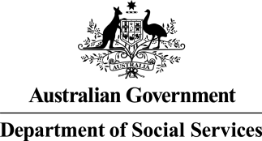


Tasmanian Allied Health Workforce Supply Project

Use of Allied Health Assistants in the Tasmanian Disability Sector

**** Funded by the Australian Government Department of Social Services 

# Background

NDS has received NDIS Sector Development Funding from the DHHS (Tasmania), to develop and implement strategies to increase the supply, utilisation and capability of the allied health and disability support workforce. Extending from this, it is hoped that people with disability and developmental delay with NDIS plans in regional, rural and remote Tasmania will have access to adequate and relevant therapy supports in order to achieve their goals.

One of the agreed project outcomes is the establishment of traineeships in Certificate IV Allied Health Assistance, as it has been shown elsewhere that allied health assistants (AHAs) can provide a range of supports that extend and facilitate the role of the allied health professional (AHP).[[1]](#footnote-1) [[2]](#footnote-2)

To ensure that these traineeships are targeted appropriately, barriers and opportunities in the use of AHAs in the Tasmanian disability sector were investigated through project stakeholder engagement activities (see community and clinician forum reports for full details).

This report provides a brief summary of relevant findings and suggests a viable model for targeting and implementing the planned AHA traineeships within available project timeframes and resources.

# What is happening now?

Whilst the use of AHAs in the disability sector has been limited historically, it is expected to increase now that funding is available for AHAs to deliver therapy supports under a participant’s NDIS plan. The Federal Government has signalled that allied health assistants are a favoured form of workforce innovation by including them as a priority for the Innovative Workforce Fund, and several state governments have projects to encourage their use in disability. Currently however, anecdotal evidence suggests that their use remains low compared to the health and aged care sectors.

Project stakeholder engagement has revealed that St Giles is the only provider that employs the use of AHAs in the Tasmanian disability sector. Whilst St Giles had been doing this for a number of years, they report that NDIS funding has now allowed their AHAs to increase their scope, and that the demand for AHAs to deliver therapy supports has increased to the point where they are now increasing their AHA workforce.

St Giles is a large, established not for profit disability support organisation (DSO) that provides a variety of supports (including therapy) for both children and adults with disabilities and developmental delays. They actively support their AHA workforce to gain their Certificate IV in Allied Health Assistance by collaboratively working with TasTAFE. They also provide regular formal supervision, and opportunities for professional development. They acknowledge that this is possible because they have a large and cohesive multi-disciplinary therapy and management team structure.

The following section outlines the barriers to extending the use of AHAs in the Tasmanian disability sector more broadly.

# Barriers in the use of AHAs in the Tasmanian disability sector

Project engagement has uncovered significant contention in the use of AHAs to provide therapy supports in the disability sector. This push back is largely coming from AHPs within the sector.

Whilst many AHPs recognise that under certain conditions AHAs can play a role in delivering therapy and in extending therapy reach and effectiveness, very few have expressed interest in working with AHAs and supporting their role in the provision of therapy in the disability sector.

Where interest has been expressed, it has been with the caveat that there is currently a lack of clarity regarding how AHAs will provide supports under the NDIS, and the viability of the idea is questioned due to limited resourcing. Specific areas of concern are listed below.

## NDIS pricing

The 2017/2018 NDIS pricing for the AHA line item ($41.71) is $3 lower than a standard disability support worker (DSW) rate ($44.72)[[3]](#footnote-3). Providers report this makes it difficult to justify the time and resources they perceive are needed to support the role of the AHA.

“I would like to understand the viability of a model that uses AHAs more - at the current rate this seems unlikely” (Clinical manager)

Additionally, it is recognised that tasks involved in supporting the role of the AHA do not always occur within client facing time, and the inadequacy of funding within NDIS plans for non-client facing time is regularly raised as a barrier by AHPs and providers.

These are issues NDS has raised in pricing discussions with the NDIA for some time.

## Quality assurance and risk management in a resource constrained setting

When a therapy task is delegated to an AHA, the AHP is responsible for assessing the appropriateness of the task to be delegated, ensuring the AHA is capable of undertaking the task, and providing appropriate training and supervision. The AHP then remains accountable for the completion of the task once it has been delegated.

In order to successfully manage this relationship and the risks involved, it is recognised that the AHP in question should have experience in delegation and supervision, and have the time and resources required for training and supervision activities made available to them.[[4]](#footnote-4) [[5]](#footnote-5)

During engagement activities several AHPs raised their concern that AHAs may go beyond their scope if not adequately supported and monitored, therefore placing vulnerable clients at risk.

Many AHPs feel that the Tasmanian disability therapy sector is insufficiently resourced to undertake the tasks outlined above, whilst effectively managing risk and delivering quality therapy supports. Much like the rest of Australia, the Tasmanian disability sector is in a state of flux as the NDIS rolls out. Existing therapy providers are undergoing a process of significant change and new providers in the market are still finding their feet.

“(With the introduction of AHA) you are adding additional complexity in an already unstable market” (Tasmanian AHP working in disability sector)

Tasmania is further challenged by the thin market due to the geographically dispersed population and short supply of AHPs due at least in part to the fact that several AHP occupations in demand under the NDIS (occupational therapists, speech pathologists, podiatrists and physiotherapists) need to be recruited from outside the state, as university preparation for these occupations is not available in Tasmania.

Reflecting this, most registered NDIS therapy providers in Tasmania are small or sole providers. Many are new to the private or not for profit space having historically worked in government services that are in the process of being disbanded through the NDIS roll out process.

Most existing DSOs in Tasmania either do not have a therapy workforce, or have only one or two AHPs on staff. There is limited capacity within the sector to support a new AHA workforce, given the associated resource commitment required. St Giles is the exception, rather than the norm as they are a multifaceted organisation with access to both state and federal government funding (in addition to NDIS funding packages), as well as significant philanthropic and private funding sources. They have large multi-disciplinary allied health teams in several locations around the state that work across several specialised skill areas including but not limited to early intervention, rehabilitation therapy, and the provision of seating and specialised equipment.

The idea of using community based AHAs in rural and remote communities in Tasmania where AHPs do not currently have a strong presence drew a particularly strong push back from many AHPs. There was a similar response to the idea of AHAs working in organisations without strong links with AHPs.

“I am concerned that not enough attention will be paid to establishing well-structured services…I don't think it is enough to expect that 'good relationships' will be established between AHAs and consultant AHPs” (AHP who has worked in rural Tasmania)

In spite of the significant barriers, there is some recognition of the potential benefits for the use of AHAs or a similar role to improve therapy services and address some of the issues being experienced in the disability sector. Ideas and areas of opportunity are provided in the following section.

# Areas of opportunity for AHAs in the Tasmanian disability sector

In spite of the resistance outlined above, most AHPs were able to come up with a number of therapy tasks they would be happy to delegate to an AHA when asked. They also came up with the following possible benefits to the use of AHAs without any additional prompting:

* Health literacy – increase general community knowledge of health
* Communication with community members regarding available services
* Helping clients navigate the NDIS
* Local contact to set up technology and facilitate communication with the AHP

Of those issues with therapy provision in the disability sector that were identified through project stakeholder engagement, AHAs could be one way to address the following:

* General lack of allied health service availability in rural and remote areas
* Allied health services that are available aren’t always person centred or appropriate for people with disability and developmental delay
* Lack of appropriate supports for behaviour management
* Lack of knowledge on allied health professionals’ role in supporting people with disabilities and developmental delays
* Lack of information about allied health service availability
* Lack of support for effective working relationships between AHPs and the disability support workforce

In contrast with the resistance from many AHPs, the idea of increasing the use of AHAs in the disability sector to extend therapy reach was generally well accepted by regional rural and remote community members during engagement activities. DSOs also expressed enthusiasm for the establishment of an AHA like role within their organisation as a way to improve linkages between their services and AHPs who have sought after skills and knowledge.

Several AHPs in the private or not for profit disability sector also described how much they rely on establishing good relationships with local supports for clients in more rural and remote areas as they aren’t always able to carry out outreach visits due to time and financial restrictions. Lack of support for travel to therapy services was also a common issue raised by community stakeholders.

Several AHPs that currently informally collaborate with disability support workers (DSWs) to deliver therapy supports to NDIS clients expressed their concern that many DSWs lack the skills needed to carry through therapy recommendations. A desire was also expressed by AHPs to improve relationships and connections with DSWs in order to improve therapy outcomes for clients, as they are a local support that knows the client and context well and are well placed to implement supports.

# Summary

Given the current weakness of support from AHPs in advancing the role of AHAs in the disability sector, a staged approach to training is likely the most viable way forward right now. We believe that full use of AHAs can be made in the disability sector, but this needs to be done gradually. It is clear that significant groundwork is needed to support the establishment of a stand-alone AHA role.

NDS suggests that rather than pursuing formalised Australian apprenticeship traineeships in Certificate IV Allied Health Assistance, training should begin with a skill set providing an introduction to allied health and the role of the AHA. This could then progress to a full traineeship as the role becomes clearer and firm supports and connections with AHPs are established.

To maximise traction, this training could be specifically targeted at experienced DSWs that are employed by NDIS registered DSOs. DSWs are already a sustainable layer in the disability workforce, and interact with AHPs on a regular basis in supporting people with disability. Both DSOs and AHPs have expressed a desire to strengthen connections between AHPs and DSWs in order to improve client outcomes. We anticipate that DSOs and AHPs will see the benefit of the emerging AHA role, as therapy supports are more appropriately directed and implemented.

Another possible cohort that could be targeted for this training is workers in the early childhood space who interact with children with developmental delay/disability, including childcare and early childhood education workers. This will be explored further.

As such this strategy addresses a utilisation issue, by aiming to strengthen the impact of therapy services, rather than addressing a therapy supply issue. This is further detailed in the following section.

## Current model

The model in figure 1 shows the current therapy relationship where the connection between the AHP and DSW is one way and tenuous. Given the current sector context, this could result in several issues including: not recognising a need for therapy where one exists, therapy that is not person-centred, or therapy recommendations not being implemented appropriately.

Figure 1 Model of therapy support when the DSW has no additional training

Symbolic diagram using circles to show the person with disability at centre with incomplete arrows connecting them with the DSW/DSO and AHP. The arrow between the AHP and DSW is also incomplete and there is no arrow between the DSO and the AHP.

## Proposed model

The models in figures 2 and 3 show the strengthening of therapy when the DSW receives training in therapy skills, and a formal relationship is established between the AHP and the DSO. The therapy relationship is now two-directional; where a need for therapy exists it is more likely to be recognised, therapy is more person-centred and follow-up is improved.

Figure 2 Model of therapy support when DSW receives training and AHP employed by DSO

Symbolic diagram using circles to show the person with disability now connected to the 'upskilled' DSW and AHP with one solid 'strong' arrow. The arrow between the AHP and the up-skilled DSW is also solid and both now overlap with the DSO.

Figure 3 Model of therapy support when DSW receives training and AHP/s contracted by/consultant to DSO

Symbolic diagram using circles to show the person with disability now connected to both DSW and AHP with one solid 'strong' arrow. The arrow between the AHP and DSW is also solid and there is now a solid arrow between the DSO and the AHP where there was no connection before.

In order to maximise the sustainability and effectiveness of training inputs these DSWs should be experienced and of high quality, ideally they will already have completed a Certificate III in Individual Support (Disability), as there is significant cross over between this and the Certificate IV in Allied Health Assistance.

A commercial relationship would also need to be established between the DSO and the AHP, either through a contracting or consulting agreement or by being directly employed in their service. Given that DSWs are already employed by the DSO and providing individual supports, there may be more flexibility in therapy billing arrangements, negating the issue of the lower pay rate for the AHA line item. That is, the advanced skills could be used during support hours and not necessarily as an AHA.

Given limited project time frames and resources, the pricing issues, and the limited support for the use of AHAs from AHPs unearthed through project engagement, this proposed model presents the most viable way forward right now.

# Recommendations

1. Training for AHA be run as therapy skill set training to provide an introduction to allied health and the role of the AHA, rather than a more formal traineeship in Certificate IV AHA.
2. Training to be targeted at interested NDIS registered DSOs with AHPs already on staff, or those planning to take on AHPs either through direct employment or through a contract arrangement.
3. Training will be available to people based in all areas in Tasmania outside of Hobart (regional, rural and remote areas of the state).
4. Support to be offered to trainees and employers to pursue further enrolment options to complete the full Certificate IV in Allied Health Assistance.

1. Dew, A et al (2014) ‘Local therapy facilitators working with children with developmental delay in rural and remote areas of western New South Wales, Australia: the ‘Outback’ service delivery model’, in the Australian Journal of Social IssuesVol.49 No.3, p 309 – 328. [↑](#footnote-ref-1)
2. Health Workforce Australia (2014) Assistants and support workers: workforce flexibility to boost productivity, Commonwealth Government. [↑](#footnote-ref-2)
3. NDIS Price Guide: Victoria, New South Wales, Queensland, Tasmania. Valid from 1 July 2017 [↑](#footnote-ref-3)
4. Speech Pathology Australia. Position Statement: Working with support workers. 2014 [↑](#footnote-ref-4)
5. Occupational Therapy Australia. Position Paper: The role of allied health assistants in supporting occupational therapy practice. 2015 [↑](#footnote-ref-5)