

Victorian Allied Health Workforce Research Program

Speech Pathology Workforce Report

July 2016

Speech Pathology Workforce Report

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Abbreviations and acronyms

ABS	Australian Bureau of Statistics
AH	Allied health
AHA	Allied health assistant
AHOMT	Allied Health Organisation Mapping Tool
AHWQ	Allied Health Workforce Questionnaire
AIHW	Australian Institute of Health and Welfare
CPD	Continuing professional development
EBA	Enterprise bargaining agreement
EFT	Equivalent full time
FEES	Fibreoptic endoscopic examination of swallowing
FTE	Full time equivalent
NDIS	National Disability Insurance Scheme
NFP	Not for profit
SPA	Speech Pathology Australia
VFSS	Video fluoroscopic swallowing study

Executive summary

Overview

This report provides an overview of the speech pathology workforce in Victoria in 2015 - 2016. It is based on survey responses from 740 individual speech pathologists (approximately 50% of the Victorian speech pathology workforce); four focus groups involving 11 participants; and surveys from 69 organisations that provide services across 311 different locations or sites in Victoria.

Public sector employees were slightly over-represented in the survey sample, with 48% of respondents stating that they were public sector employees as compared with 42% in the Australian Bureau of Statistics (ABS) 2011 census data.

Findings

Speech pathologists	Survey	ABS, 2011 ^a
Victorian population	740	1,438
Female	97%	97%
Aboriginal and / or Torres Strait Islander	1%	.003%
Australian trained	96%	
Age 30 years and under	29%	33%
55 years and older	11%	
Median age (years)	36	
Median income / annum	\$60,000 to \$69,000	
Public sector	48%	42%
Private sector	22%	
Not for profit sector	12%	
Principal area of practice	Paediatric language disorders - 30%	
Clinical stream	Disability – 16%	
Reporting advanced scope of practice role	22%	
Work with allied health assistants	37%	
Reported use of telehealth	13%	
First qualification to practise	Bachelor degree 71% Master's degree - Graduate entry - 13%	
Hold PhD	4%	
Intention to stay in profession for more than 5 years	78%	
Work for two or more employers	31%	
Of those with a supervisor, speech pathologist as a supervisor	54 %	
% of workforce primary role in non-metro	33%	

^a Source: Australian Bureau of Statistics (ABS) Census, 2011

Speech pathology has a perceived oversupply due to recent rapid growth in new graduates; however the complete picture is much more complicated. Anecdotal evidence suggested there was unmet community need for speech pathology services including reports of long waiting lists, concerns regarding capacity to deliver quality patient care due to inadequate resources and delays in providing necessary services, lack of funding to recruit speech pathologists to meet demand, high workloads and staff burnout. At the same time, there were reports of speech pathology graduates being unable to find work.

Speech pathologists reported a need for funding models to adapt to reflect current evidence about the best ways to deliver services. Funding models are based predominantly on a one-to-one service delivery framework with limited opportunities for community development, group service delivery, transdisciplinary practice, intensive intervention programs and extended rehabilitation. Additionally, community based

funding models need further development to ensure private practice can deliver affordable, accessible care for patients.

Responding to the current challenges in meeting community need would be greatly enhanced by access to systematic approaches to identify need for allied health (AH) services. Such information would assist the speech pathology profession to present rigorous business cases to managers and funders to guide resourcing of speech pathology services. Improved understanding of the role of SPs by medical professionals and the community would also be important to improving access to services.

Victorian speech pathologists reported that in the context of demand for services exceeding the current workforce, issues of workload and burnout needed greater attention. In circumstances where services were unable to backfill for staff absences there was a dual impact of placing increased pressure on remaining staff and decreasing service capacity. Improved resourcing would open up opportunities to plan more effectively as well as develop and implement innovative service delivery models that deliver longer term solutions that better meet community needs.

Having adequate staffing capacity to meet demand, provide backfill and enable CPD, project and research capacity, enables services to plan, innovate, and create longer term solutions to better meet community health need, provide patient centred care and improve outcomes and health service efficiencies.

Geographic differences were reported in the capacity to fill speech pathology positions. For instance, one service reported more than 100 applicants for a new graduate position. In contrast, two other services received no applications for a grade 2 and grade 3 position. Unfilled positions were reported in outer metropolitan Melbourne and regional centres, but not inner metropolitan Melbourne areas. Respondents reported that funded vacant positions were typically filled within six months.

Workforce capacity issues were accentuated by structural issues in the workforce. In particular, some organisations fund speech pathology positions on short term, temporary or part-time contracts. These positions were less attractive from a recruitment perspective and impacted on the profession's building workforce capacity. Effective use of AHAs was recognised as a way to increase speech pathology service capacity and efficiency; however these positions were subject to the same funding challenges as speech pathology services.

The speech pathology workforce has relatively few senior positions. However, leadership from senior roles is necessary to build advocacy on behalf of patients and the profession, and to provide governance structures for more junior staff regardless of their employment location. In this context, speech pathologists reported the need for improved career advancement opportunities and wanted the use of transparent criteria to guide career progression. Despite the limited number of senior roles, some organisations experienced challenges recruiting to senior speech pathology roles. This suggests that opportunities exist to implement proactive approaches to succession planning within the profession.

Speech pathologists also noted the opportunity to improve workforce capacity and career advancement potential through better access to continuing professional development (CPD) relevant to specific areas of practice. Support through time, funding, and availability of appropriate CPD will be key to enhancing individual career advancement and the development of the profession. Professionals in smaller organisations and rural areas expressed the greatest challenges in accessing CPD. Despite this, the speech pathology workforce is highly qualified; 20% have higher degree qualifications and 30% bring diverse skills from a previous career. There would be benefits in improving explicit opportunities to capitalise on the intrinsic workforce capacity.

Speech pathologists were motivated by the type of work they do and clients they work with, achieving a positive work / life balance, and having access to professional development opportunities. While most were satisfied with the type of work they performed and the clients they worked with, there was dissatisfaction with their pay, and opportunities for professional development and career advancement.

Anecdotally, workforce retention was perceived as a concern within the speech pathology workforce. The self-reported attrition rate from the speech pathology workforce is 1% in the next 12 months, increasing to 22% in five years. Within 12 months, 14% of speech pathologists propose to change jobs, with the majority seeking better job opportunities or working conditions.

There were no systemic skills gaps identified within the speech pathology profession; however several organisations identified specific skills that would be of benefit locally, including clinical skills across a range of practice areas, knowledge of the health and service system, and supervision skills. Improved access to CPD may be a way to resolve several local skills gaps.

Conclusions

Key areas of consideration for the speech pathology workforce going forward include:

- Developing metrics of community need / demand for speech pathology services.
- Increasing leadership representation for the profession to support the development of early career professionals and to advocate at a high level for adequate resourcing and provision of services.
- Improving career structures and understanding of career progression opportunities.
- Supporting innovative ways to access relevant CPD opportunities for practitioners in metro and particularly regional areas.
- Creating new ways of working that provide opportunities for early career professionals and support workload management for the existing workforce.
- Increasing evidence and knowledge base of the professions models of care to improve referrals and business cases for optimal staffing levels to improve patient outcomes.
- undertake modelling around AH, nursing and medical staffing numbers and mix that ensure optimal service capacity and health outcomes
- Improving ongoing mechanism for capturing data about the speech pathology workforce trends.
- Improving recognition and understanding of the profession and ability to advocate for the profession.

Introduction

The Victorian Allied Health Workforce Research Program (the program) aims to contribute to the evidence base about 27 selected Victorian allied health (AH) professions in the public, private and not-for-profit (NFP) sectors in Victoria. The data will be used to inform the policies and programs of the Department of Health and Human Services, provide a platform of evidence on which to build further understanding and development of the AH workforce, as well as guide any improvements to the associated education and training system.

This report presents the data arising from research on of the speech pathology workforce in Victoria.

Please note: terminology used in this report reflects that used in the survey process by Southern Cross University, rather than standard Department of Health and Human Services terminology.

Background

Who are speech pathologists?

Speech pathologists are AH professionals who work to ensure that people can:

- communicate effectively,
- eat and drink, balancing enjoyment and safety,
- connect and belong,
- exercise their right to self-determination,
- fulfil their day-to-day needs,
- participate in and contribute to their community,
- learn to their full potential, and
- expand and achieve their life choices.

To realise these outcomes, speech pathologists work directly with individuals to achieve their communication, eating and drinking goals across all life stages, as well as developing the knowledge and skills of their families and support networks. Some of the causes of communication, eating and drinking difficulties may include developmental delays, brain injuries, learning disability, intellectual disability, cerebral palsy, dementia, and hearing loss.

Speech pathologists also work to facilitate communication accessibility and inclusiveness in every community; advise communities, government and funding bodies on policy and programs; and develop and deliver initiatives that build the capacity of the whole population and prevent and minimise communication, eating and drinking difficulties.

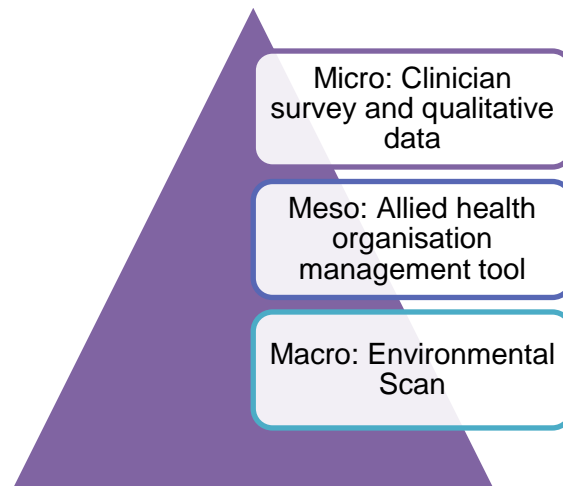
The work contexts of speech pathologists include early intervention services, early childhood education and care services, primary and high schools, hospitals and rehabilitation services, community health services, mental health services, residential aged care facilities, specialist centres, disability services, correctional facilities, libraries, government departments, universities and research institutes, and population health and health promotion programs.

Speech pathology is not a registrable health profession under the *National Registration and Accreditation Scheme / Australian Health Practitioners Regulation Agency*. Speech Pathology Australia (SPA) is the peak body for the profession in Australia and provides self-regulation. SPA is a member of the *National Alliance of Self Regulating Health Professions*.

Method

A three tiered approach was used to capture workforce data at macro, meso and micro levels (Figure 1).

Figure 1: Three tiered research approach



Macro

Environmental scan

The environmental scan examined 27 AH professions in Victoria during the first six months of the research program. The process involved engagement with each of the professional associations regarding workforce trends and issues alongside an analysis of a range of existing data sources. A 'snapshot' was generated for each profession which included key workforce statistics, workforce trends and issues presently affecting the profession, and those likely to affect the profession in the future. An environmental scan has been produced as a stand-alone document for each profession. Relevant findings from the speech pathology environmental scan have been incorporated into this report.

Meso

Subsequent to the environmental scan, four professions (SP, physiotherapy, allied health assistance and sonography) were analysed in-depth at organisational and individual level using the approaches described below. The rationale for focussing on these professions first is that they were all high priority professions for Department of Health and Human Services and existing data sources offered different coverage for each profession. Therefore, the in-depth analysis for each of the four professions required different research methodologies and consultation strategies to achieve the project aims.

Allied Health Organisation Mapping Tool

At the meso level an Allied Health Organisation Mapping Tool (AHOMT) was developed which provides information on the profession's size, location, skill set, recruitment and retention issues, and organisational contexts. The AHOMT was developed using a Qualtrics online survey tool and distributed electronically. It was completed at a regional or organisational level, typically by a team leader or human resources department, to provide detailed information about the workforce structure and organisation.

The AHOMT was adapted from a previously developed tool called the Service Proforma, which was designed to be completed by a multidisciplinary team leader to provide team or service level information about the staffing size, organisation and configuration. The Service Proforma tool was substantially

modified for this project to be completed at an organisational level for specific disciplines. Despite substantial initial piloting, the first iteration of the AHOMT presented some challenges for complex organisations with multiple sites. In particular, organisations providing services across geographic locations felt that the nuances of specific sites were not being addressed (for example, outer Melbourne has different recruitment issues to inner metropolitan Melbourne).

To address this issue, a modified version of the AHOMT (AHOMT2) was developed that could be completed at a team level, and a new tool, the Allied Health Human Resource Tool was developed to capture the whole of organisation workforce data (workforce numbers and location).

Allied Health Human Resource Tool

As outlined above, the Allied Health Human Resource Tool was introduced after the first round of data collection to address a perceived gap in the data, i.e. the geographic location, numbers and grades of workers, particularly for large, complex organisations. This tool was also developed online using Qualtrics and distributed electronically.

Micro

Allied Health Workforce Questionnaire

Individual clinician data were captured through the Allied Health Workforce Questionnaire (AHWQ). The AHWQ captured information about education and training, the nature of work, location of work, job satisfaction and career development opportunities, as well as open ended questions exploring issues that the profession specifically identified as being important.

Participants who completed the AHWQ were invited to provide their contact details for future follow-up.

Focus groups

Survey respondents who agreed to be followed-up via email were invited to participate in one of four focus groups, stratified by grade (or equivalent pay level), rurality and public / private sector. The focus groups explored issues that were highlighted in the survey responses. The questions were developed in consultation with the reference groups and Department of Health and Human Services. Each focus group was held via teleconference using GoToMeeting and took around 90 minutes. The focus groups were recorded and detailed contemporaneous notes were taken and used as the basis for analysis. Where necessary the recordings were accessed for clarity or confirmation.

Research governance

The research was overseen by an overarching research advisory group comprising experts from many health disciplines and sectors. In addition, each of the four professions had a discipline specific reference group comprising members of the profession who represented specific sectors or subgroups (such as new graduates, public, private and NFP sectors, and academics). The advisory group and the reference groups were consulted about the research approach, survey distribution methods and engagement strategies, as well as providing substantial input into the survey content and piloting. The discipline specific reference groups also advised on the content of the focus group questions, aided the interpretation and verification of the final reports, and provided feedback on the penultimate drafts of the discipline specific reports.

Distribution approaches

Surveys were initially distributed through the reference groups, the professional associations and Department of Health and Human Services contact lists. In addition, a communications database was

developed comprising employers, professional networks and associations, individual professionals and relevant contacts for each profession. This database evolved during the project and continues to evolve.

The AHWQ and AHOMT surveys were circulated from October until 31st December 2015. The Allied Health Human Resource Tool and modified AHOMT were circulated during February and March 2016.

Other methods of distribution and marketing included Department of Health and Human Services newsletters and road shows, a stand at the National Allied Health Conference, and regional conference presentations.

Analyses

The Qualtrics survey tool generates descriptive results for all questions in Microsoft Word and Microsoft Excel formats. In addition, all survey data were exported directly into SPSS V21 where they were analysed descriptively, and where appropriate, correlations and ANOVA analyses were performed.

Data limitations

- The challenge of distributing and marketing a survey commissioned by a single government department to distributed health services, non-government services and private providers means that the data may not be representative of each profession.
- It was difficult to engage with the large number of small private speech pathology practices. As a result, it is not possible to determine the representativeness of the data for this group.
- Distribution of revised AHOMT (AHOMT 2) may have confused some respondents and created some challenges for data analysis.
- The focus group participants were invited from the AHWQ respondents who agreed to be followed-up. This may have resulted in selection bias. However, more than half of all survey respondents agreed to further follow-up.

Results

The source of data in the tables and figures going forward is AHWQ or AHOMT survey response data unless otherwise specified.

Responses and respondents

Respondent numbers for each of the different data collection methods are presented in Table 1 below.

Table 1: Respondent numbers by data collection approach

AHWQ (individuals)	HR survey (organisations)	AHOMT1 (organisations)	AHOMT2 (organisations)	Focus groups
740	14 (57 sites / locations)	43 (197 sites)	26 (114 sites)	Grade 1 – 1 interview participant Grade 2 – 2 focus group participants Grade 3 – 5 focus group participants Grade 4 – 3 individual written responses

Allied Health Workforce Questionnaire

The AHWQ survey consisted of 69 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

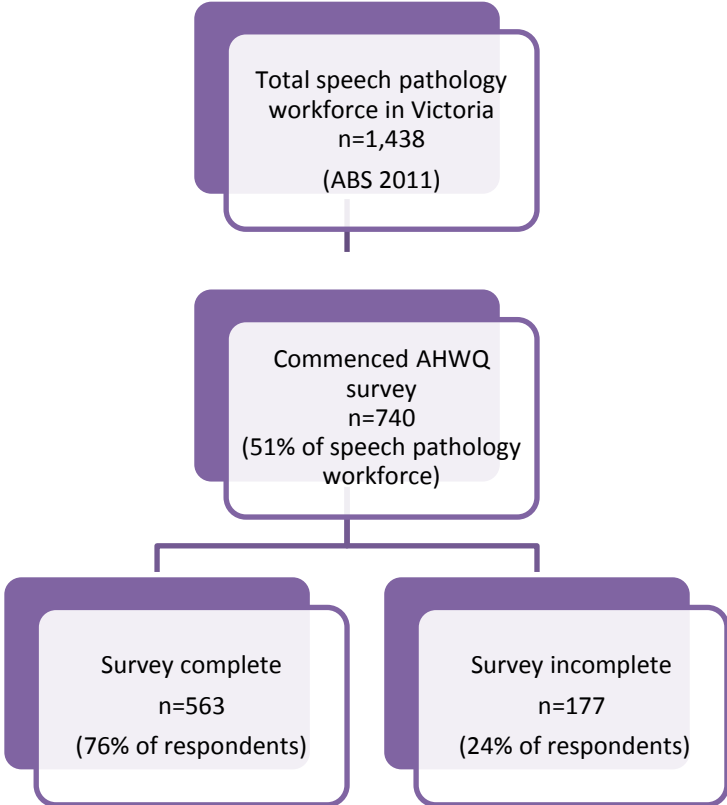
A total of 740 speech pathologists completed at least one question on the survey and submitted their survey¹. The range of responses to an individual question was from 563 to 1,367². Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

Of the 740 speech pathologists who submitted the AHWQ (50.7% response rate based on 2011 ABS workforce data), 88% (n=659) were employed in the speech pathology workforce at the time of completing the survey. Seven respondents were actively seeking work as a speech pathologist (Figure 2).

¹ A survey was considered complete if the respondent answered the last survey question and submitted the survey, even if they did not provide answers to every survey question.

² Some questions allowed for multiple responses

Figure 2: Survey responses



Capacity

Capacity refers to the ability of the profession to meet the needs of the community in terms of workforce numbers and allocation of staff, skill mix, ratios, geographic distribution, organisation of the workforce, and their ability to influence these factors at the political, professional and organisational level (Figure 3).

Figure 3: Workforce capacity framework



Key findings

- The majority of surveyed speech pathologists worked in metropolitan Melbourne, in the Victoria public sector.
- Preschool aged children were the most prevalent client cohort.
- Despite anecdotal evidence of high levels of unmet need, there is limited empirical data to define and quantify this need. The challenge of meeting community demand was reported as a significant contributor to stress and burnout.
- Supply of early career speech pathologists was strong due to recent increases in training programs.
- No organisations reported positions of any grade / pay level that were unfilled for more than six months, however challenges were reported in attracting experienced clinicians to senior roles as well as attracting speech pathologists to temporary and part-time roles.
- The majority of respondents were employed at a grade 2 level or equivalent. Lack of opportunities for career advancement beyond this level was identified as a contributor to speech pathologists leaving the profession. Speech pathologists in larger organisations identified better career advancement opportunities than those in smaller services. Although participants indicated they undertook advanced scope roles, the specified roles were typically not recognised by the reference group as advanced scope. The high numbers of post-graduate qualifications in the speech pathology workforce may present opportunities to recognise areas of advanced practice and new formal career pathways.
- Just over one third of participants reported delegation to allied health assistants (AHA) as being part of their role.
- 6% of participants used telehealth to deliver direct services to clients. A further 5% indicated the use of telehealth as 'other'. There is potential for further use of telehealth for delivery of services access and access to CDP for speech pathology.
- Pay was a source of dissatisfaction for many speech pathologists. The majority (60%) indicated they earn between \$50,000 and \$90,000 and 20% earn less than \$40,000.
- There is strong evidence that speech pathologists that have grown up in regional areas are more likely to return to these areas.
- Self-employed speech pathologists tended to be older and have been qualified for longer.
- The most commonly reported primary setting for delivery of speech pathology services was the community (11%), followed by schools (10%).

Workforce distribution

Demographics

Based on the most recent published data at the time of this report, there was a total workforce of 1,438 speech pathologists working in Victoria in 2011 (ABS 2011). The workforce profile was 97% female with just over half (52%) working in full-time employment. For 77% of the workforce, the highest qualification was a bachelor degree, 4% held a graduate diploma or certificate, and 16% a post-graduate degree.

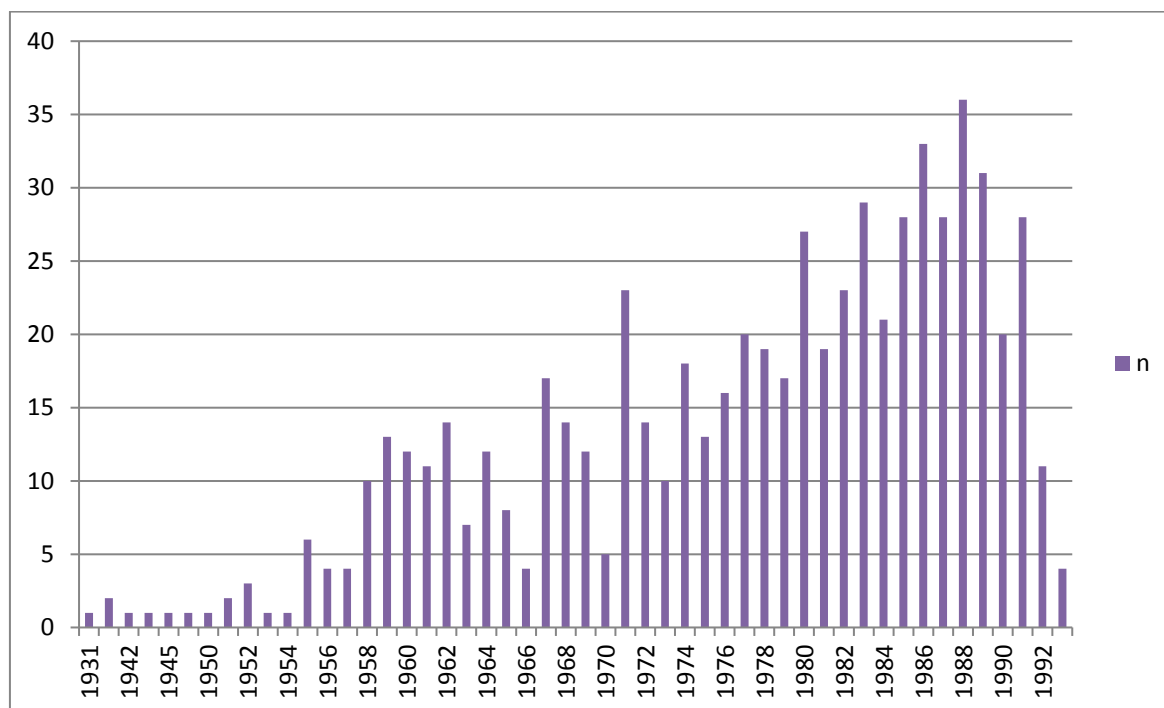
AHWQ survey respondents were predominantly female (96%) with an average age of 38 years (range 23 – 84 years) (Figure 4). A small percentage of respondents were 55 years and older (11%) while 29% of respondents were 30 years and under (Table 2). These findings closely reflect 2011 ABS data, with the exception that public sector employees were over-represented in the AHWQ survey data.

Table 2: Demographics (n=740) compared with ABS 2011 data

Demographics	AHWQ		ABS 2011 ^a
	n	%	%
Female	625	96%	97%
Aboriginal and / or Torres Strait Islander	7	1%	0.003%
Australian citizen / permanent resident	648	99%	-
Age 55 years and over			
Age 30 years and under	188	29%	33%
Median age			
Public sector	293	48%	42%
Private sector	139	22%	59%
NFP sector	59	12%	Not specified

^a Source: Australian Bureau of Statistics (ABS) Census, 2011

Figure 4: Year of birth (n=651)



Geography

More than two thirds (65%, n=476) of AHWQ survey respondents undertook their primary role in metropolitan Melbourne while less than 10% worked in the Grampians (5.71%, n=42) and Gippsland (3.54%, n=26) regions (Table 3). Many speech pathologists worked in a single local government area (n=199, 41%).

Table 3: Geographic distribution (n=735) compared to ABS 2011 data

Victorian region	Barwon South West	Gippsland	Grampians	Hume	Loddon Mallee	Northern and Western Metro	Eastern Metro	Southern Metro	Other State	Overseas	Total
Primary location (AHWQ)	57	26	42	56	53	242	103	131	23	2	735
Primary location (AHWQ) %	8	4	6	8	7	33	14	18	3	0.3	100

Seventy per cent (70%, n=426) of the speech pathology workforce were city-based; almost one-third (29%, n=124) of these originally came from regional areas. However, the majority (66%) of the regional workforce (n=183) grew up in regional areas. There was strong evidence from this study that speech pathologists that have grown up in regional areas were more likely to return to these areas.

Similarly, there was a strong correlation between speech pathologists who originate in regional areas undertake their training in regional areas. This suggests that the provision of regionally based speech pathology training builds regional capacity and workforce self-sufficiency.

Sector

Just under half of the AHWQ survey respondents were employed in public sector health services (Figure 5). Those working in the private sector and the Victorian public sector were the youngest practitioners with mean ages of 36 years and 39 years respectively. Self-employed speech pathologists were older (mean = 49 years) and have been qualified for longer (mean =21 years) (Figure 6).

Figure 5: Employment sector of current main employer

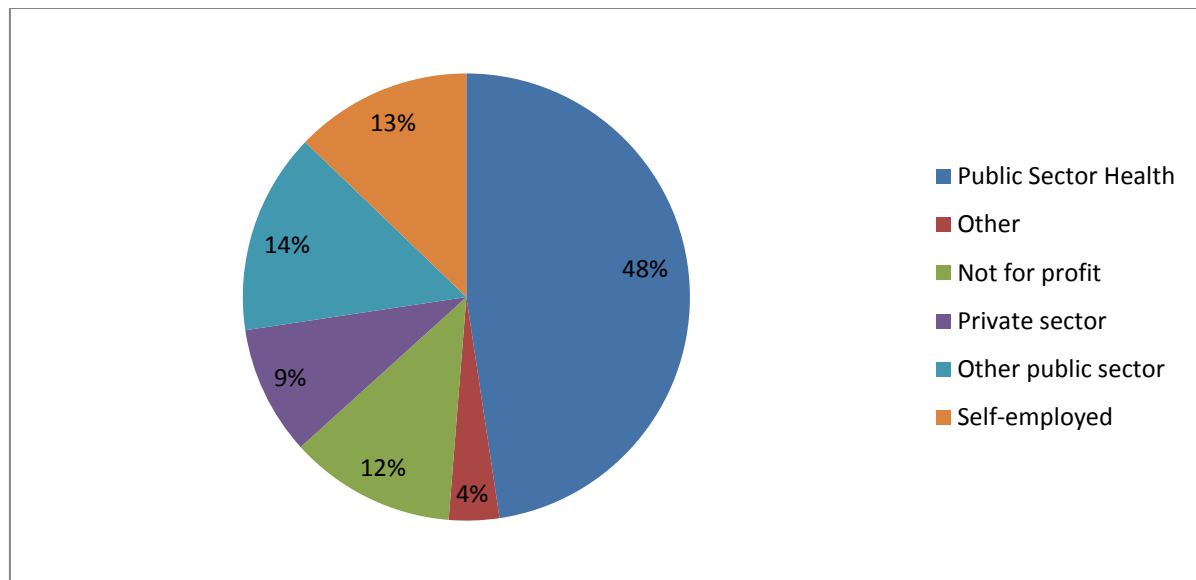
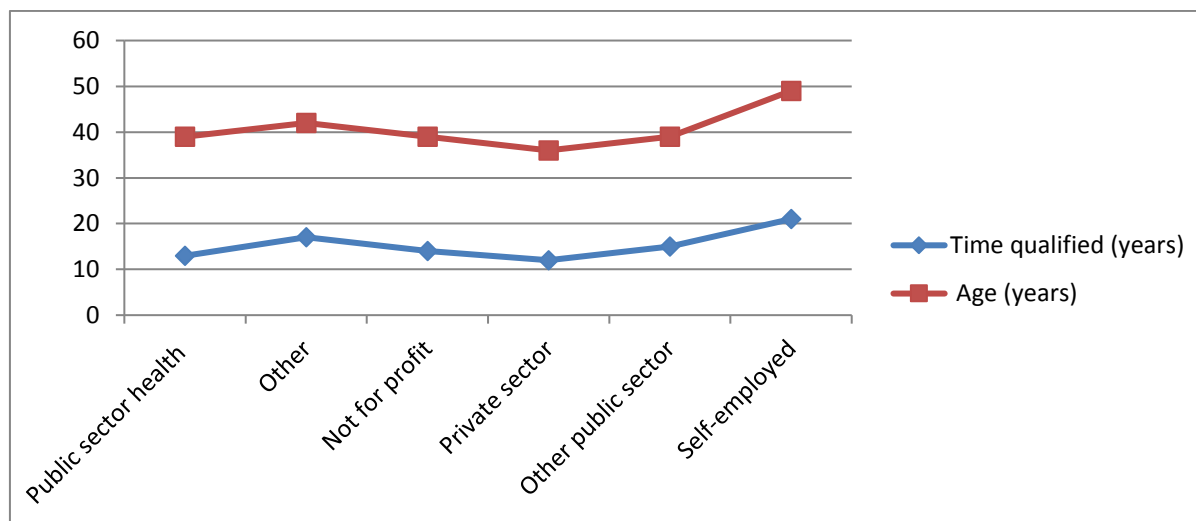


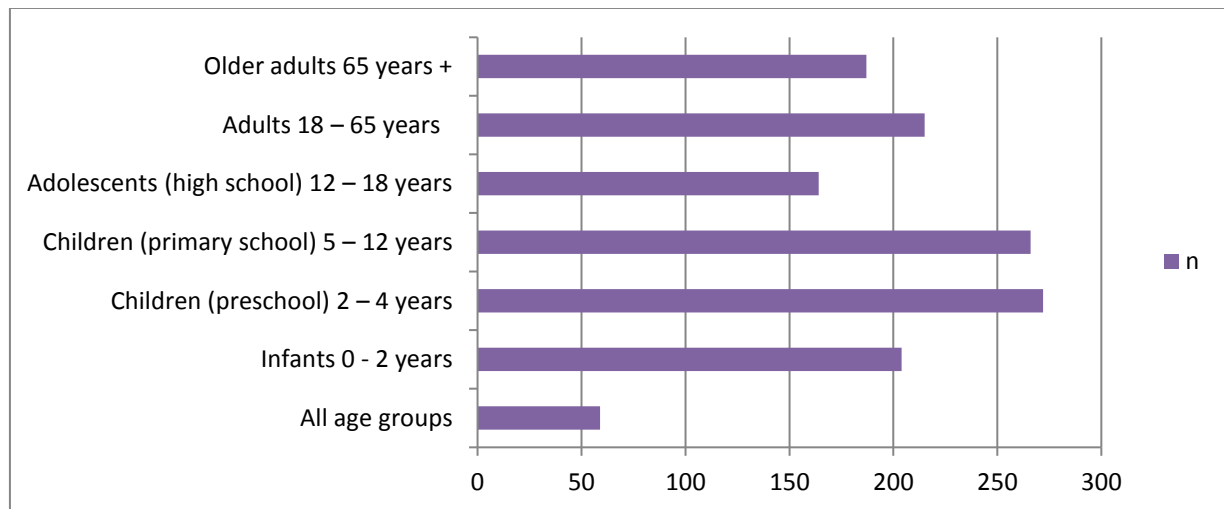
Figure 6: Relationship between average practitioner age, sector and number of years qualified



Clients

AHWQ survey respondents identified pre-school and primary school age children as the most common clients (n=538/1367, 39%), with adults forming the second largest group (n=402/1367, 29%) (Figure 7).

Figure 7: Clients by age (n=1367) ^a

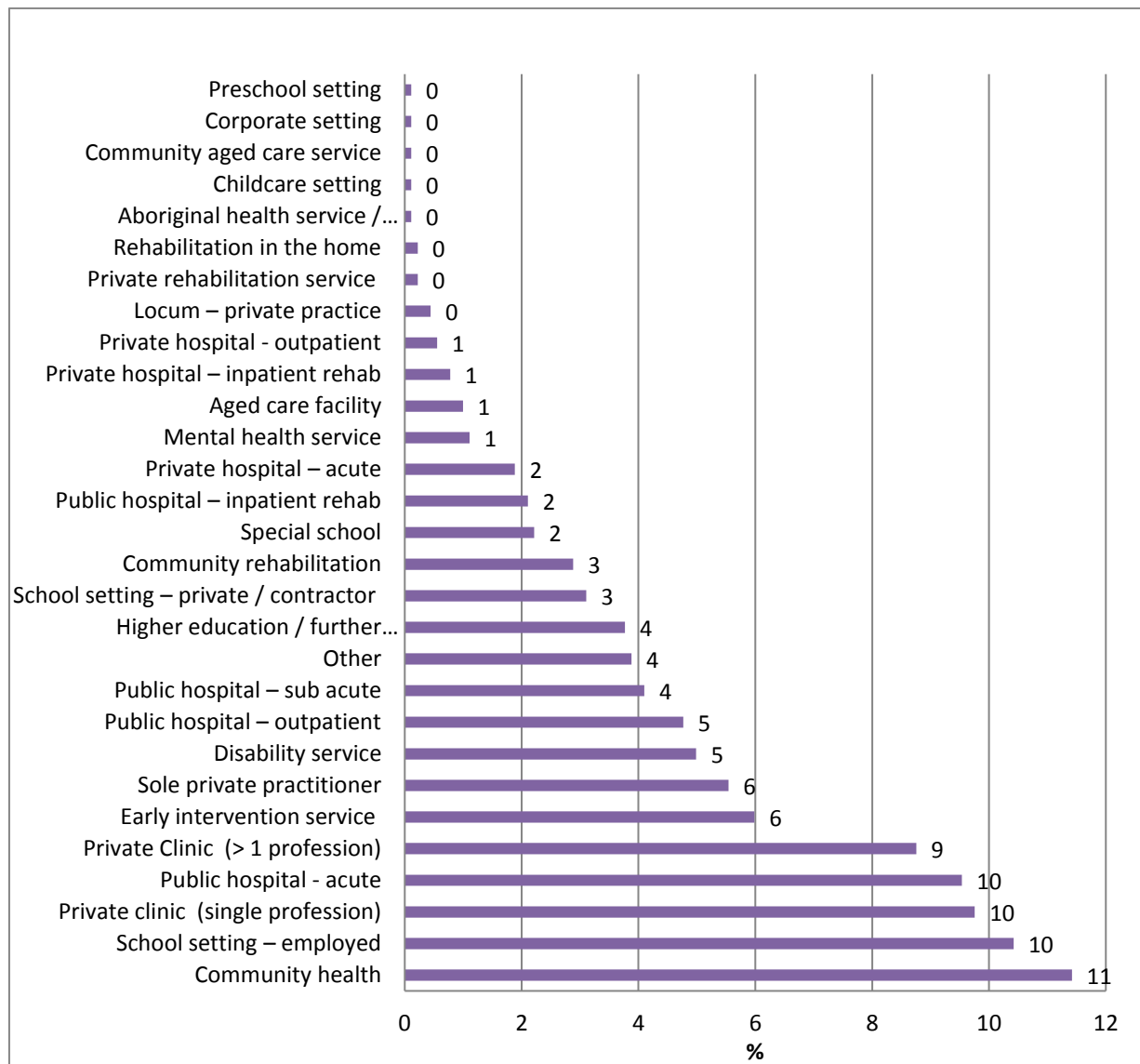


^a Respondents could select more than one response.

Settings

The most commonly reported primary setting by AHWQ survey respondents for delivery of speech pathology services was the community (11%), followed by schools (10%), private clinics with sole practitioner (10%), public hospital acute setting (9.5%) and private clinic multiple practitioners (9%) (Figure 8).

Figure 8: Setting for service delivery of current main employer (n=902)^a



^a Respondents could select more than one response

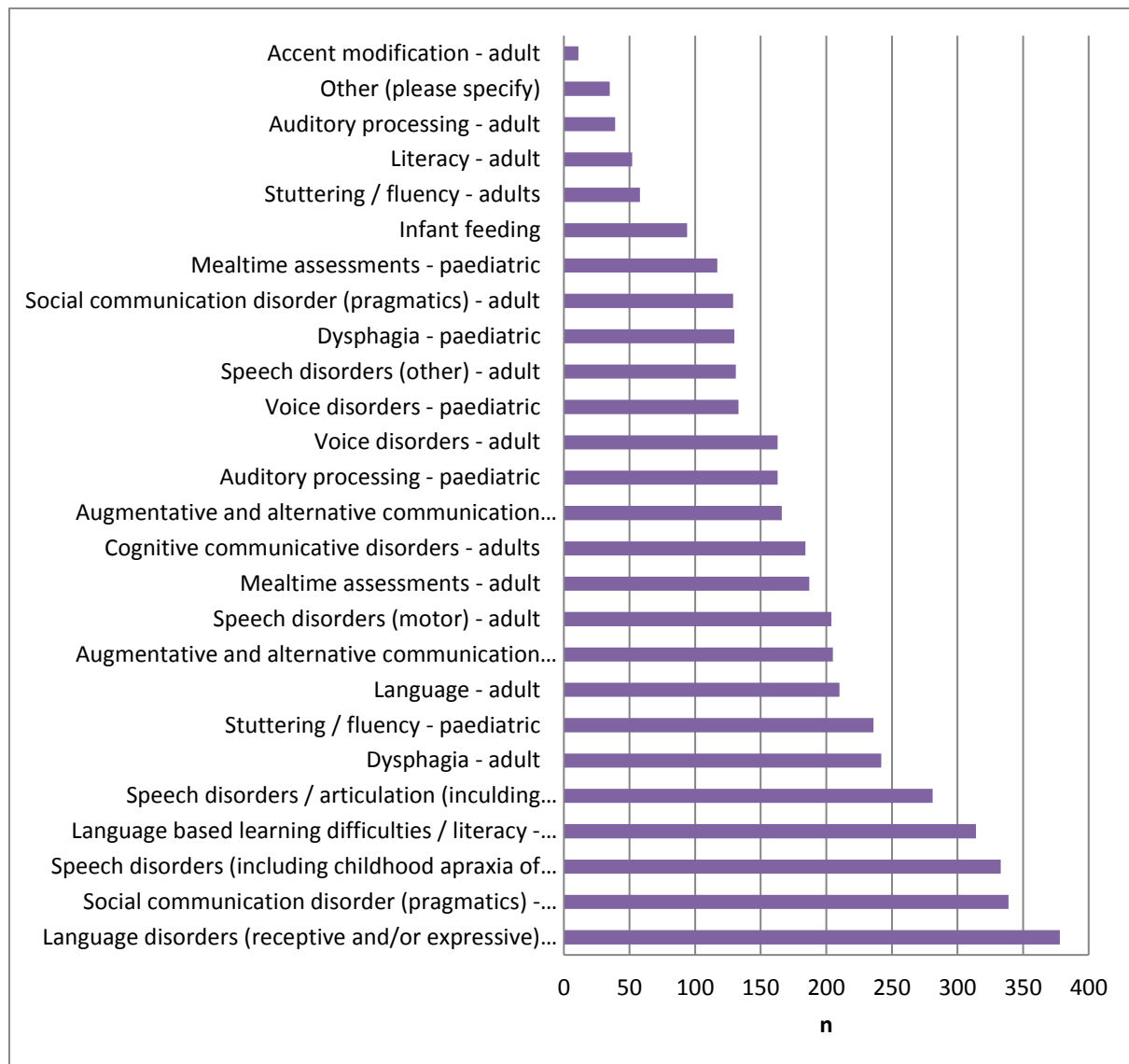
Area of practice

As would be expected from the client groups, the top area of reported clinical practice by AHWQ respondents was paediatrics including language disorders (n=378), social communication disorders (pragmatics n=339), speech disorders including childhood apraxia of speech (n=333) and language based learning difficulties / literacy (n=314).

The next most common area of clinical practice relate to the adult population and included language, augmentative and alternative communication, motor speech disorders, cognitive communication disorders, and mealtime assessments. The least reported areas of clinical practice included fluency, literacy, and auditory processing for adults (Figure 9).

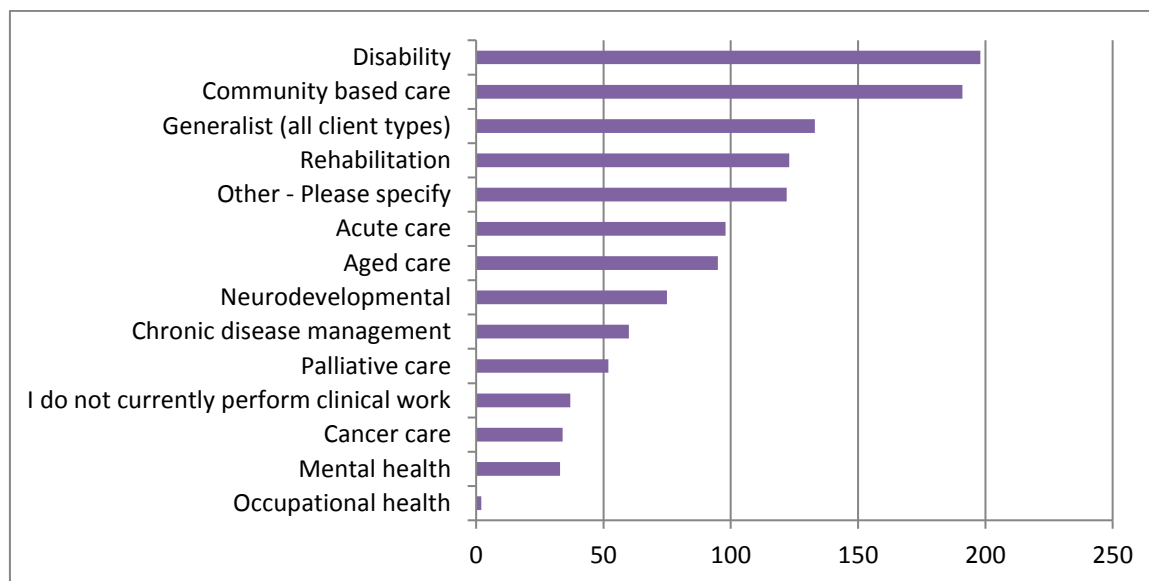
The majority of respondents reported their clinical stream as disability (197/1240, 16%), followed closely by community based care (184/1240, 15%). Interestingly a substantial proportion of respondents reported their clinical stream as 'generalist' (133/1240, 11%) (Figure 10).

Figure 9: Areas of clinical practice (n=1240)^a



^a Respondents could select more than one response

Figure 10: Clinical Stream (n=1240) ^a



^a Respondents could select more than one response

Demand

There was anecdotal evidence of widespread demand and unmet need for speech pathology services. However, limited empirical data was available to demonstrate, quantify and define this stated need. This reinforces the findings of this research program’s speech pathology environmental scan relating to lack of systems to measure and report on community need for speech pathology services. In turn, this compromises the capacity to develop a business case to effectively advocate for appropriate resourcing of speech pathology services.

Qualitative feedback provided by practitioners on the AHWQ identified the need to improve speech pathology service access in the following ways:

- Improved workforce to patient ratios
- Improved funding / appropriate reimbursement for services
- Improved equity of access across contexts, sectors and demographics
- Increased access to devices / equipment for clients
- Appropriate access to service infrastructure

“Access for clients who need the services of an experienced speech pathologist is the most pressing issue in both the public and private sectors. In the public sector there are huge waiting lists and very few services, in the private sector services cost money and although many clients do try to pay for ongoing therapy, for many this is not an option.”

“We were unable to recruit to the full hours of a maternity leave contract. This has resulted in increased waiting times and we can only provide services to high risk / complex clients at present.”

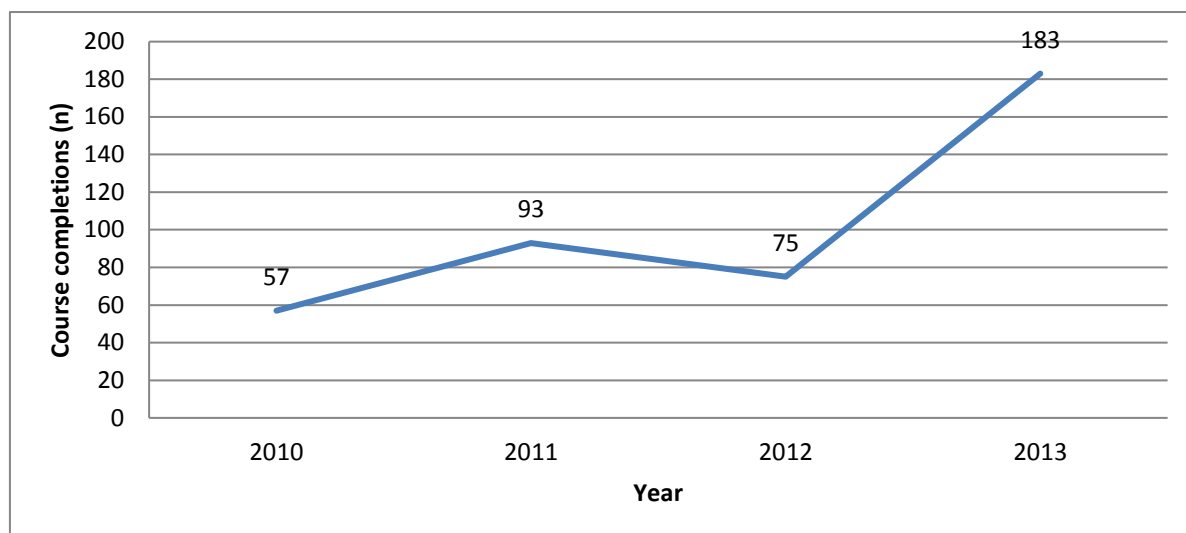
Supply

There are a number of factors that interact with and influence the supply of speech pathologists. These include the size of the workforce, number of new graduates, age and gender profile, employment grades, remuneration, geographical remoteness and local approaches to recruitment.

Student completions

In 2013, 183 domestic speech pathology students completed speech pathology training at a Victorian tertiary education facility (unpublished data, Department of Education and Training³). This is a 221% increase since 2010 when 57 students completed speech pathology (Figure 11). Graduate numbers are likely to continue to increase, given the continued growth in student commencements. In 2010, 133 domestic students commenced speech pathology studies in Victoria and by 2013 this had increased to 244 students.

Figure 11: Victorian university domestic course completions 2010-2013



Source: Department of Education and Training

Workforce supply

Evidence of workforce shortages in speech pathology was patchy and varied widely by region and grade. Of 21 organisations that responded directly to a question about workforce shortages, 18 said they did not experience any shortages.

There was little evidence of shortages in grade 1 speech pathologists, except where positions had not been funded. Only two organisations reported unfilled grade 1 positions (Barwon South West and Southern Metro regions). Similarly, there was no evidence of funded positions remaining unfilled for six months or longer. Other vacancies for speech pathologists were reported in Gippsland (n=3 organisations) (Table 4 and 5).

³ The Department of Education and Training (DET) conducts the Higher Education Statistics Collection, which provides information on the number of student commencements and completions in higher education courses. While DET data does not identify those courses that lead to professional-entry for most disciplines, using information supplied by DET (in a particular field of education and course name), the Victorian Department of Health and Human Services has estimated the number of domestic students commencing and completing professional-entry courses for selected disciplines. Given this is an estimate; caution should be used in interpreting these data.

Table 4: Workforce shortages (n=21 organisations)

	Total EFT currently employed	Total headcount	Unfilled EFT in this role	Shortages in this role (EFT not funded but required to meet demand)	EFT currently unfilled for ≥ 6 months
Grade 1	42.5	48	0	2.5	0
Grade 2	71.0	90	2.8	3.9	0
Senior clinical speech pathologist	31.0	40.8	1.42	1.5	0
Deputy Chief	0.8	1	0	0	0
Chief speech pathologist	9.6	10	0.1	0.2	0
Grade 4	5.5	8	0	0.3	0
ESP SP	0.6	1	1	0	0

EFT= equivalent fulltime

However, respondents reported a number of indicators of speech pathology workforce shortages including:

- local policies to not provide services to specific client cohorts
- inability to provide services using models of practice consistent with current evidence
- limiting services to a prescribed duration of care, number of sessions, or age groups
- long waiting periods for assessment and / or treatment

These respondents identified that the follow on effects of these factors included:

- delayed assessment and review of some patients experiencing dysphagia and / or communication impairments
- some patients being 'nil by mouth' for unacceptably long periods
- discharging some patients from hospital earlier than is clinically appropriate, resulting in increased clinical risk
- compromised ability for some professionals to contribute fully to multidisciplinary team processes
- patients travelling long distances to receive services unavailable in their local communities
- stress and burnout for some professionals

Concern was also raised regarding the lack of access to leave cover and the impacts this has on service delivery and staff stress.

Beyond leave cover, respondents said that accessing resources to finance new positions was hindered by poor management support or undue delays in approving positions due to budget constraints or lack of management roles/ support.

“There’s a two year wait list in the community sector. A previous trial of an additional 0.4 EFT reduced the waitlist down to six months. In inpatient rehab and acute sectors, approximately 60% of patients referred to speech pathology are seen and 40% are not, due to not having enough time and staffing.”

“Generally hospitals don't have sufficient budget to include leave cover. As a result, speech pathology departments are often working with insufficient staff. Over time this results in stress for staff and a sense of dissatisfaction as they are not able to complete their work to the level they would like due to time restrictions and heavy caseloads.”

“The most obvious unmet need is within the school age group – with only private therapy options for school students needing therapy but not meeting disability funding categories – the cost of which is prohibitive for most families.”

“When there is a shortage of staff we need to prioritise patients with life-threatening swallowing problems. This means patients with issues such as disorders of cognition, communication or voice are a lower priority and may not receive ideal service provision.”

Table 5: Reasons for unfilled positions

No unfilled positions	Lack of applicants	Lack of suitably qualified applicants	Funding unavailable from service	Total responses
17	2	3	1	23

Respondents could select more than one response

Recruitment

Other regions reported relatively high numbers of applicants for grade 1 positions. Most speech pathology vacancies were reported to be filled within 10 weeks (Tables 6 and 7).

Table 6: Number of applications received for positions advertised in past year by grade*

Grade	None advertised	0	1-5	6-10	11-20	21-50	>50	Total responses
Grade 1*	6	0	3	2	3	0	2	16
Grade 2*	6	1	6	4	0	0	0	17
Grade 3*	10	1	2	1	1	0	0	15

* or equivalent

Table 7: Time to fill vacancies

No vacancies	0-5 weeks	6-10 weeks	11-20 weeks	> 20 weeks	Total responses
8	5	11	4	1	29

Barriers to recruitment reported by respondents included:

- short term or part-time positions
- lack of funding to fill vacant positions
- delays in human resource departments processing new positions
- the award not being competitive with other states and private providers
- difficulties attracting experienced speech pathologists
- small teams / sole positions with limited career development opportunities
- lack of relocation support
- saturation with new graduates.

Focus group participants and individual survey respondents expressed concern about an oversupply of early career speech pathologists; however the evidence to support this claim was mixed. This concern was increased by a perceived lack of growth in employment opportunities, particularly in the public sector.

Specific impacts reported included:

- high levels of anxiety expressed by students regarding their prospects of securing employment
- services receiving regular calls from recent speech pathology graduates seeking to gain experience through volunteering
- long delays for some new graduates securing employment as a speech pathologist
- high numbers of applicants for new graduate positions in metropolitan and regional areas.

“There are too many being trained into the profession, and no support for the paucity of jobs.”

“Many ‘good’ graduates are left without work. It’s very difficult to weed through the many graduate applications.”

“Although there’s over abundant applications for new graduate positions there’s difficulty finding suitably qualified senior staff with an adequate skill mix, competency and advanced scope of practice.”

Despite these observations, organisations in Gippsland that responded to the AHOMT had the largest number of unfilled positions (three) of any region. One focus group participant from a low socio economic area in this region confirmed the inability to recruit to a full-time new-graduate role. No respondents to the AHOMT reported unfilled positions in inner-metropolitan areas. Positions identified by some respondents to the AHOMT as difficult to fill included:

- temporary positions
- part-time positions, particularly at the more senior level
- part-time positions, with very limited hours, for discrete areas of practice
- senior positions requiring specific competencies and advanced scope skills.

One respondent reported the use of contracted staff to avoid burdensome recruitment and employment processes.

“Sometimes a new business case might be for 0.05-0.1 EFT. It’s hard to make those small EFT amounts attractive to a new external employee.”

“Recruitment and retention can be an issue for senior positions. Post-grad study in speech pathology clinical skills is fairly limited for speech pathologists...Many senior speech pathologists aren’t eligible for grade 4 positions as they don’t have post-grad qualifications. Or, if staff complete post-grad study, it’s in

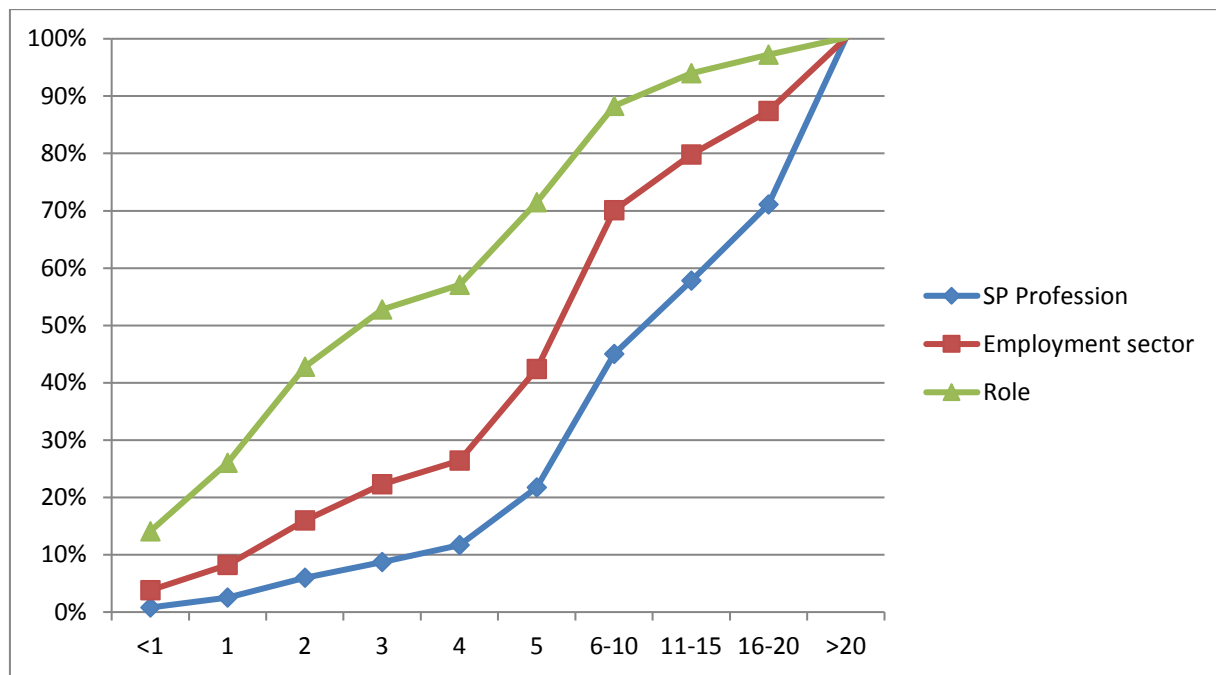
general health management and experienced clinicians move away from the speech pathology profession.”

“AH professionals in Victoria are paid at a lower rate compared to other states and territories. Organisations agree that AH professionals improve access and flow, however our numbers continue to be cut across hospital sites. We have no flexibility in our working schedules and limited availability to really work comprehensively with our clients. All we do is assess them and identify risks. Within the hospital system, there are not enough of us to achieve real and lasting change for patients.”

Retention

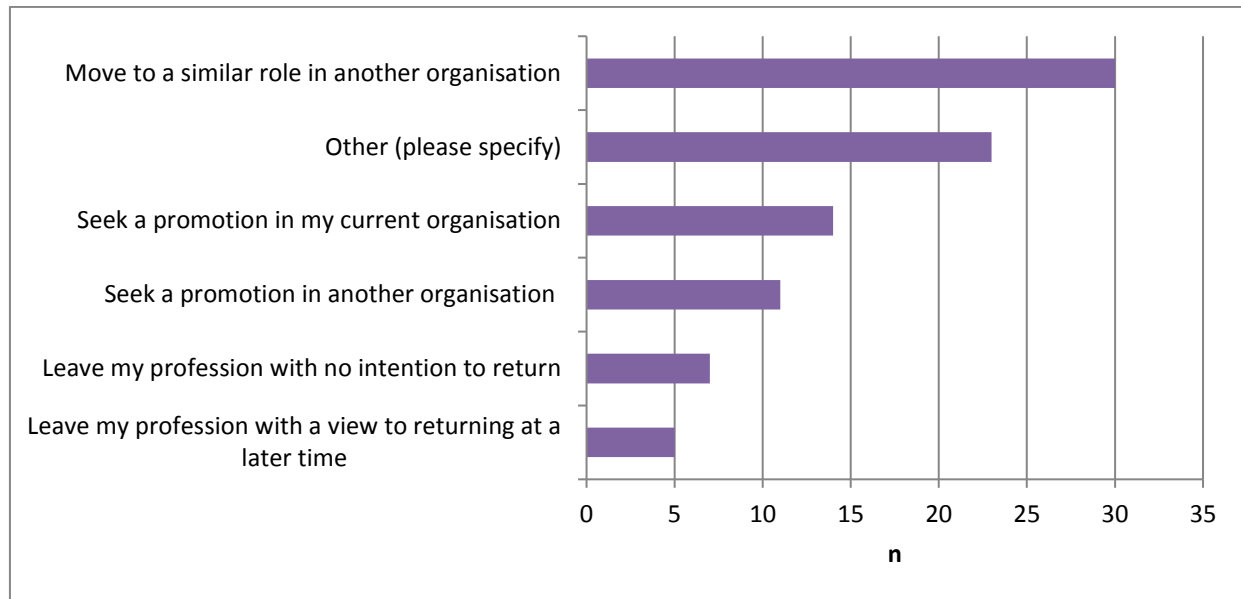
Anecdotally, there was a perception that speech pathology experiences a high rate of attrition. ‘Intention to leave’ is a known proxy for workforce dissatisfaction and job turnover. Speech pathologists were asked their employment intentions over the next 20 years. Intention to leave the profession was relatively low in the short to medium term, with less than 1% intending to leave in the next 12 months; and 12% intending to leave within four years, but nearly doubles to 22% intending to leave within five years. Sector of employment was relatively stable, however changes in role were more likely, with 14% intending to change role within the next 12 months (Figure 12). The relatively high movement of speech pathologists within the profession may account for the perception of high rates of attrition.

Figure 12: Cumulative intention to change current job situation by years (n=622)



Of those who indicated they intended to change their current employment situation in the next 12 months, 33% (n=30/90) were intending to move to a similar role in another organisation and only seven of the 90 were planning to leave with no intention of returning (one in the context of retirement) (Figure 13).

Figure 13: Career directions of those who intend to leave in the next 12 months (n=90)



Other reasons for leaving included:

- too much dysphagia;
- acting in current position, returning to previous role;
- on rotation; to gain more variety of caseload;
- dissatisfaction with management and lack of consultation;
- currently on a temporary contract;
- to change specialty;
- current lack of support;
- to expand skill set;
- to increase to full time;
- to work in a multidisciplinary team;
- organisation not maintaining existing service;
- creative outlet, positive environment;
- to gain opportunities for more positive outcomes;
- to increase job security;
- current role lacks continuing professional development (CPD) due to budget constraints.

Table 8: Reasons for leaving (respondents indicating intention to remain for <12 months) (n=277)^a

Reason	n	%
Better job opportunity	38	42.2
Better working conditions	30	33.3
Better pay	26	28.9
Contract terminates	20	22.2
Current role not challenging	19	21.1
Relocation to preferred location	17	18.9
Other (please specify)	15	16.7
Conflict with manager or other employees	14	15.6
Better benefits	13	14.4
Commute	13	14.4
Position is low status	13	14.4
Maternity leave	13	14.4
Job expectations too great	12	13.3
Change of career	10	11.1
Family reasons	5	5.6
Return to education / training	6	5.6
Physical work environment (e.g. space, equipment)	4	4.4
Health reasons	4	4.4
Travel	4	4.4
Retirement	1	1.1
Work related injury	1	1.1

^a Respondents could select more than one response.

Several issues were identified as contributing to retention challenges within specific roles and services and within the profession in general. Some were context dependent and others were identified as being more consistent across the profession. Examples of circumstances likely to contribute to speech pathologists moving on from a role or from the profession included:

- temporary positions, which people move on from in favour of permanent employment
- maternity leave, in the context of a highly feminised, young workforce

- limited opportunities for career advancement, within the profession generally and within services with a small speech pathology workforce
- in some services, inadequate leadership, management and clinical supervision skills of senior staff, which compromises staff development and daily work experiences
- stress caused by the inability to meet community need with available service resources
- within generalist services, difficulties retaining early career professionals
- sole positions, which are attractive to some, but do not suit all people
- lack of career pathways in small departments

“In education, speech pathologists that stay are those employed directly by a school.”

“People tend to go when managerial styles, stress, and policies don’t fit for them.”

“Resourcing is important. People need funding for PD [professional development], equipment, tests etc. You feel more valued if you have appropriate resourcing.”

“Once we upskill staff to a certain level, they start / add to their families. We’ve adapted to be family-friendly and offer part-time / job share positions. The benefits are we don’t lose the wealth of skills the staff have acquired. While we support this, it’s very difficult for continuity of care and staff supervision. It also effects participation in quality and research with more part-time senior or experienced staff.”

“The poor structure for career progression impacts attrition, particularly when grade 2’s hit their remuneration ceiling. People become frustrated at ‘having no-where to move up to.’”

Organisation of workforce

Pay and award

Almost half of all respondents were employed in the public sector health services (48%, n=293), followed by 13% (n=80) who were self-employed, 12% (n=75) in the NFP sector and 9% (n=59) in the private sector (Figure 5).

Nearly two thirds (65%) of respondents were employed at the equivalent of a grade 2 speech pathologist (approximately \$71,000 to \$80,000 / annum) or less. The majority (60%) reported annual earnings of between \$50,000 and \$90,000. Twenty per cent (n=121) earn less than \$40,000. Two per cent (2%, n=8) earned more than \$140,000. Of these, four were self-employed and three were in other (non-Department of Health and Human Services) public sector roles. Self-employed speech pathologists and those on ‘other equivalent pay scales’ were the most likely to be on the lowest pay rate (less than \$40,000) (Appendix Table 1).

Pay was a source of dissatisfaction for speech pathologists. Fewer than half of the respondents agreed with the statement that their current grade or salary is appropriate for the work they do (42%). Dissatisfaction with pay was highlighted in the open ended survey responses.

Satisfaction with pay varies between sectors. Public sector respondents were generally more satisfied with their pay than those employed in other sectors. Even so, the focus group findings demonstrated variability across specific contexts.

“Speech pathologists need to be paid more and have greater opportunities for pay advancement.”

“We should have pay equity across states.”

“There’s a need to employ all public service employees under the same award. Currently speech pathologists working in health and education are employed under different awards.”

“I get good mentoring and well-funded CPD. These benefits add to job satisfaction overall. The NFP sector EBA [enterprise bargaining agreement] is negotiated differently to the public sector. It certainly makes a big difference.”

Hours of work

Most speech pathologists who responded to the AHWQ performed their duties between 7am and 7pm Monday to Friday (82%). A small percentage worked on Saturdays (9%) and / or Sundays (3%) (Table 9).

A typical working week for respondents involved 21 hours of clinical work, 10 hours of management and administration and four to five hours of teaching, education, and research or project work (Appendix Table 5).

Table 9: Working pattern during a normal working week (n=754) ^a

Working pattern	Count	%
Monday to Friday (mostly day time)	616	82
Monday to Friday (mostly night time)	10	1
Saturday	71	9
Sunday	8	2
Shifts that change from day to day, or week to week	24	3
Other working pattern	25	3
Total	754	100

^a Respondents could select more than one response.

Number of employers

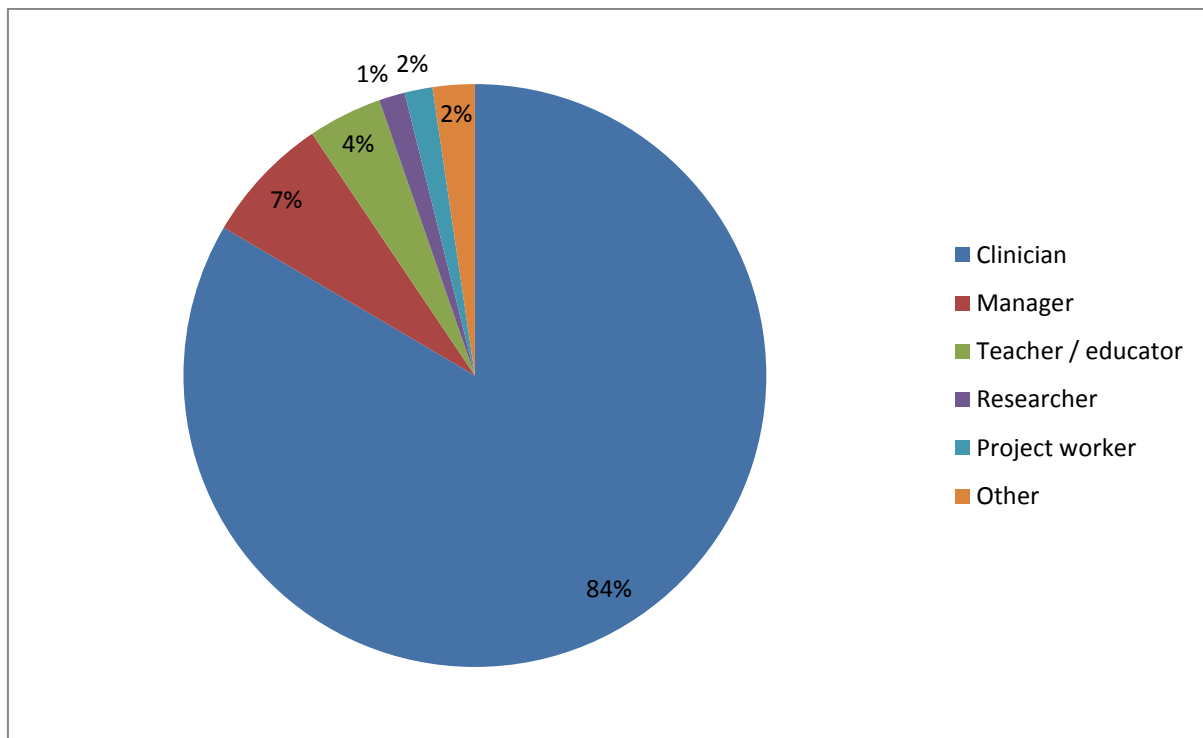
The majority of respondents indicated they worked for one employer (69%, n=448), with 31% (n=204) reporting they worked for two or more employers (range 2 to 4 employers). Appendix Table 3 illustrates the pattern of hours worked across multiple employers. The majority of speech pathologists who were working 32 to 40 hours per week did so for one employer (n=243) (Appendix Table 3). Respondents who worked less than 24 hours a week generally had a greater number of employers. This was particularly the case for those who reported working 0 to 8 hours per week, where many worked for three or more employers (n=199) (Appendix Table 5).

The vast majority of respondents reported being employed on a permanent basis (n=491), often by one (n=426) or two (n=54) employers. Thirty percent (30%) of respondents reported working for between two and four employers. Those reporting self-employment, contract or casual employment (n=360) tended to work for multiple agencies (Appendix Table 4). These speech pathologists were more likely to work flexible hours.

Roles

Respondents’ primary roles were predominantly clinical (83%, n=752) with only a small percentage reporting management (7%, n=64), teaching (4%, n=37), or research (1%, n=13) as their primary role (Figure 14).

Figure 14: Primary role across all current employers (n=901)



Scope of practice

Advanced practice

The following definition of advanced scope of practice was provided and respondents were asked to describe their advanced scope of practice role.

Work that is currently within the scope of practice for your profession, but that through custom and practice has been performed by other professions. The advanced role requires additional training, competency development as well as significant clinical experience. Examples include non-medical prescribing (e.g. pharmacy, podiatry), physiotherapy led post-operative review clinics; physiotherapy and occupational therapy led spasticity and intervention clinics.

Just less than one quarter of respondents (22%, n=137) reported working in an advanced scope of practice role (Appendix Table 6). The speech pathology profession formally recognises the following advanced scope roles: neuromuscular electrical stimulation (NMES), fiberoptic endoscopic evaluation of swallowing (FEES), laryngectomy and tracheostomy management. Other areas are considered to be extended scope including transdisciplinary practice tracheal suctioning, and prescribing and administering medicines.

The roles most commonly reported as advanced practice roles were FEES (n=15), video fluoroscopic swallowing studies (VFSS) (e.g. videofluoroscopy / videostroboscopy) (n=13), and paediatric feeding / dysphagia / sequential oral sensory (SOS) feeding program (n=11) (Table 10). However, many of the reported roles were not within the profession's recognised advanced practice roles. The high numbers of post-graduate qualifications in the speech pathology workforce may present opportunities to recognise areas of advanced practice and new formal career pathways.

Table 10: Advanced practice roles described by participants (n=137)

Role	n
Fibreoptic endoscopic examination of swallowing (FEES)	15
Videofluoroscopy / videostroboscopy (VFSS)	13
Paediatric feeding / dysphagia / SOS	11
Transdisciplinary (e.g. physiotherapy handling and OT sensory interventions)	8
Laryngectomy management	8
Tracheostomy management	8
Autism assessment	4
Project work	4
Mental health clinic	4
Behaviour management	3
Key worker / case management	3
Family support / family services coordination	3
Training	3
Youth Justice	2
LSVT	2
Prescribing	2

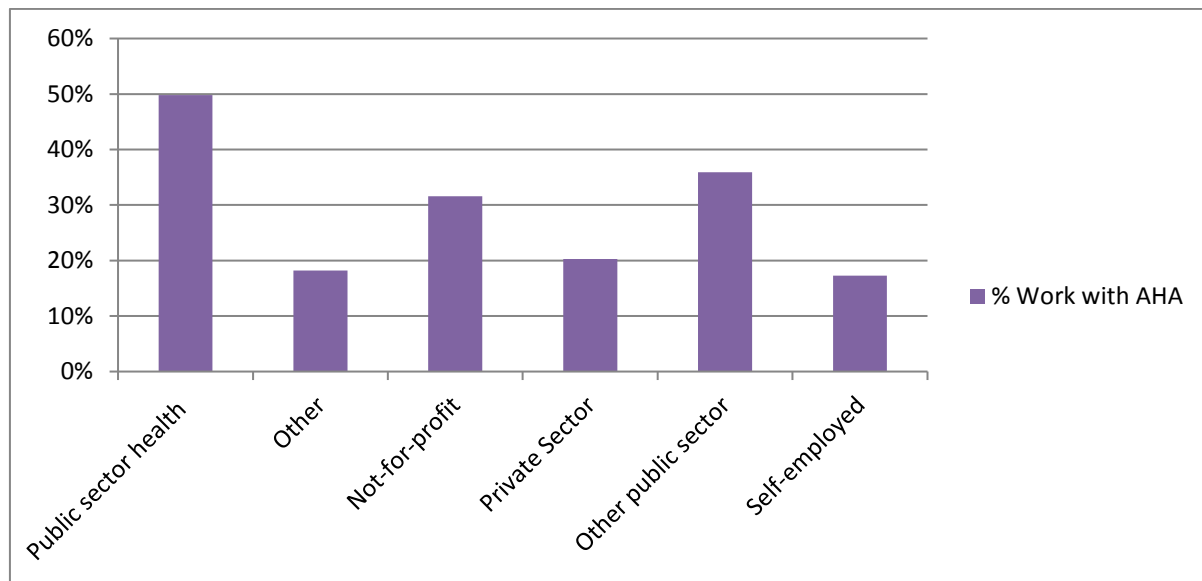
Allied health assistants (AHA)

Thirty seven per cent of survey respondents (n=233) said their work involved delegation to an AHA; however there were large variations by sector. Public sector employees were more likely to work with AHAs than those in other sectors (Figure 15).

“There is an understanding that increasing the speech pathology AHA workforce would significantly improve our efficiency and patient care, however budgets and funding have made it difficult to move quickly on this.”

“We’ve attempted to get some funding for a part-time AHA but haven’t been successful. We had someone for three months, part time, doing lots of work with children. It worked well, and freed up the paediatric speech pathologists to do more high level clinical work. It was really valuable.”

Figure 15: Delegation to AHAs by sector (n=623)



Telehealth

When asked about their use of telehealth, 88% (n=549) of speech pathology respondents indicated they made no use of telehealth for any purpose. Delivery of services directly to clients using video-conferencing was reported by 6% (n=38) of respondents. Three individuals indicated they provide these client services with the support of a telehealth assistant. A further 5% (n=34) indicated 'other' and described a range of different uses of telehealth, including:

- providing clinical sessions by phone and using Skype and Facetime
- holding meetings with the families of clients
- providing clinical support to allied health assistants
- accessing and delivering training
- participating in professional meetings and networking
- providing clinical supervision to other speech pathologists

A small number of speech pathologists indicated they access clinical supervision using video-conferencing or other remote technology (1%, n=5)

Workforce movement

To identify movement between sectors and settings, respondents were asked to describe the location, sector, role and duration of their first position (starting position), most recent position, and their three most significant positions in between. The results are presented as percentages as not all respondents had five roles. The numbers of respondents for each position are summarised in Table 11, and Figures 16 to 19 illustrate broad trends in shifts between locations, sectors and settings.

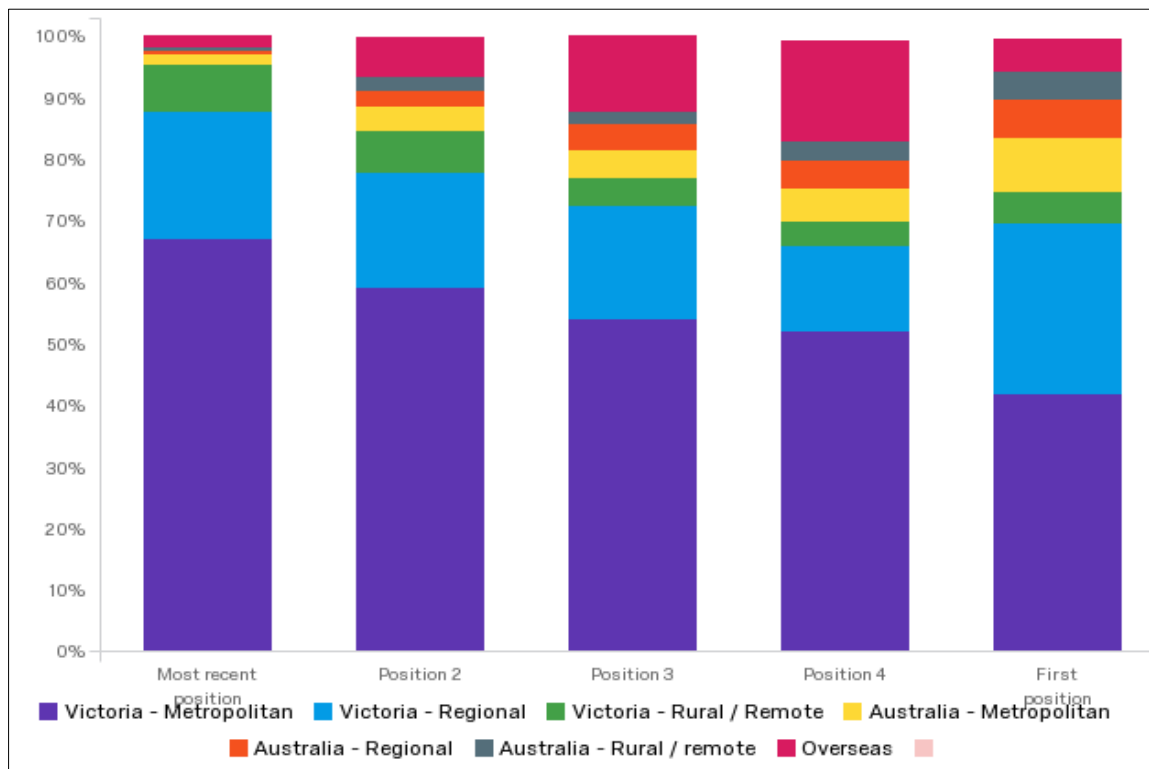
Table 11: Number of respondents for each position

Position	Numbers of respondents
Most recent	632
Position 2	520
Position 3	377
Position 4	241
First (starting) position	269

Changes in location

Originating from a rural or regional area is an important predictor of location for future study and work. Most (n=571, 87%) of the speech pathology workforce studied in urban areas; of whom, 33% (n=186) came from regional areas. Of those educated in regional centers (n=82), the vast majority (88%, n=72) were originally from regional areas (Appendix Table 10 and 11). The odds ratio demonstrates that a speech pathologist that was educated in a regional area is 15 times more likely to have grown up in a regional area compared to a speech pathologist educated in the city having grown up in a regional area. Similarly, the odds that speech pathologists currently working in a regional area grew up in a regional area is 4.8 times higher than the odds that speech pathologists currently working in the city grew up in a regional area (Appendix Table 11).

Figure 16: Changes in location across the career path

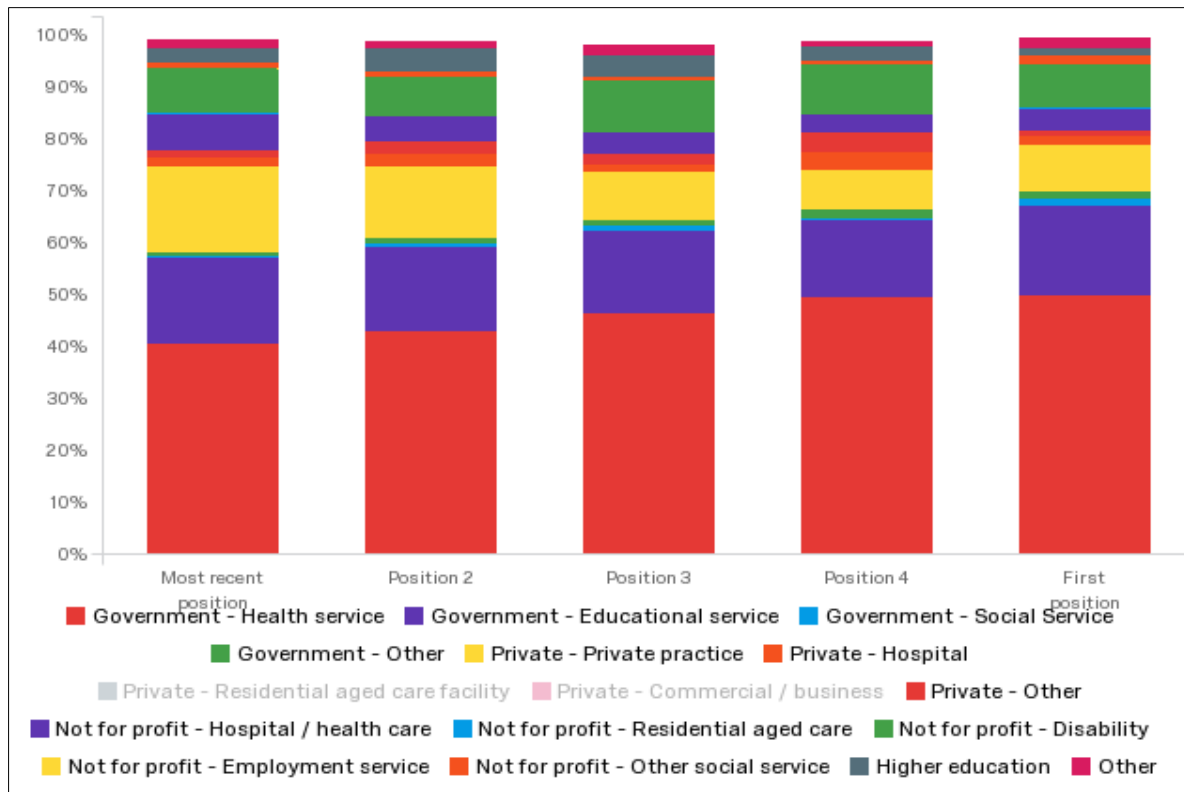


The AHWQ data shows clear trends in the career paths of speech pathologists with a strong increasing trend towards metropolitan settings over time (Figure 16). The percentage of respondents reporting they work in a metropolitan area in Victoria increased by almost a quarter from first position (42%) through to

most recent position (67%). At least 20% of speech pathologists participated in overseas work at some point in their career.

Changes in sector

Figure 17: Changes in sector over the career path

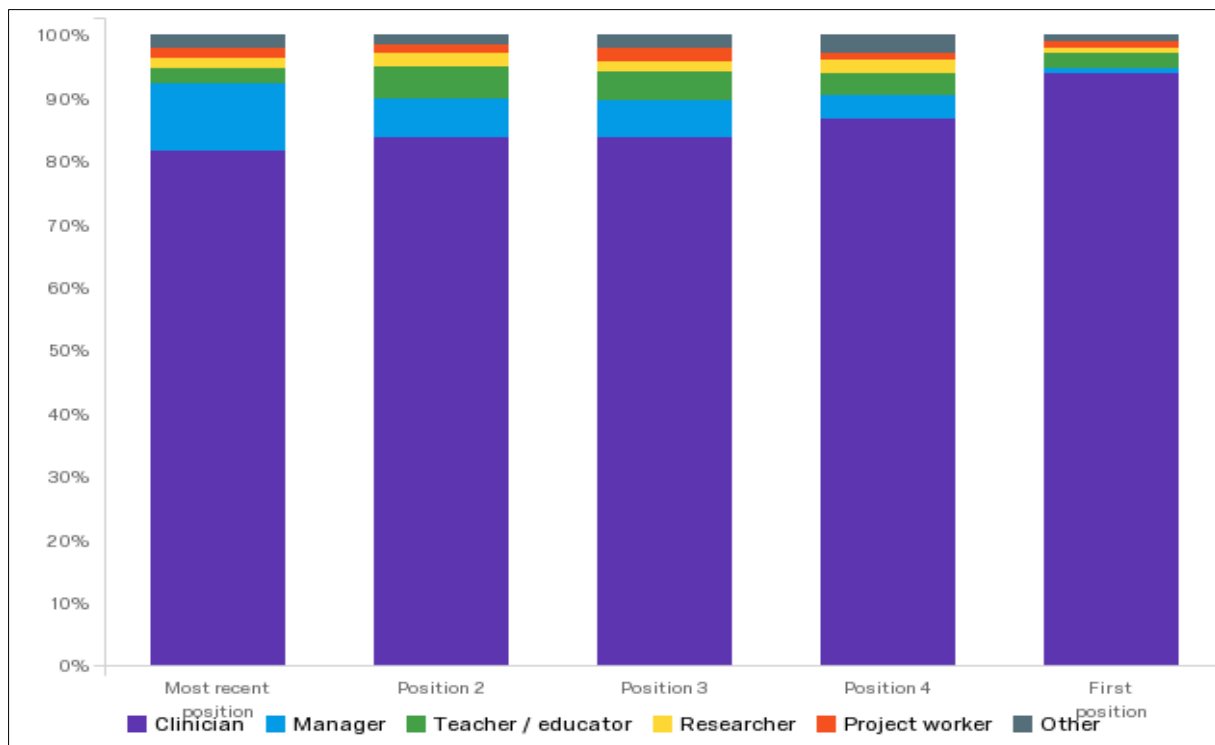


(Note that some of the potential sectors were suppressed in this output due to small numbers of respondents, therefore the bars do not total 100%).

From the available data (Figure 17), there is a slight trend for speech pathologists to move away from government health service positions into other sectors over the course of their career (51% first position compared with 40% most recent position). Those employed in educational services however have a tendency to stay within this sector (17% in both first and most recent position). This is also the case for those employed in the NFP disability sector and other government services. The other trend is for a movement towards private practice over time with 9% reporting private practice as a first position compared with 17% as their most recent position.

Changes in role

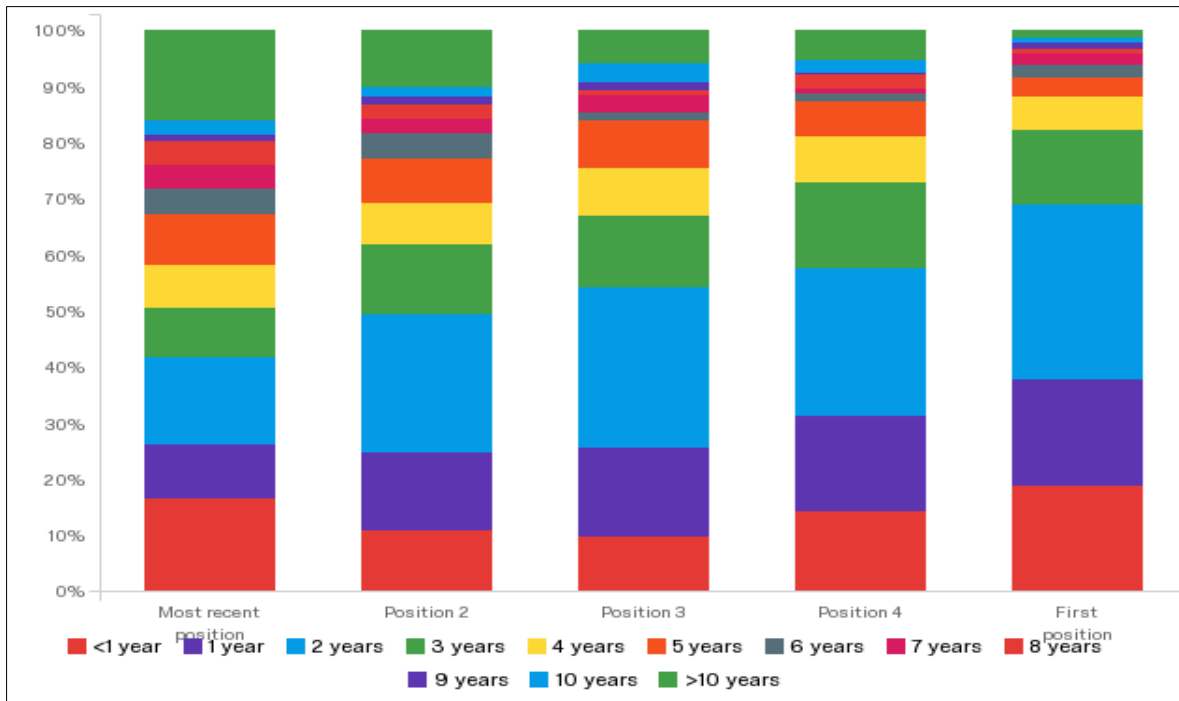
Figure 18: Changes in role over the career path



From the available data (Figure 18), there is a slight trend for speech pathologists to progress away from clinical roles into other roles over the course of their career (94% first position compared with 82% most recent position). This corresponds with a slight trend for speech pathologists to move into management roles as their career progresses (1% as first position compared to 11% most recent position). The proportion employed as teachers/educators or project workers however appears to stay relatively stable across the career pathway.

Years in role

Figure 19: Years in each position over the career path

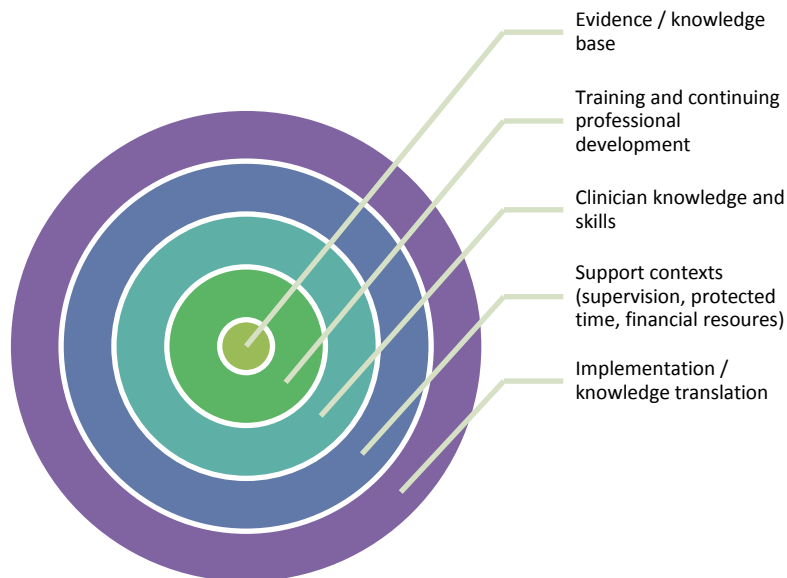


The time that speech pathologists spend in each role appears to increase over the duration of their career (Figure 19). Seventy per cent (70%) of respondents reported staying three years or less in their starting position. In comparison, 40% of respondents reported staying five years or more in their most recent position.

Capability

Capability refers to the strength of the evidence underpinning relevant speech pathology activities, access to training and continuing professional development (CPD) to develop the appropriate skills, the standard of skills practitioners have to deliver evidence-based services, the contextual supports available (supervision, mentoring, dedicated time and appropriate funding models), and opportunities for change in practice to occur (i.e. knowledge translation and implementation) (Figure 20).

Figure 20: Workforce capability framework



Key findings

- The speech pathology profession recognises the need to improve the evidence base for many areas of practice, increase application of existing evidence and support translation of new evidence into practice. Barriers to implementing evidence-based practice include funding models, local service delivery policies and workload.
- Over a third of speech pathologists come to the profession with prior professional or employment experiences.
- The majority enter the profession through a bachelor degree, with others entering through a graduate entry master degree. A proportion of speech pathologists have post-graduate qualifications in speech pathology and / or other skill areas. There is opportunity as a number of speech pathologists hold, or are studying for, higher degrees by research.
- Access to CPD was identified as a difficulty, although this varied by service type and rurality. Organisations providing CPD and mentorship were viewed more favourably than other organisations that provide less support in this regard. Localised CPD may be an appropriate way to address local skills gaps.
- Developing high standards of clinical quality in the speech pathology profession demands quality pre-entry clinical placements with an appropriate breadth of experience relevant to the settings and client groups clinicians are likely to work with.
- Access to clinical supervision is mixed, but is seen as key to ensuring clinical governance, and supporting clinical quality and competence.

Evidence / knowledge base

The profession recognises there is a need to significantly improve the evidence base for many areas of speech pathology practice, the application of existing evidence and best practice standards, and the support for translation of evidence into practice. Additionally, one respondent identified the need for better tools to measure and report on outcomes.

Focus group participants reported having to work within the constraints of funding models that are not consistent with current best practice models and evidence and therefore effect the translation of this recognised evidence. For example, many funding models and local service policies provide limited opportunity to support community development, group service delivery, transdisciplinary practice, intensive intervention programs, and rehabilitation over an extended period of time.

Workload was also cited as a barrier to implementing evidence based practice.

“Models like the NDIS [National Disability Insurance Scheme] focus on individual funding, but evidence points to many benefits coming from community engagement and raising awareness in the community.”

“We are unable to provide services in line with the current evidence base due to lack of EFT”.

I think we need grade 4 clinicians and educators to close the gap on current speech practice and the evidence.

Training and continuing professional development

Prior work experiences

The AHWQ survey findings demonstrated that Victorian speech pathologists have a range of prior work experiences.

Over one third (37%) of respondents reported having worked in a role or profession other than speech pathology (Appendix Table 7). For those who had worked in other professions or roles, more than half (56%) had worked in these professions or roles for three or less years and were most likely to have worked as administrators (15%), health care workers (excluding nursing, 12%) or teachers (10%). A very small percentage worked as AHAs (2%) (Appendix Table 9).

Qualifications

The AHWQ survey findings demonstrated that Victorian speech pathologists enter the profession through both pre-entry and graduate entry pathways, and some hold or are working towards additional post-graduate qualifications. On average, each speech pathologist holds 1.6 qualifications (Table 12).

Pre-entry speech pathology qualifications

The most common qualification held by respondents was a bachelor degree (n=612). This was also the dominant entry qualification for participants to practise as a speech pathologist. Ninety seven participants hold a graduate entry master's degree and 92 of these indicated this to be their main qualification to practise as a speech pathologist (Table 11).

Fifty seven respondents also hold a certificate or diploma qualification. It is unclear whether these were part of their career pathway into speech pathology.

A number of speech pathologists hold, or are studying for, higher degrees by research. Thirty three hold and a further seven are completing a masters by research, and 26 hold and a further 17 are currently completing a PhD.

Table 12: Qualifications held or currently studying (n=662)

Qualification	Current qualification/s	Qualifications currently studying	Main qualification to practise
Certificate III	14	1	0
Certificate IV	29	5	0
Associate diploma	11	0	3
Advanced diploma	14	2	5
Bachelor degree	612	8	468
Honours degree	75	0	32
Graduate certificate	47	8	0
Graduate diploma	60	8	2
Master's degree - Graduate entry	97	4	92
Master's degree – Clinical	65	7	52
Master's degree - Management (e.g. MBA)	12	8	0
Master's degree - Research	33	7	4
Professional Doctorate	2	0	0
PhD	26	17	0

The majority of respondents (75%) attained their main qualification to practise as a speech pathologist in Victoria, or another Australian state (21%), predominantly NSW or South Australia; only 4% were trained overseas (Table 13).

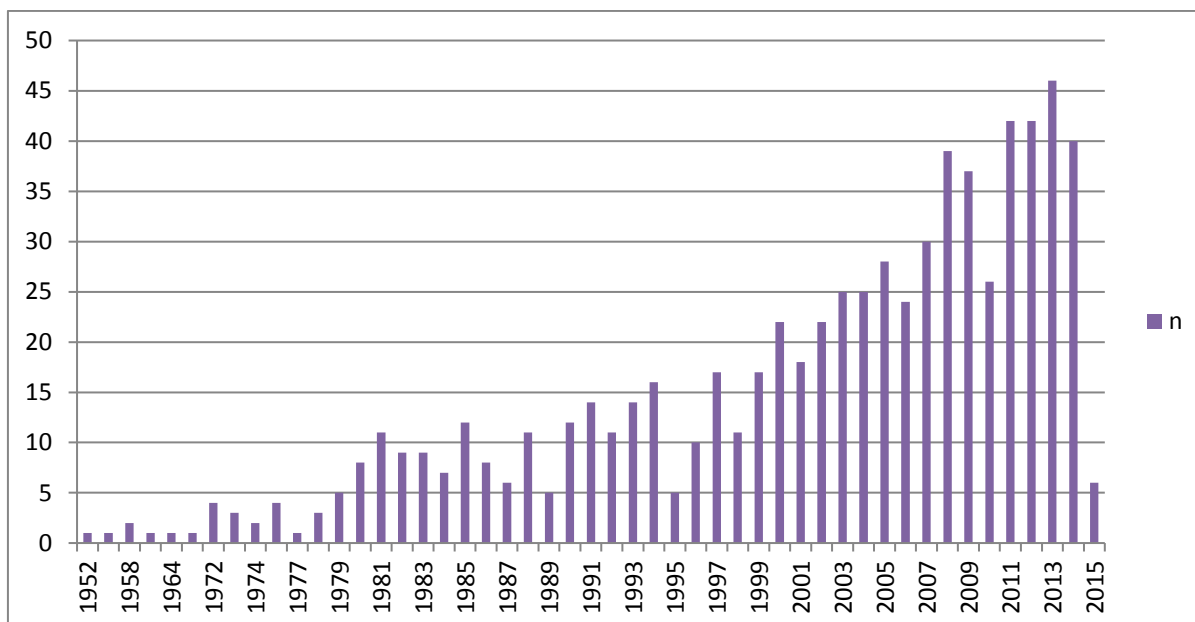
Table 13: Origin of first qualification (n=708)

Origin	n	%
Victoria, Australia	529	75
Other Australian state or territory	150	21
- New South Wales	96	
- Australian Capital Territory	0	
- Tasmania	0	
- South Australia	25	
- Western Australia	6	
- Northern Territory	1	

Origin	n	%
- Queensland	19	
New Zealand	1	0.1
United Kingdom	12	2
United States of America	2	0.3
South Africa	6	0.9
Other overseas country (India, Ireland)	8	1

On average, practitioners had been qualified as a speech pathologist for 15 years (range 0 – 64 years) (Figure 21).

Figure 21: Year of qualification (n=662)



Continuing professional development (CPD)

Many respondents reported poor access to CPD. They indicated inadequate CPD opportunities impede their capacity to incorporate evidence-based practice and research into their work. Lack of access to funding for CPD was particularly evident for rural / regional practitioners. In contrast, some respondents from organisations with larger speech pathology departments indicated that they were well supported in their professional development through internal support from their employer and through access to funding for external CPD.

“Our hospital has ceased funding for professional development. Working in a regional setting travelling and paying for professional development is very expensive and often unaffordable.”

“My workplace is very attractive for accessing experienced mentors and CPD. Not a lot of people in rural settings have that.”

Respondents identified specific needs for increased CPD in paediatric dysphagia, use of technology, complex communication needs, and working in transdisciplinary teams.

Career development opportunities

When surveyed about career progression opportunities and pathways, a high proportion of respondents reported a general lack of opportunity to progress their career with their current employer, locally, and in the profession generally (Figure 22). Further, less than half reported having access to the training (46%) or mentoring (44%) necessary to progress their career.

This research identified the need for improvements in:

- Clinical career structures
- Opportunities for professional advancement in all areas – metropolitan, regional, rural, and remote
- Employment opportunities and job stability in public services
- Research career opportunities, including co-location of research positions with clinical services
- Promotion based on merit and work ethic, not years of service
- Support and opportunities for early career speech pathologists
- Professional development and post-graduate study opportunities, including in specific domains of practice, e.g. dysphagia, autism, and fluency.

“There are minimal career development opportunities in Victoria, although the union are currently trying to fix this with the latest EBA in the public hospital system.”

“We do not have grade 4 positions, despite attempting to develop them. So from the clinical point of view it is less than ideal.”

A particular challenge is the need to hold post-graduate qualifications to advance to a grade 4 position. Individuals spoke of difficulties finding the time and financial means to undertake post-graduate study, often whilst balancing family commitments. However, they recognised this is likely to be an increasing expectation within the profession generally.

“I am grade 3 with no desire to move into management. What is next for me?”

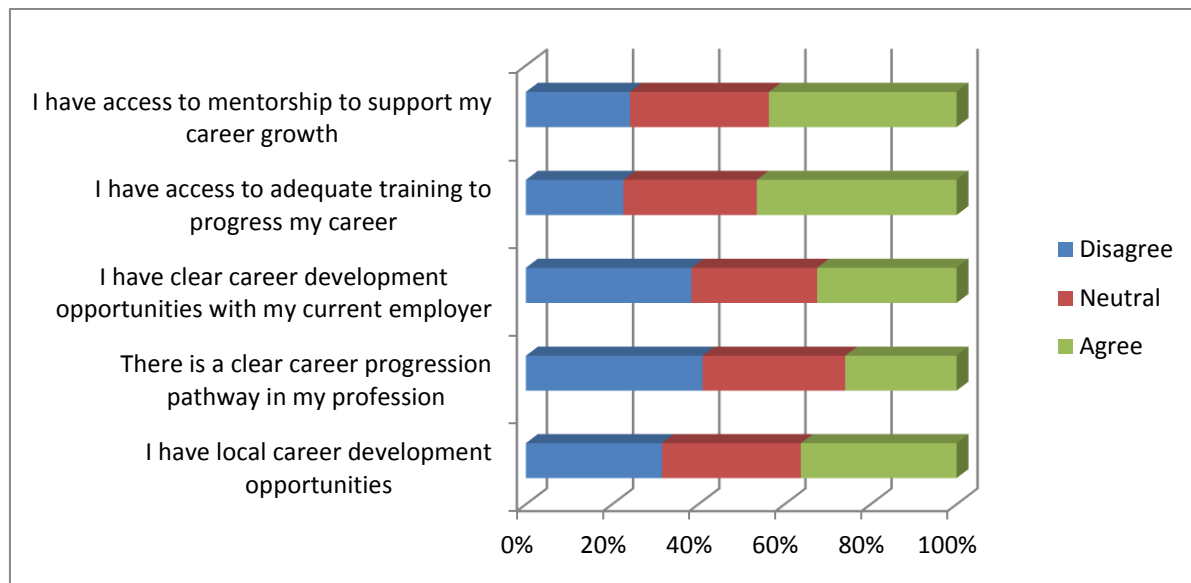
“Working rurally I’m wondering what’s next. I’m in my late 40s, expect to work for many more years, with lots to offer. But there’s nowhere else to progress to – you’d have to get lucky or create something.”

“There is pressure to do research and move to grade 4, do a masters or a PhD. This is a challenge with young kids. I’ll need a grant so I can eventually become a grade 4 in this setting...I’d be quite happy to see patients for the rest of my life, if I had the right funding and job to do that.”

Despite the challenges expressed by many, focus group participants from larger services identified positive experiences in relation to career development opportunities.

“(My service) provides a great range of opportunities for skill development and career progression. There are many education and training opportunities internally... and subsidised courses. This has enabled me to obtain (post-graduate qualifications) which has enabled me to get the opportunity to be seconded into a grade 4 role...Everyone is encouraged to use and share their skills in the department, in AH, the organisation and externally.”

Figure 22: Career development opportunities (n=580)



Clinician knowledge and skills

A small number of survey respondents and a high proportion of focus group participants reported experiencing significant pressure to support the rapidly increasing demand for clinical placements for pre-entry speech pathology students. Specific concerns were raised about students receiving training emphasising discrete and specialised areas of practice at the expense of foundation skills required across clinical domains.

An early career focus group participant explained that new graduates who have not had clinical placement experience across the range of key clinical domains felt compromised in the roles they can confidently apply for. This places another layer of difficulty on securing employment. One focus group participant explained that new graduates in their service undertake training in a range of competencies before practising independently as the service no longer assumes their competence when they reach the workplace.

“Students need a better prepared degree that includes increased high quality clinical placements and workshops.”

“Students come to us for their final placement and speak about having all these skill classes like FEES and VFSS...There seems to be a shift to top down learning – where they touch on all these different areas and expect it to generalise without laying down those basic foundations.”

Survey respondents indicated a high level of agreement with the statements ‘I have the skills necessary to do my current job’ and ‘I have all the tools necessary to safely perform my job.’ Respondents who reported the least confidence in their skills to perform their job were those on the lowest pay scale, they were also the most likely to be working part-time for multiple employers. This raises important issues about the way this workforce is supported (Figures 23 and 24).

Figure 23: Clinician knowledge and resources (n=586)

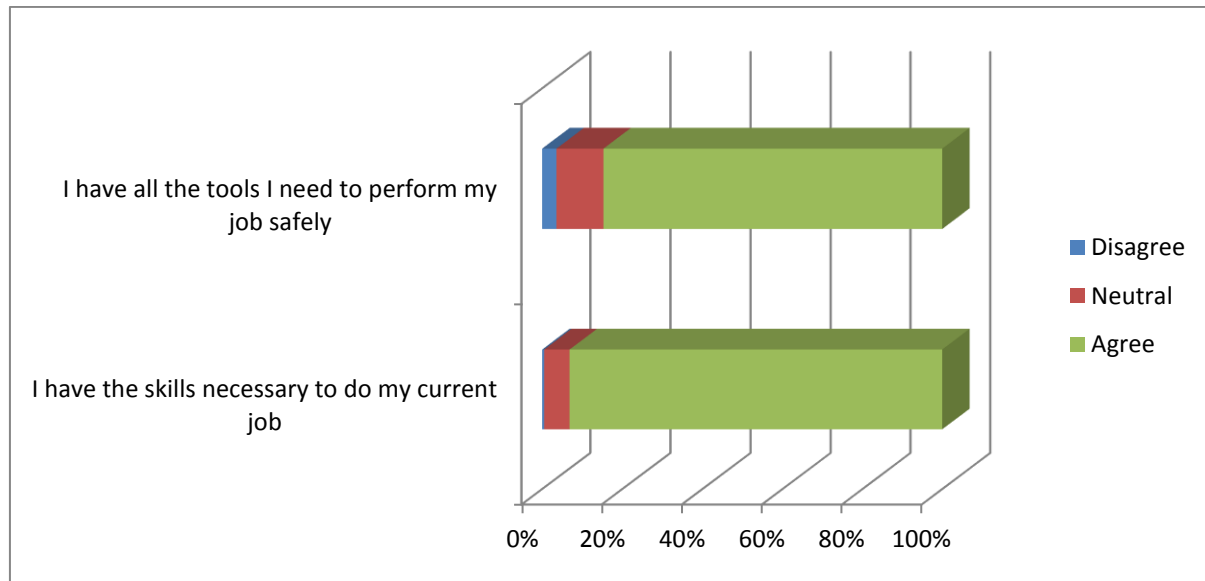
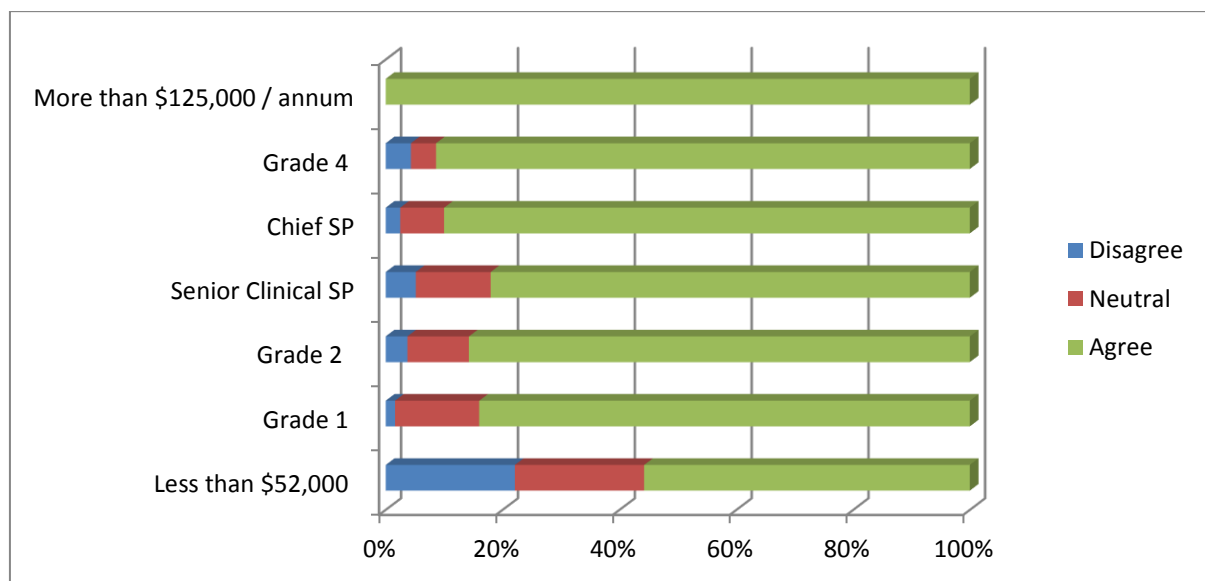


Figure 24: Clinician knowledge and resources: Compared to grade / pay level



Skill gaps

Several employers identified specific skills gaps for their local speech pathology workforce; however no single skill was consistently identified as a gap for the workforce as a whole. Examples of local skill gaps included:

Clinical skills

- breadth of skills to support a generalist caseload
- paediatrics
- early intervention
- videofluoroscope (VFSS)
- fiberoptic endoscopic evaluation of swallowing (FEES)
- neurosurgery
- neurorehabilitation

- ear, nose and throat
- mental health
- oncology
- burns
- disability
- assistive devices

Systems knowledge

- knowledge of public health systems and how hospitals work
- referral systems from inpatient to community

Supervision skills

- Poor access to CPD presented a barrier to responding to these local skill requirements.

Respondents expressed particular concern about the transition to the NDIS and the implications for clients, practice and the profession. Focus group participants with disability sector experience expressed concern that speech pathologists are likely to embark on practice in this area without appropriate skills and inadequate insight relating to their skill gaps.

“You don’t know what you don’t know when you’re young and inexperienced.”

Support contexts to enhance capability

Supervision and support

Associated with the need for better career development opportunities and CPD was a recognised need for better supervision and support within the speech pathology profession. Although some research participants report high standards of supervision and support, this was not consistent across the workforce. There were sectoral and geographic differences in the levels of access to professional support.

Self-employed practitioners were less likely to have access to clinical supervision, formal management support or to perceive they have professional career development opportunities. They were also more likely to be professionally isolated. However, they reported better access to training opportunities than other groups.

In contrast, public sector employees were more likely to report having access to clinical supervision, management support, mentorship, and career pathways. However, focus group respondents spoke of colleagues in public community health who seek and personally fund supervision and support external to their workplace, and speech pathologists in rural roles and those working in sole positions did not have ready access to supervision.

The survey findings showed almost 30% of clinical practitioners do not have access to a clinical supervisor (Figure 25). For those who are supervised, 54% were supervised by a speech pathologist and 12% were supervised by another type of AH professional (Figures 26 and 27).

Overall levels of access to supervision and support varied across grades, with speech pathologists earning less than \$52,000 per annum reporting the least ability to access support (Figure 27).

“There needs to be formal requirements for supervision for new graduates and inexperienced clinicians across all work settings including private practice.”

“Quality supervision in rural and remote areas is a significant gap.”

“In our service we have a very robust clinical governance structure for allied health, with excellent clinical supervision, professional development, attainment of clinical and mandatory competencies at all levels. We are strongly encouraged to participate in quality and research activities and all staff are involved in some way and are very much acknowledged and celebrated regarding this.”

Figure 25 Professional background of clinical supervisor (n=568)

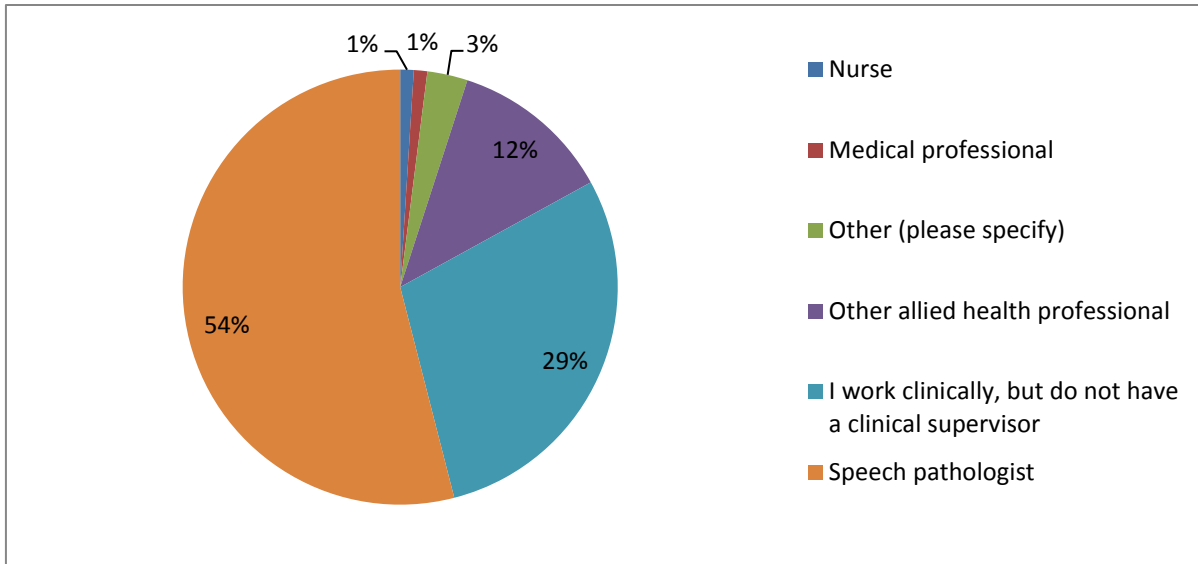


Figure 26: Access to clinical supervision and support (n=580)

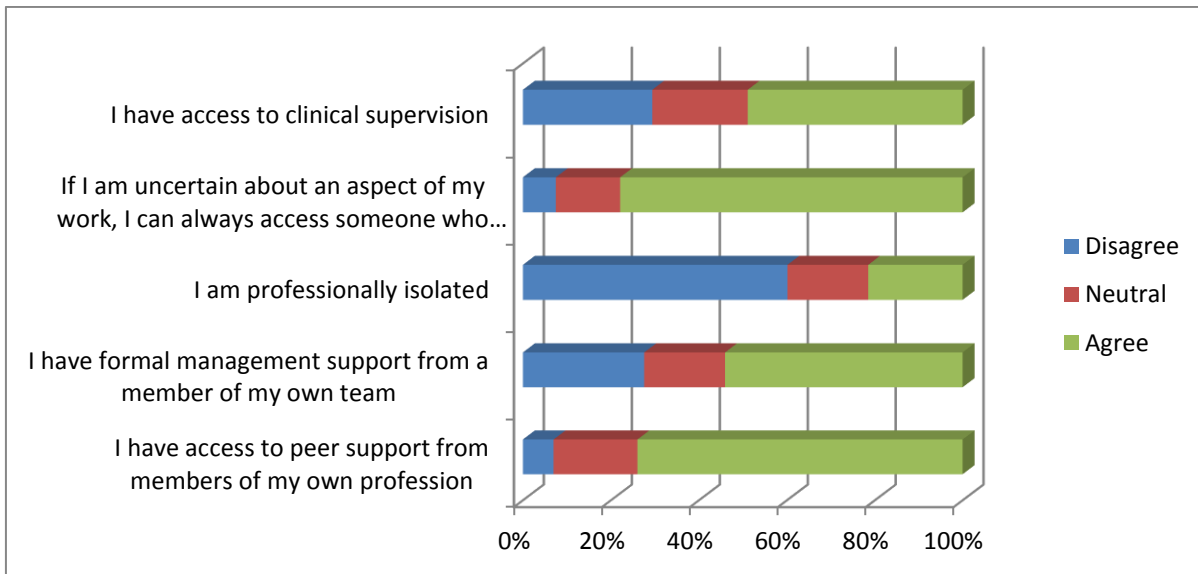
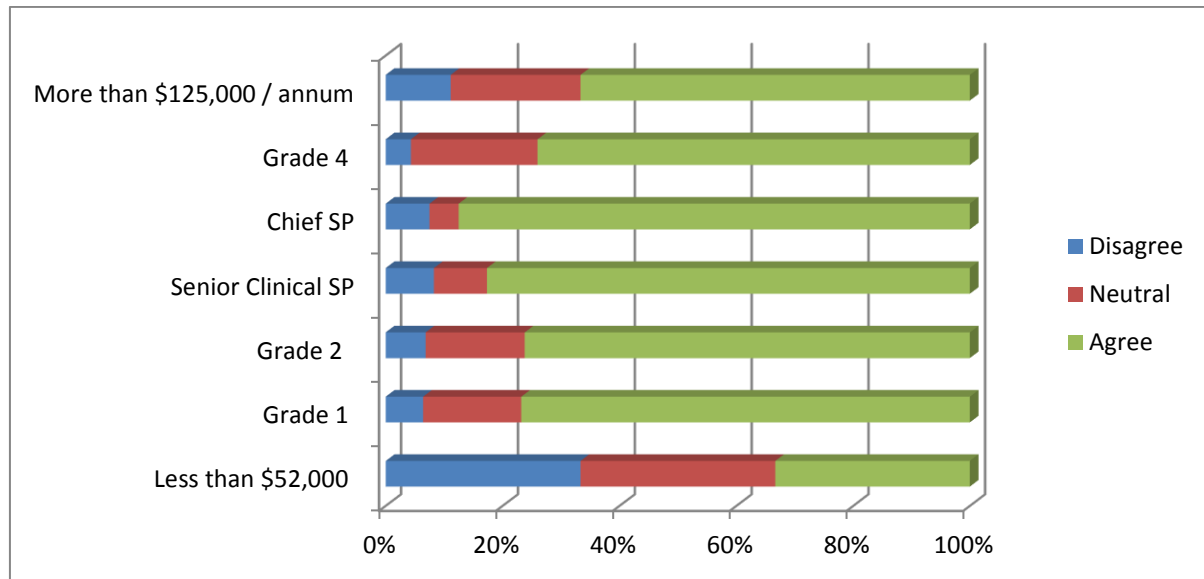


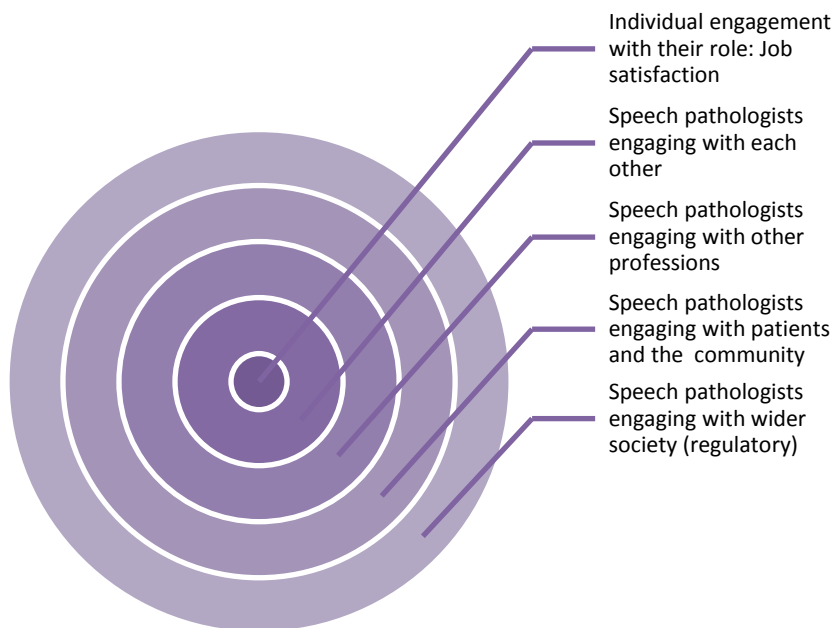
Figure 27: Access to clinical supervision and support by grade / pay level



Engagement

Engagement involves a continuum from the individual practitioner's engagement with their role to the wider engagement of the profession with society through regulatory mechanisms. Within this course there is engagement with the profession, engagement with other professions, and engagement with patients and the community (Figure 28).

Figure 28: Model of engagement



Key findings

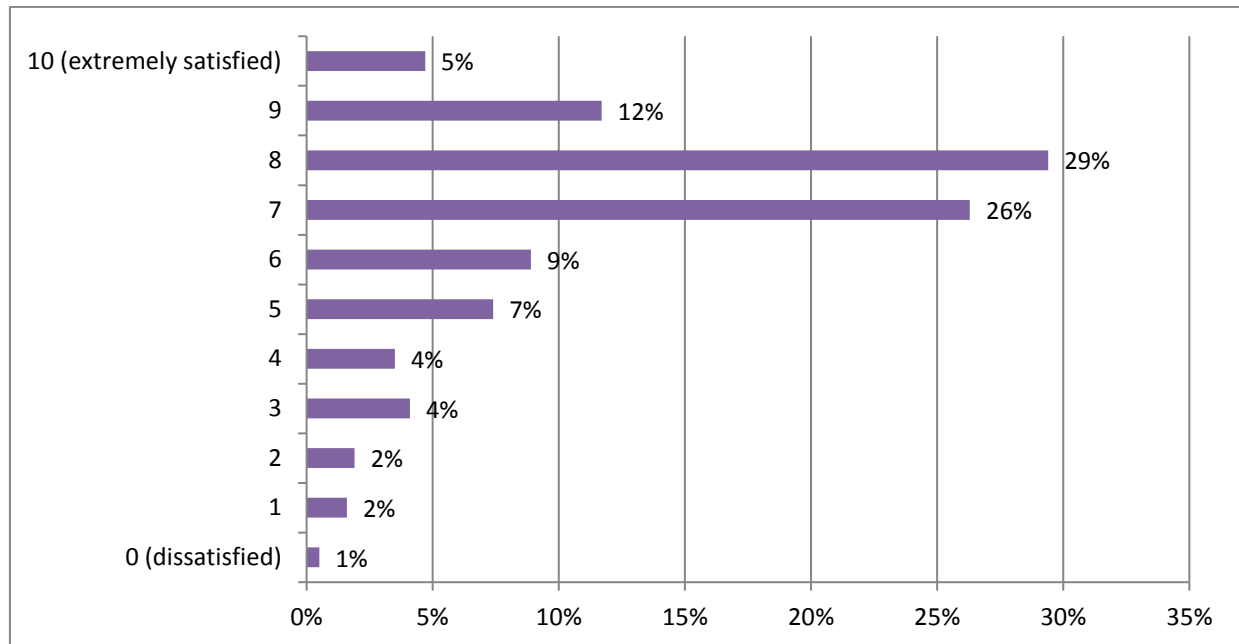
- Overall the speech pathology profession reported high levels of job satisfaction; however 22% intend to leave the profession within the next five years.
- The high levels of satisfaction are largely associated with the roles in clinical service provision.
- Key motivators for speech pathologists include the type of work they do, the clients they work with, and having a good work / life balance. Speech pathologists were largely satisfied with their type of work and clients; however there is substantial room for improvement around work / life balance. There are sectoral differences in experience of work / life balance with those working in the NFP sector reporting the greatest satisfaction.
- Respondents expressed some concerns about the cost of professional membership and perceived lack of advocacy by the professional body for the profession.
- Speech pathologists perceive they are not well understood by other professionals or the general public.
- A number of respondents believe professional registration is a key variable in gaining professional recognition.

Individual role engagement

Overall, Victorian speech pathologists who responded to the AHWQ were highly satisfied with their job (Figure 29). Mean satisfaction score was 8 on a scale of 0 – 10. Only seven (1%) intended to leave the profession in the next 12 months: this was primarily due to retirement.

Public sector employees reported the highest level of satisfaction with their income (Figure 33).

Figure 29: Overall satisfaction (n=622)



Qualitative findings from the AHWQ and focus groups suggested that the high levels of satisfaction were largely due to enjoyment of their clinical work and interaction with clients, contributing to meaningful outcomes for clients, and working with a team.

The most important factors affecting employment choices were work / life balance, the type of work and clients, professional development opportunities and support, location, and flexibility of hours (Figure 30). Satisfaction levels with these factors suggested that a proportion of staff were dissatisfied with their work / life balance, income and career development opportunities (Figure 31).

“As my role becomes more management focused, the opportunity to work clinically, with a variety of people, is what gives me the most job satisfaction.”

“Often I have the opportunity to see someone in the early stages of a diagnosed condition – and I follow them through to the end. I enjoy working with clients over time.”

“We’re all pretty dedicated to our jobs – but work / life balance is lost as a result.”

Figure 30: Importance of factors affecting employment choices (n=590)

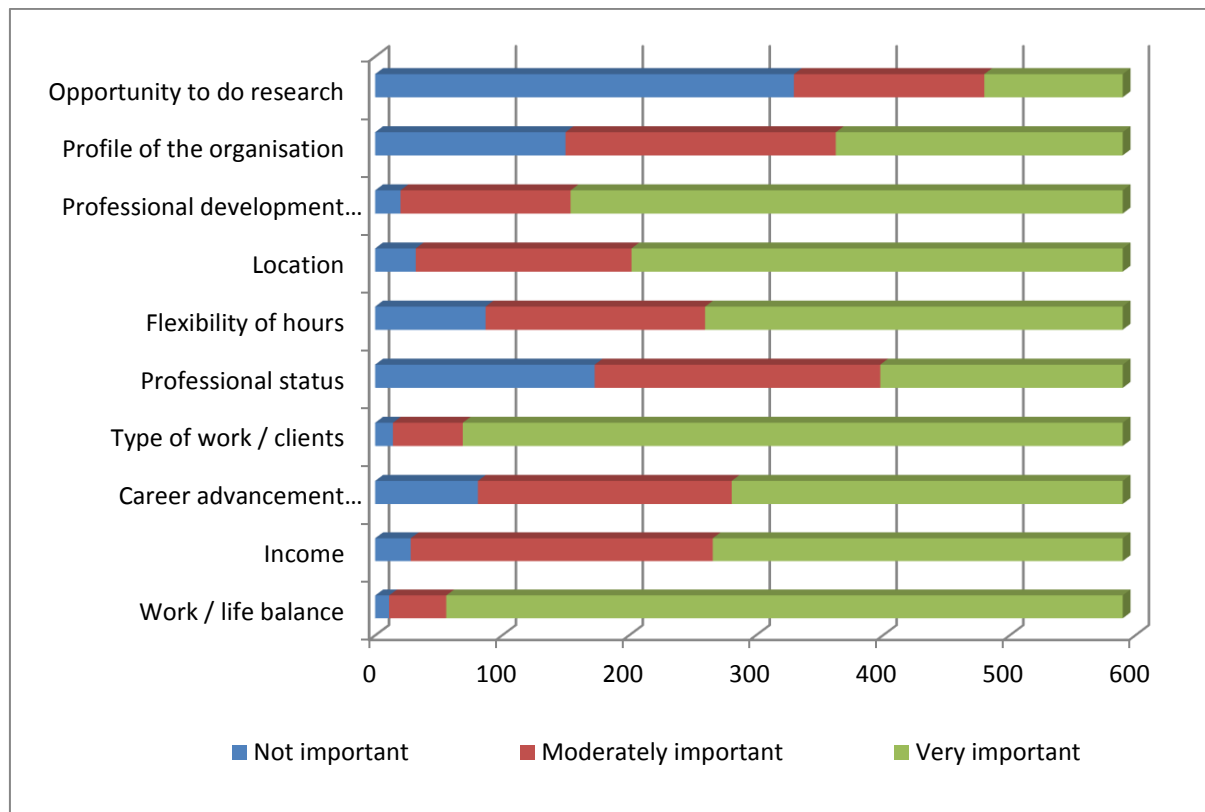
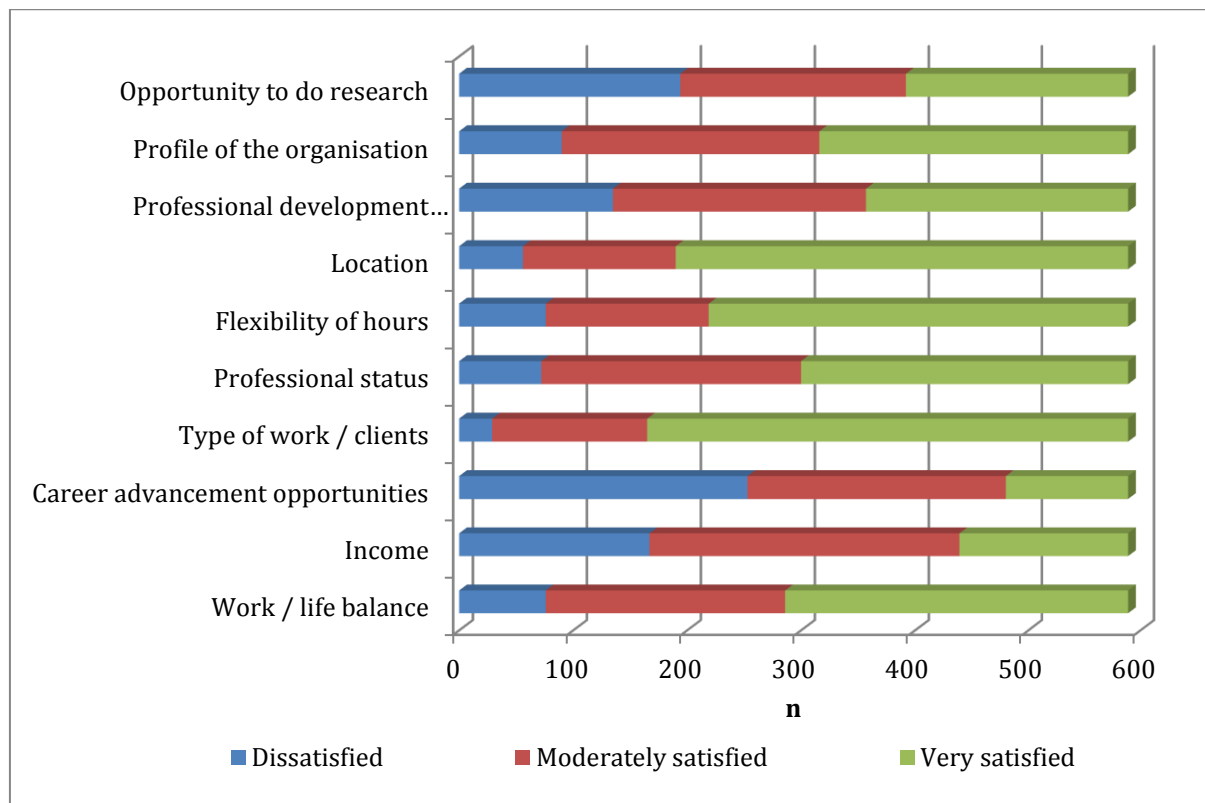


Figure 31: Current satisfaction with factors affecting employment choices (n=590)



There were interesting sectoral variations in levels of job satisfaction. Self-employed practitioners scored more highly on satisfaction with all attributes of their work, with the exception of work / life balance,

where they had the lowest scores and income and were marginally less satisfied than public sector employees. Employees in the NFP sector were the most satisfied with their work / life balance and flexibility of their hours but the least satisfied with their income and career progression opportunities.

A small number of AHWQ participants identified job security as a factor influencing job satisfaction. This appeared to be largely related to the changing nature of work and contracts combined with the increasing numbers of new graduates.

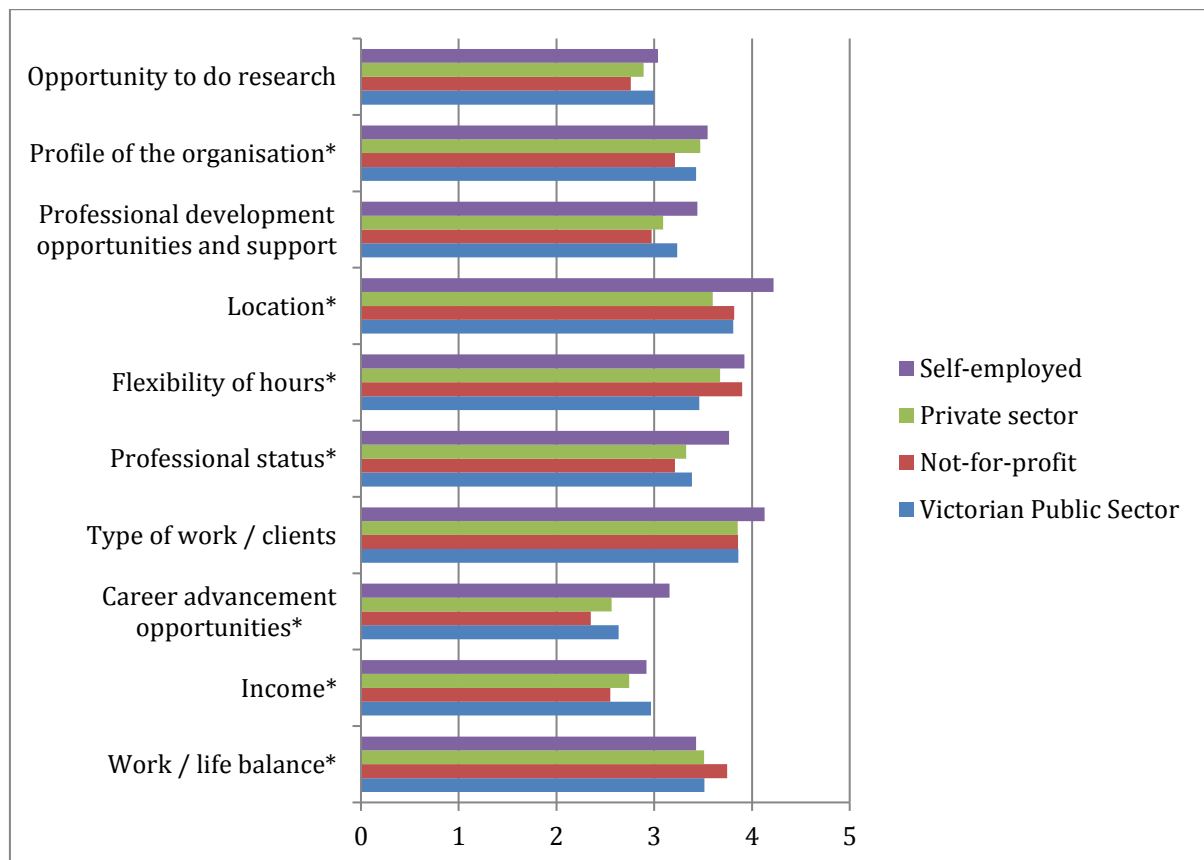
“I’ve been able to grow and develop in my role over 20 years. I’ve been able to do 50/50 clinical and management. I don’t see that opportunity for staff working with me now.”

“I’ve done the same job for 30 years, so I must have career satisfaction! I work directly with clients. I’ve chosen never to go into senior management. I’ve had flexibility – down time and up time, maternity leave, flexi-time, taking holidays etc. It’s been very family friendly. It’s interesting working with families. It’s very rewarding. I get immense career satisfaction.”

“There needs to be more flexibility for professionals having children. By my second baby, I had to choose between children or speech pathology. I chose children and am now having to go through the re-entry.”

“For me at the moment the most important thing is job security. With the introduction of the NDIS, I don’t really know what this means for my job and if I will still have one.”

Figure 32: Relationship between employment sector and level of satisfaction with job attributes ^a



^a 0 – 5 scale where 5 is the most satisfied

Intra-professional engagement

Feedback in the survey provided limited information about the engagement of speech pathologists with their profession; however some participants highlighted the cost of membership and perceived lack of advocacy by the professional body on behalf of the profession as issues. This may impact on funding support for services.

“Membership to our professional body is prohibitively expensive. Other clinicians comment they don't get ‘value for money’ and the body does not make gains in changing the situation for speech pathologists.”

Inter-professional engagement

The most common observation by speech pathologists regarding their relationships with other professions was that the role and contribution of speech pathology is poorly understood by a range of other relevant professions. In particular, respondents emphasised the need to improve the understanding of the medical profession regarding the breadth and depth of the speech pathology role and the circumstances in which a speech pathologist can assist individuals with a range of needs.

Some speech pathologists noted that poor understanding of their role is affecting the move towards multidisciplinary and transdisciplinary practice. Where understanding of the speech pathology role is not well established, challenges arise in ensuring speech pathology skills are effectively incorporated within these team processes. In this context of multi- and transdisciplinary team practice, some respondents also raised concerns regarding the effectiveness of clinical governance arrangements across disciplines within a team.

Finally, practitioners noted that as scope of practice extends and expands within speech pathology, and other professions, improvements are needed in understanding and recognising the advanced and extended scope roles speech pathologists can contribute. The low level of general understanding about the speech pathology role contributes to the challenge of increasing the understanding in the expanded scope roles.

“I would like the profile of speech pathologists to be raised. Other disciplines do not understand the breadth of skills and learning that speech pathologists have.”

“Often even GPs have no idea of what a ‘speechie’ role involves. It seems to be our biggest issue presently.”

“With NDIS coming to our region soon, it's important for the people involved in planning individual services and goals to understand what is available and the importance of our work.”

“Liability related to working under a transdisciplinary, key worker model is needed. There is not clear information about what is appropriate for a speech pathologist to do under this model, and the safety concerns related to working outside of your profession.”

Community and society engagement

Speech pathologists indicated the importance of improving community understanding of the role of the profession, increasing community awareness of when speech pathology services may be warranted, and how and where to access services.

Speech pathologists also emphasised the importance of their role as advocates, at both the individual and community level. Connected to this theme was the need to advocate for the specific contributions the speech pathology role brings in diverse sectors such as disability, aged care, education and mental health.

Finally, the need for effective professional regulation and national registration were identified as important issues for the profession. Speech pathologists suggested that inclusion in the *National Registration and Accreditation Scheme* would contribute to perceptions regarding the importance and value of the profession. Respondents also associated registration with quality assurance and monitoring of professional standards following graduation and as a way of protecting the title of 'speech pathologist'.

"Our community needs to better recognise the role of speech pathologists in communication management and the possible adverse events caused by poor or no management of communication impairments."

"Speech pathologists need a stronger advocacy role to promote the rights of people with communication disabilities."

"Registration is important, so that only people with the relevant qualifications can call themselves a speech pathologist."

Conclusion

The speech pathology profession in Victoria is highly qualified, however there are few formal avenues to recognise or reward advanced scope roles within the profession.

The profession is experiencing an influx of newly qualified speech pathologists. However a lack of funding for new roles means that there are several areas in which newly qualified speech pathologists cannot find work while existing staff are overworked and unable to meet community demand for services. The perceived oversupply of speech pathologists is of concern for some members of the profession; however the growth in the workforce provides opportunities for the profession to identify novel ways to address previously unmet client needs. The challenge is to ensure that the growing workforce is adequately supported through appropriate clinical supervision and access to CPD. Provision of local training and support can also be used to meet local, specific skills requirements. The growth of the NDIS presents opportunities for growth of the speech pathology profession and to increase the provision of paediatric services.

Speech pathologists were largely satisfied with their roles, and particularly value quality client interactions and employers who provide work / life balance. They believe that they would benefit from greater professional recognition and there was a strong sense from many members of the profession that regulation is a way to achieve this.

References

Australian Bureau of Statistics. (2012). *2011 Census data*.

Appendix

The following section contains additional data, figures and tables referred to in the main report relating to the data collected through the AHWQ speech pathology survey.

Responses and respondents

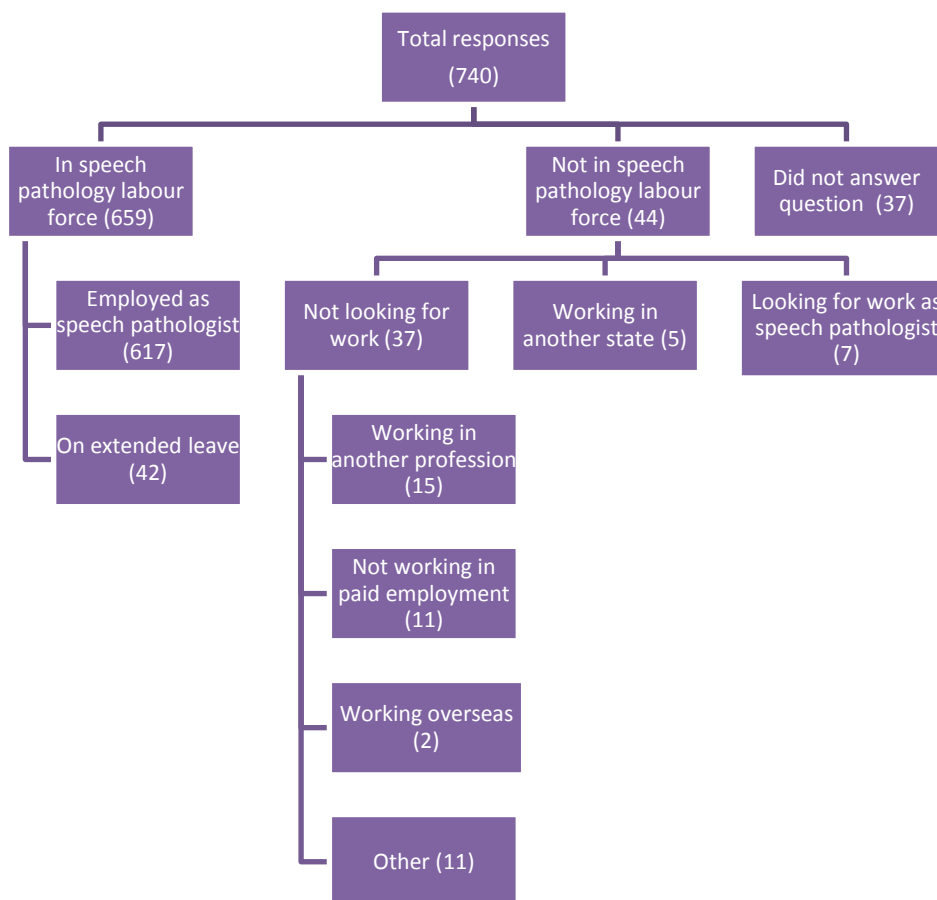
The AHWQ survey consisted of 69 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result the number of responses for each question varied and is included in the presentation of the data for each question.

A total of 740 speech pathologists completed at least one question on the survey and submitted their survey. The range of responses to an individual question was from 563 to 1,367. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

A total of 166 respondents (22%) provided their email address and agreed to be followed up for future research.

Most respondents (88%) were employed in the speech pathology workforce at the time of completing the survey. Seven respondents were actively seeking speech pathology work.

Figure 1: Current employment status⁴



⁴ All data in the Appendix Figure 1 and Tables 1 - 11 comes from the AHWQ survey

Table 1: Current employment grade / pay level by employment sector (n=606)

Equivalent pay grade / level	Victorian Public Sector	Not-for-profit	Private sector	Other public sector	Self-employed
Less than \$1,017 / week	4	5	12	3	17
	1.33%	6.67%	20.69%	3.26%	21.25%
Grade 1 \$1,017 - \$1,348 / week	63	20	18	22	6
	20.93%	26.67%	31.03%	23.91%	7.50%
Grade 2 \$1,316 - \$1,535 / week	125	37	16	25	22
	41.53%	49.33%	27.59%	27.17%	27.50%
Senior Clinician \$1,595- \$1,789 / week	73	10	8	28	19
	24.25%	13.33%	13.79%	30.43%	23.75%
Deputy Chief \$1,595 - \$1,696 / week	0	0	0	0	1
	0.00%	0.00%	0.00%	0.00%	1.25%
Chief \$1,595 - \$2,402 / week	21	2	2	9	9
	6.98%	2.67%	3.45%	9.78%	11.25%
Grade 4 / Clinical Educator \$2,016 / week	15	1	2	2	2
	4.98%	1.33%	3.45%	2.17%	2.50%
More than \$2,402 / week	0	0	0	3	4
	0.00%	0.00%	0.00%	3.26%	5.00%
Total	301	75	58	92	80
	100.00%	100.00%	100.00%	100.00%	100.00%

Table 2: Total annual income before tax (n=619)

Total annual income before tax	n	%
Less than \$40,000	121	19.55
\$40,000- \$49,999	48	7.75
\$50,000- \$59,999	109	17.61
\$60,000-\$69,999	95	15.35
\$70,000-\$79,999	95	15.35
\$80,000-\$89,999	77	12.44
\$90,000-\$99,999	30	4.85
\$100,000 - \$109,999	18	2.91
\$110,000 - \$119,999	12	1.94
\$120,000 - \$129,999	3	0.48
\$130,000 - \$139,999	3	0.48
More than \$140,000	8	1.3

Table 3: Hours worked per week across multiple employers

Hours	Employer 1	Employer 2	Employer 3	Employer 4	Total
0 – 8	48	120	29	2	199
8 – 16	84	39	3	0	126
16 – 24	113	31	3	0	147
24 – 32	94	5	2	0	101
32 – 40	243	7	3	2	255
>40	68	3	0	2	73

Table 4: Nature of employment

Employment	Employer 1	Employer 2	Employer 3	Employer 4	Total
Permanent	426	54	7	4	491
Temporary	29	12	0	0	41
Self-employed	93	50	12	0	155
Contract	80	47	10	2	139
Voluntary	0	0	1	0	1
Casual	18	41	7	0	66
Locum	2	0	2	0	4
Other	2	1	1	0	4

Table 5: Hours of paid work in each role per week

Role	n	Min	Max	Average	Standard Deviation
Clinical	618	0	56	21.00	10.32
Management and administration	538	0	50	10.24	8.31
Teaching or educating	360	0	52	4.87	5.31
Research	157	0	56	4.57	7.91
Other (please specify)	46	0	44	4.96	8.47
Project work (not involving direct clinical or research)	226	0	30	4.08	4.47

Table 6: Model of Care

Model of care	n	%
Participants reporting their work includes an advanced practice role	137/637	21.5
Participants who delegate to allied health assistants (AHA)	233/623	37.4
Use of telehealth (including video conferencing for supervision)	81/630	12.9

Table 7: Employment in a profession / role other than a speech pathologist

Answer	Response	%
No	405	63%
Yes	240	37%
Total	645	100%

Table 8: Time worked in other professions / roles

Time	Profession 1	Profession 2	Profession 3	Profession 4	Profession 5	Sum	%
< 1 year	27	11	4	1	0	43	11.7
1 - 2 years	64	27	5	4	1	101	27.6
2 - 3 years	35	19	6	1	1	62	16.9
3 - 4 years	22	10	2	2	0	36	9.8
4 - 5 years	26	9	3	1	0	39	10.7
5 - 10 years	34	9	7	3	0	53	14.5
>10 years	25	5	2	0	0	32	8.7
Total Responses	233	90	29	12	2	366	100.0

Table 9: Types of profession / roles undertaken other than speech pathologist

Type of roles	n	%
Academic	4	1.7
Administrator	36	15.0
Allied health assistant	4	1.7
Business owner	2	0.8
Childcare worker	4	1.7
Disability services / support worker	5	2.1
Finance industry	5	2.1
Hospitality	20	8.3
Manager	21	8.8
Nurse	5	2.1
Other (e.g. chaplain, ballet teacher, life guard, cleaner, vet assistant)	36	15.0
Other health care (not nursing)	29	12.1
Project officer	19	7.9
Researcher / research assistant	7	2.9
Retail	20	8.3
Teacher (including early childhood, ESL, primary, secondary, music teacher)	23	9.6

Table 10: Location of work Compared to location of childhood

Childhood location	Workplace location		
	Metro	Regional	Total
Metro	302	62	364
Regional	124	121	245
Total	426	183	609

The odds ratio (OR= 4.8) indicates that the chance of a speech pathologist currently working in a regional / rural area having grown up in a regional area is 4.8 times higher than that for speech pathologists currently working in a metropolitan area having grown up in a regional area.

Three-quarters (n=421, 76%) of speech pathologists who studied in the city are currently working in the city, while 24% (n=19) of those who studied in a regional area are also now working in the city (Table 22). Of those speech pathologists who currently work in a regional or rural area (n=190), most were educated in the city (n=130, 68%).

Table 11: Location of work compared to location of study

Study location	Workplace location		
	Metro	Regional / Rural	Total
Metro	421	130	551
Regional	19	60	79
Total	440	190	630

The odds ratio (OR = 10.2) indicates that speech pathologists working in the city were 10 times more likely than speech pathologists working in regional / rural areas to have been educated in the city.