, are unable or limited in their ability to advocate for themselves.

Participation in society must be supported by appropriate access to communication. The ability to communicate effectively – talk with and listen to others easily, learn, share, ideas, express our needs and wants and be part of a social or work conversation – is a basic human right that is often taken for granted.

Speech Pathology Australia supports the government's commitment to ensuring that people with disabilities have the same opportunities as other Australians – to a quality education, to appropriate health care, to have a job where possible and to access buildings, transport and social activities.

Many people with disabilities in Australia have the potential to communicate and improve their quality of life, yet currently are not given a voice due to lack of access to services, poor public awareness and fragmented service provision.

Speech Pathology Australia contends that through the National Disability Strategy and the creation of a Long Term Disability Care and Support Scheme, recognition be afforded to the complex and variable nature of communication and/or swallowing disability, and its potential to impact social inclusion and participation at many levels and in many diverse ways.

One of the critical tasks of both the Disability Strategy and the Disability Care and Support Scheme will be to secure national agreement on the definitions of disability and to be explicit about inclusions, including communication and/or swallowing impairment.

Speech Pathology Australia looks forward to further consultation as the work for a long term disability care and support scheme is progressed. The Association supports the development of an equitable and adequately funded system of providing necessary care and supports to people with disability, including those with moderate and severe communication and swallowing impairment.

For further consultation, please contact:

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Appendix 1

Statistics on communication and swallowing impairment

A severe communication impairment may affect as many as 8-10 people per 1000 population. (Beukelman, D, R., & Ansel, B.) (1995)

One in seven users of government disability services (over 5 years of age) has little or no effective communication. (Speech Pathology Australia 2008) and over 40% of users require assistance with communication. (Australian Institute of Health and Welfare (2005)

18.1% of five year olds are 'developmentally vulnerable' with respect to Language and Cognitive Skills and Communication and General Knowledge outcomes, while a further 29.8% are 'developmentally at-risk' across both these domains. (Australian Early Development Index) (2009)

At 2 years of age, 20% of Australian children have speech and language delay while 50% of this group will have persisting language delay at 4 years. A further 10-15% of children not identified at 2 years will be identified at 4 years with a speech and/or language impairment. (Reilly S., et al 2009)

One in 4 children have difficulty understanding and using language upon school entry. (McLeod & Harrison, 2009)

Speech and oral language difficulties are a significant risk factor in literacy development. Baseline literacy skills are non existent in 14% of children at 15 years of age. (Speech Pathology Australia 2008)

Communication impairment is evident in 75% of children with autism; 69% of children with Down syndrome and 55% of children with cerebral palsy. (Speech Pathology Australia 2008)

Over 70% of indigenous children in remote communities suffer from chronic otitis media that can cause permanent hearing loss and inhibit language and literacy development. (Department of Education and Training, Western Australia). (2006)

Around 20% of Australians over 50 years of age experience difficulties swallowing food and/or drink. (Speech Pathology Australia 2008)

More than 50% of Australians with dementia experience communication difficulties. (Speech Pathology Australia 2008)

Of all people who suffer a stroke, 25% develop aphasia (acquired speech and language difficulties) (Speech Pathology Australia 2008)

Augmentative or alternate communication devices are used by 13,000 Australians. (Speech Pathology Australia 2008)

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