Allied Health Professions Australia

Submissions in response to Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability | Public Hearing 10 – Counsel Assisting Submissions

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This submission has been developed in consultation with AHPA's allied health association members.

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About AHPA and the allied health sector

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 130,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, providing services including diagnostic and first-contact services, preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses, supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

AHPA provides representation for the allied health sector and supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

Responses

AHPA restricts its responses to those Submissions of Counsel Assisting ('the Submissions') that have greatest relevance to the allied health workforce.

Overall, we strongly advocate that all relevant allied health professions that assist people with cognitive disability should be included in the Submissions' response to the various propositions and in relevant recommendations.

Proposition 1: Competency framework

AHPA supports a framework which identifies that core competency is required across health services and providers.

People with cognitive disability are a broad and varied group. They may also live with comorbid conditions including autism, physical disability and sensory disability; and/or may be experiencing consequences of stroke or brain injury, mental illness or age-related cognitive disabilities. These conditions may be a consequence of or exacerbated by cognitive disability; for example, cognitive disability such as acquired brain injury can interface with neuromusculoskeletal conditions and therefore a person with cognitive disability may need osteopathic treatment.

Other conditions, such as hearing or vision impairment, may have no direct relationship to the cognitive disability but nevertheless require the treating practitioner, such as an optometrist or audiologist, to understand the particular needs and challenges for the person with cognitive disability.

Types of treatment provided for people with cognitive disability will also vary depending on the age of the person and the context in which the health professional is working, such as a school, hospital or the community, or within the framework of the NDIS.

Allied health services such as physiotherapy and occupational therapy are commonly involved in assisting people with cognitive disability who have mobility issues, but other professions such as exercise physiology, osteopathy, chiropractic, podiatry and orthotics/prosthetics also provide treatment. While psychology, occupational therapy and social work can all directly assist with mental health issues, music and creative arts therapies may also support people with cognitive disability. Music therapy's mode and validation of non-verbal forms of expression can be particularly effective where language use is problematic, thereby enabling social connection and boosting self-esteem, motivation and confidence.

The impacts of practices such as occupational therapy and psychology demonstrate that it is unrealistic to draw a rigid distinction between the 'physical' and the 'mental' health needs of people with cognitive disability. The blurred boundary is particularly evident in some other allied health professions such as speech pathology and dietetics. As submitted in our response to Proposition 5, a more holistic understanding of the necessary supports for people with cognitive disability then leads naturally to consideration of collaborative and interprofessional modes of health provision.

Our view is that any health professional may be called upon to provide services for people with cognitive disability. All practitioners should therefore understand the potential communication and behavioural factors that might need to be considered in working with a person with cognitive disability, and must be competent to undertake safe and high-quality clinical interventions.

Similarly, those workers involved in providing direct support to people with cognitive disability alongside health professionals should understand how to work with this cohort and to collaborate in providing appropriate interdisciplinary care. Allied health assistants, disability support workers and the personal aged care workforce should therefore also be considered as in scope for a competency framework.

The framework should also recognise that as we have noted, some professions, or particular members of a profession, work more commonly with people with cognitive disability and so require more advanced levels of competency. Professions which have members with a specific disability focus should be considered the primary targets for training within the allied health sector.

We therefore recommended that the competency framework be based on core competencies relevant to all service providers, but that it also include different competency levels to reflect a continuum of skills, knowledge and attributes relevant to the specific work context and required competencies of the service provider. For example, a Level 1 description for a core competency may be relevant to allied health assistants, whereas a Level 3 category may be relevant to a profession that works consistently with people with cognitive disability, such as speech pathology.

With regard to Recommendation 1 and its alternative, the structure and membership of any working group established to address these issues should ensure that allied health is able to participate on an equal footing with medical entities. Membership should include, as well as AHPA itself, the various allied health professions represented on AHPA's Disability Working Group, bodies representing allied health assistants across disability and aged care, and the Australian Council of Deans of Health Sciences.

Proposition 2: Active involvement of people with cognitive disability

AHPA supports the inclusion of people with cognitive disability in the development and delivery of curricula, but the scope of Recommendation 3 should be broadened to encompass all registered and self-regulating health professions.

Mandating or encouraging education providers to make changes to the development of curriculum content without consultation may impact on the relationships between education providers and accreditation bodies. It is therefore recommended that accreditation authorities work with education providers to:

- scope current practice with respect to curriculum development and delivery
- identify enablers and barriers
- develop a shared understanding of requirements and expectations
- develop an agreed implementation strategy with a period of transition.

Proposition 4: Accessibility, adjustments and supports

AHPA strongly supports the proposition that training and education of health professionals address accessibility, adjustments, communication knowledge and skills, together with supports for decision making and providing consent.

We recommend that the development of training and education programs regarding communication knowledge and skills be undertaken in consultation with our member Speech Pathology Australia, individuals with communication issues, accreditation bodies and education providers.

Proposition 5: Collaboration and a multidisciplinary approach

AHPA supports Proposition 5 and the associated development of agreed competencies and learning outcomes for working collaboratively with families, support people and advocates, and in interprofessional practice. As submitted in our response to Proposition 1, people with cognitive disability may often have multiple health needs that are best met by interprofessional collaboration and coordination of other supports.

For example, a case study from one of our members concerns ‘Jane’, an 11-year-old girl living with physical and intellectual developmental delays who requires an increased level of support in her daily life, including assistance with personal care and transport to school. Due to her developmental delays, Jane has difficulty managing her emotions and behaviours which can lead to outbursts including swearing and pushing. Jane can also touch people inappropriately and become overfamiliar with them, as she struggles to recognise appropriate boundaries with others due to her intellectual disability and associated reduced social and communication skills.

As a result, Jane has difficulty engaging socially with her peers at school and participating in group activities, including sport. This is exacerbated by her physical developmental delays, which have led to poor gross motor skills compared to other children her age. As a result, Jane has disengaged from activities she used to enjoy, which has further reduced her social and community participation.

To effectively support Jane, occupational therapy, speech therapy, psychology and exercise physiology services are all necessary.

A second illustration concerns a 60 year old woman with cognitive developmental delay, acquired brain injury due to previous ECT, borderline personality disorder, chronic anxiety, congenital deafness, failing eyesight, leg lymphoedema, obesity, insulin-requiring type 2 diabetes, severe mobility restriction with dual hip replacement and one shoulder reconstruction, and resultant polypharmacy. The professions required to manage this highly complex case are medical (various), district nurse, psychologist, physiotherapist, occupational therapist, optometrist, audiologist, podiatrist, pedorthist, dietitian and community pharmacist. All of these professionals need to know how to work effectively with a person with cognitive disability, so restricting the list of allied health to speech pathology and psychology is manifestly inadequate.

The agreed competencies should be developed using an evidence base of core knowledge and skills, and through consulting key stakeholders with relevant experience and expertise.

The competencies agreed across health professions should not only relate to the healthcare of people with cognitive disability – they should also be embedded across the entire curricula. This would encourage and facilitate everyday collaborative practice across service boundaries.

Proposition 6: Core education and training in university and vocational study

AHPA supports initiatives to strengthen university curricula to be inclusive of cognitive disability and to incorporate education about cognitive disability as early as possible in health degrees.

Without devaluing core education and training, we also note that university and vocational skill acquisition and development must be adequately supported and extended in subsequent practice. This needs to be consistent across professions (see our submissions in response to Proposition 10).

Proposition 7: Supervised clinical placements

AHPA supports appropriately funded mapping of current clinical placement opportunities in allied health.

We strongly support Recommendations 4 and 5, including targeted funding to facilitate and expand the range of high quality supervised clinical placements in allied health. Such placements are currently lacking in allied health outside hospital settings, due to the lack of financial provision for such strategies through the NDIS and the limited resources of private allied health providers. In further support of Proposition 5, AHPA proposes that education providers be encouraged to develop interprofessional clinical placement opportunities.

Proposition 8: Review of accreditation standards

AHPA supports this proposition, but we strongly advocate for broadening Recommendation 6 to include all allied health professions in scope for a competency framework, including allied health assistants. We also argue for the need to also consider disability support workers and the aged care workforce as being in scope (see our submissions in response to Proposition 1).

We support review of accreditation standards by the relevant authorities to ensure consistency with required cognitive disability competencies, but requirements for review must encompass those allied health professions that self-regulate as well as those that are regulated under AHPRA.

Consistent with our submissions in response to Proposition 1, we anticipate that accreditation standards will differ according to the profession and the competency levels relevant to particular roles.

Amendment of accreditation standards and requirements will also require an implementation strategy with a period of transition.

Proposition 10 Continuing professional development

AHPA supports this Proposition on the basis that CPD for health professionals with respect to the care and treatment of people with cognitive disability will contribute to increasing awareness of the needs of people with cognitive disability and result in appropriate modifications of environment and practice. This is also vitally important to ensure students and new graduates are placed in environments which enhance their understanding and practice in relation to cognitive disability.

We propose a recommendation which encourages education providers to review, develop and promote relevant CPD resources to ensure consistency with the forthcoming competency standards, including the various levels required (see our submissions in response to Proposition 1).

As submitted in response to other propositions, it is important to facilitate this provision of CPD for the full range of workers with people with cognitive disability. With respect to allied health, the range of relevant allied health professions is broader than psychology and speech pathology, and CPD considerations must encompass both self-regulated professions and those regulated by AHPRA. If all professions are learning the same principles in their multidisciplinary settings, this provides consistency and a safer environment for the person with cognitive disability. There is no point in the speech pathologist being fully competent and appropriate if the physiotherapist in the same clinic, seeing the same patient, has had no training at all.

Proposition 11: Resources

AHPA supports initiatives to facilitate collaboration and working relationships across accreditation authorities and education providers (Recommendation 8).

More specifically, we support the establishment of some form of network of Centres of Excellence on cognitive disability, together with enhancing access to shared resources, including a national online repository available to all health professionals.

While these mechanisms are being considered and developed, a more holistic approach to treating people with cognitive disability could be enhanced by a recommendation for facilitation of a network of ‘practice leaders’ on cognitive disability drawn from each health profession.

With regard to Recommendation 9, we refer to our submissions in response to Propositions 2 and 8.