NDIS Speech Pathology Assessments Explained | Bloom

Canonical:
https://bloom-healthcare.com.au/blog/ndis-speech-pathology-assessment-what-they-look-at-and-why-it-matters/

Details:

An NDIS speech pathology assessment does two things at once. It builds a picture of what is happening with communication and swallowing, and it converts that picture into the evidence the NDIA needs to decide whether support is reasonable and necessary. Under the NDIS, speech pathology covers spoken, non-spoken and signed communication, the use of symbols and augmentative and alternative communication, and swallowing.

This page goes past the process and into the substance: what each domain actually measures and why that matters in daily life, how swallowing risk is handled and when it stops being a therapy question and becomes a safety one, what the report has to contain to survive a plan reassessment, and how a speech pathology assessment differs from the other assessments people are often told to get instead.

If swallowing safety is the reason you are reading this, skip to the swallowing section. Coughing at meals, choking, recurrent chest infections and unexplained weight loss are not things to work through in order.

The domains, and what each one actually tells you

What gets assessed depends on age, goals and what is presenting. A comprehensive assessment usually considers several of the following. The point of listing them this way is that each domain answers a different practical question, and knowing which question you need answered helps you brief the clinician.

Receptive language: does the person understand what is said to them?

Receptive language is the ability to understand spoken and written language. In practice it covers comprehending what others say, following instructions including multi-step ones, understanding vocabulary and concepts in everyday contexts, and processing information from conversations, teaching and written material.

Why it matters functionally: receptive difficulties are routinely misread as not listening, not trying or behaviour. A child who cannot hold a three-part instruction is not being defiant. An adult who agrees to something in a meeting and then does not do it may not have understood it. Assessment separates a comprehension problem from a compliance problem, and that distinction changes what support is appropriate.

Expressive language: can the person get their meaning out?

Expressive language is using words and language to communicate: vocabulary, sentence formation, organising thoughts, expressing needs, wants and feelings, and taking part in conversation.

Why it matters functionally: when a person cannot make needs known, the frustration usually shows up somewhere else, often as distress or escalation. Expressive language findings frequently sit underneath a behaviour support referral.

Speech sound production: can other people understand them?

This covers articulation (producing individual sounds accurately) and phonology (using the sound system of the language correctly, including how sounds combine in words). The functional measure is intelligibility, meaning whether people can reliably understand the person in everyday situations, not whether sounds are correct in a quiet room with a clinician.

Why it matters functionally: intelligibility determines whether a person can be understood by strangers, at a counter, on the phone, or by a support worker who is new that week. That is a participation issue, not a cosmetic one.

Social communication and pragmatics: can they use language in context?

Pragmatic language is the social use of language: turn-taking, reading cues and body language, staying on topic, and adapting how you speak to different people and settings.

Why it matters functionally: someone can have intact vocabulary and grammar and still be unable to hold a conversation, keep a job or maintain friendships. Pragmatic findings often explain why a person with apparently good language is socially isolated.

Voice and fluency

Voice covers pitch, volume and vocal quality, including whether the person can be heard at appropriate loudness without strain or hoarseness. Fluency covers the smoothness and rhythm of speech, including stuttering.

Why it matters functionally: voice problems can make speaking physically uncomfortable and limit how long someone can communicate before fatiguing. Fluency difficulties affect confidence and willingness to speak, which shows up as avoidance rather than as a speech complaint.

Literacy and phonological awareness

Where relevant to age and presentation, assessment can cover reading comprehension and decoding, writing and spelling, and phonological awareness, which is the ability to hear and manipulate sounds within words and is the foundation for reading.

Why it matters functionally: literacy difficulty limits access to written information, which increasingly means access to services, forms, transport and work.

Feeding and swallowing

Covered in its own section below, because the stakes are different.

Swallowing: the part of the assessment with safety consequences

Dysphagia means swallowing and feeding difficulty. It can arise from conditions including stroke and Parkinson's disease, and it is common in older adults, but it also affects children and adults with disability.

The signs that warrant prompt assessment

Coughing during or after meals or drinks

Choking episodes

Recurrent chest infections

Significant or unexplained weight loss

Wet or gurgly voice after eating or drinking

Meals taking much longer than they used to, or food being avoided

If these are present, this is a priority area to address quickly through the right clinical pathway. It should not wait behind a communication goal in a queue.

Why it is a safety issue and not only a comfort one

Aspiration is when food or fluid enters the airway instead of going to the stomach. It can lead to aspiration pneumonia, which is a serious complication. Untreated swallowing difficulty also drives malnutrition, weight loss and dehydration, and it reduces quality of life by making mealtimes stressful and social eating something to avoid.

One thing worth understanding, because it changes what a good plan looks like: aspiration risk is not determined by swallowing mechanics alone . Oral hygiene, general health, mobility and medications all influence it. That is why a plan that only modifies food textures, and does nothing about mouth care or positioning, is an incomplete plan.

What a swallowing assessment involves

A clinical swallowing assessment brings together:

Case history , covering medical background, previous swallowing or eating concerns, medications and any history of chest infections

Physical examination of the mouth and throat muscles, to check structure and muscle function

Observation of eating and drinking , watching the person manage different foods and fluid consistencies in a realistic setting

From that, the speech pathologist identifies the nature and severity of the impairment and determines which food and fluid consistencies are safe.

What comes out of it

The usual output is a Mealtime Management Plan : a personalised set of strategies covering swallowing techniques, positioning to optimise swallowing mechanics, adaptive equipment, muscle-strengthening exercises where they are indicated, texture-modified food and fluid specifications, and guidance for the people who support the person at meals.

This is normally developed with a dietitian involved, because texture modification changes what a person can physically get into their body. The speech pathologist sets the safe consistencies. The dietitian makes sure that within those consistencies, nutrition and hydration stay adequate. Neither profession can do the other's half well.

A swallowing assessment with a mealtime management plan is a bigger piece of work than a single session. It usually involves observation across more than one setting, liaison with family, support coordinators and other clinicians, the written plan itself, and training so support workers apply it the same way every time. Plan and fund it as a package rather than as one appointment.

Augmentative and alternative communication, and the evidence for assistive technology

Where speech is unreliable or absent, the assessment considers AAC. The NDIS recognises that speech pathologists support the use of symbols and assistive technology, including augmentative and alternative communication methods.

An AAC assessment works through four separate questions, and they are separate on purpose:

What does this person need to say? Mapped against actual daily settings: home, school, work, community. Not a theoretical vocabulary, the real messages.

What access method works? Touch, switch access, eye gaze, or partner-assisted scanning. Motor control, vision, cognitive processing and fatigue all bear on this, and the answer is found by trialling rather than by assuming.

Which system fits the person and their settings? Trials compare devices and apps on navigation, speed of message generation, how vocabulary is organised and customised, compatibility with the chosen access method, portability, durability, and whether it holds up in the places it will actually be used.

Who needs training, and in what? Communication partners include family, educators, support workers, peers and employers. Partner training is as decisive to the outcome as the device, which is why it belongs in the report and not in a follow-up email.

The assessment also looks at how the person handles real exchanges: initiating with unfamiliar people, taking turns, and repair strategies , meaning what they do when they are misunderstood. A device that produces messages but leaves the user stuck the moment communication breaks down has not solved the problem.

For the funding request, the NDIA requires sufficient evidence to decide what is reasonable and necessary for assistive technology. The strongest evidence is formal assessment data (standardised language results, communication samples across contexts, documented functional limits, a recorded baseline) and trial data (how the person performed with the recommended system compared with the alternatives, and confirmation of the access method). Contextual material such as school reports, medical records and carer observations supports the case but does not replace those two.

What the report has to do, and why format decides outcomes

The NDIA has said reports for plan reassessment should explain the therapy approach and provide evidence of outcomes achieved and progress made toward goals. That sentence is doing a lot of work, and it is the reason report structure is not an administrative detail.

A strong report makes six things easy to find:

The goals and the functional impact day to day. Written as what is hard in ordinary life, with the link to disability visible.

What was assessed and what the findings mean functionally. A standard score with no translation into daily life is close to useless to a delegate.

What has already been tried , including what did not work and why. This is the part most reports omit, and it is the part that answers the value-for-money question.

Measurable outcomes , with a baseline and targets, so progress can be measured against something recorded rather than remembered.

Recommended frequency and focus of support, tied explicitly to the goals.

AAC and assistive technology recommendations where relevant, with evidence of suitability and expected benefit.

The four reasonable and necessary considerations sitting behind all of this are whether the support relates to the disability, whether it is likely to be effective and beneficial, whether it represents value for money, and what other supports are already available, including informal support from family and community.

The practical implication is blunt. Ask for the baseline to be recorded at the first assessment. A report written twelve months later cannot demonstrate progress that nobody measured at the start, and no amount of good writing fixes that afterwards.

How this assessment differs from the ones people confuse it with

Families and support coordinators are often told to get an assessment without being told which one. These answer different questions.

Assessment	Answers	Reach for it when
Speech pathology	Communication and swallowing: understanding, expression, speech clarity, social use of language, voice, fluency, literacy, swallowing safety	Communication or swallowing is affecting daily function, learning, work, participation or safety, or AAC is being considered
Occupational therapy functional capacity assessment	Daily living function across personal care, mobility, community participation, work and leisure, and the physical, cognitive and emotional factors behind them	You need broad evidence of how disability affects everyday functioning, including for housing or home modification decisions
Psychology assessment	Mental health, emotional regulation, cognition and behaviour, including neuropsychological testing of attention, memory and intellectual function	Mood, anxiety, trauma, cognition or behaviour is the barrier, or a diagnostic question needs answering
Paediatric developmental assessment	Overall development across domains as a baseline	Concerns are broad or unclear and you need to know which specific assessment to pursue

They overlap, and often more than one is needed. A child with autism and communication difficulty might need speech pathology for language and AAC suitability, occupational therapy for daily living and self-care, and psychology for emotional regulation. They are not substitutes for one another, and one report will not stand in for another at a plan reassessment.

Timing, sessions and what to expect

Speech Pathology Australia indicates assessments take 30 to 60 minutes on average, with some running over an hour and, in some cases, sessions of up to three hours. Multiple sessions are often needed. Complexity drives this: a single articulation question is not the same job as a language, literacy and AAC question, or a swallowing question requiring observation across settings.

Assessment can be delivered in person, by telehealth, or as a combination, and can draw on input from family and from school where relevant. Telehealth suits interviews, some language tasks and review. Swallowing observation and AAC access trials generally need someone in the room.

One factor the origin article touches on but which is worth stating plainly: the environment is often part of the barrier . Noise, time pressure, sensory load, unfamiliar communication partners, device availability and routine all change how a person performs. An assessment done only in a quiet clinic room can overstate ability. If the difficulty happens at school pickup or in a busy kitchen, say so and ask

for observation where it actually occurs.

Where the assessment fits outside the NDIS

Speech pathology is not only an NDIS service, and the funding source determines the rules.

The NDIS primarily serves people under 65 with disability. Participants already in the scheme when they turn 65 are not automatically moved out, and are not automatically transferred to aged care.

Support at Home is the Australian Government's in-home aged care program for older Australians, generally 65 and over, and 50 and over for Aboriginal and Torres Strait Islander people. It commenced on 1 November 2025, replacing the Home Care Packages Program and the Short-Term Restorative Care Programme. Speech pathology is available under it as a clinical allied health service delivered in home and community settings.

For older adults, the clinical picture often differs from disability-related communication needs. Vocal cords lose elasticity and lung capacity falls, producing hoarseness and reduced volume. Swallowing muscle changes raise the risk of malnutrition and aspiration pneumonia. After stroke, therapy is generally about restoring lost communication and swallowing function. In dementia, the aim shifts to maintaining ability for as long as possible and building compensatory strategies, including cognitive-communication work on attention and memory. In Parkinson's disease, voice and swallowing are both commonly affected, and specific voice programs such as Lee Silverman Voice Therapy are used.

If you are moving between systems, do not assume anything carries across. Categories, evidence expectations and reporting requirements are set separately by each.

Preparing well, and what to bring

The origin article has a good checklist. Two additions that materially change the quality of the assessment:

Bring examples with dates. Not "he has trouble with instructions" but "on Tuesday he was asked to get his bag, put his shoes on and line up, and he got the bag and stopped". Specific, dated, repeated examples are what turn into functional findings.

Bring the failures, not just the difficulties. What has already been tried, and what stopped working, is the single most useful thing you can hand a clinician, and it is what the NDIA looks for when weighing whether further support is likely to be effective.

Access

Bloom Healthcare's Speech Pathology team works with children and adults across communication and swallowing, in homes, schools, the community and by telehealth, and coordinates with occupational therapy, physiotherapy, psychology, positive behaviour support and dietetics where the goals overlap. There are also dedicated Sydney speech pathology and aged care speech pathology pathways.

To start, use the referral form or call 1300 771 465 . Referrals come from participants, parents and carers, support coordinators, GPs, paediatricians, schools, supported independent living providers and community teams.

Common questions about NDIS speech pathology assessments

Do I need an assessment before speech pathology goes into my plan?

When you ask for therapy supports to be included, the NDIA expects an assessment or report from your therapist, and it may request further assessment and reporting. Without a report there is little for a delegate to weigh against the reasonable and necessary criteria.

How long does an assessment take?

Speech Pathology Australia indicates 30 to 60 minutes on average, with some assessments running over an hour and, in some cases, sessions of up to three hours. Multiple sessions are common where language, literacy, AAC or swallowing all need attention.

Is swallowing really part of speech pathology?

Yes. NDIS therapy supports guidance covers speech pathology for both communication and swallowing disability support needs. Swallowing and mealtime work is a core part of the profession, not an add-on.

What should I do if my child or the person I support is coughing at meals?

Treat it as a priority and raise it directly rather than adding it to a general referral. Coughing with meals, choking, recurrent chest infections and unexplained weight loss all point to possible aspiration risk, which can lead to aspiration pneumonia. Ask for the swallowing question to be assessed through the right clinical pathway first.

Will texture-modified food fix a swallowing problem?

It is part of the answer, not the whole answer. Aspiration risk is also influenced by oral hygiene, general health, mobility and medications, so a plan built only on thickened fluids and modified textures is incomplete. Texture modification also changes nutritional intake, which is why a dietitian is normally involved to keep nutrition and hydration adequate within the recommended consistencies.

Can a speech pathology assessment support an AAC or assistive technology request?

Yes, and it is often the backbone of the request. The NDIA requires sufficient evidence to decide assistive technology is reasonable and necessary. The strongest material is formal assessment data plus documented trial results comparing the recommended system against alternatives, along with the confirmed access method and the training needs of communication partners.

What is an access method, and why does it get its own assessment?

It is how the person physically operates the system: touch, switch access, eye gaze, or partner-assisted scanning. It depends on motor control, vision, processing and fatigue, and it cannot be assumed from a diagnosis. Getting it wrong is the most common reason an expensive device ends up unused.

Why do reports matter so much at plan reassessment?

Because the reassessment applies the reasonable and necessary test again. A report that shows goals, functional impact, what was assessed and what it means, what has been tried, measured outcomes against a baseline, and a justified recommended frequency, gives the delegate what they need. A report that records attendance does not.

What if nobody recorded a baseline at the start?

Then progress cannot be demonstrated for that period, and no report can retrofit it. The practical fix is to record a baseline now so the next reassessment has something to measure against. Ask for it explicitly at your next appointment.

Do I need a speech pathology assessment or an occupational therapy functional capacity assessment?

They answer different questions. Speech pathology covers communication and swallowing. An occupational therapy functional capacity assessment covers daily living function across personal care, mobility, community participation, work and leisure. If the barrier is understanding, being understood, or eating and drinking safely, you need speech pathology. If it is broad daily functioning, or a housing or home modification question, you need the functional capacity assessment. Sometimes both.

Can the assessment be done by telehealth?

Partly. Case history, functional interviews, some language tasks and review sessions work well remotely. Swallowing observation and AAC access trials usually need to be in person, in the setting where the difficulty happens.

Does speech pathology stop at 65?

No. NDIS participants already in the scheme when they turn 65 are not automatically transferred out. Older Australians who are not NDIS participants can access speech pathology as a clinical allied health service through Support at Home, the in-home aged care program for people generally aged 65 and over, and 50 and over for Aboriginal and Torres Strait Islander people, which commenced on 1 November 2025 in place of Home Care Packages and Short-Term Restorative Care. The rules and evidence expectations are set separately by each system.

What can speech pathology not do?

It cannot diagnose or manage the underlying medical condition, order imaging, or replace medical review where a swallowing problem may have a medical cause. It also cannot answer occupational therapy, psychology or dietetic questions. Where those overlap with a communication or swallowing goal, the speech pathologist should be coordinating with the relevant clinician rather than working around them.

What is the topic of this Bloom Healthcare blog post?

The blog post, titled 'NDIS Speech Pathology Assessment: What They Look At and Why It Matters,' explains what NDIS Speech Pathology assessments cover, what reports include, and how the results support participant goals.

What is an NDIS speech pathology assessment?

An NDIS speech pathology assessment is a comprehensive evaluation designed for NDIS participants seeking support for communication or swallowing difficulties within the National Disability Insurance Scheme framework.

Who conducts NDIS speech pathology assessments and what are they trained to do?

Speech pathologists conduct these assessments. They are highly trained allied health professionals who assess, diagnose, and treat a wide range of challenges related to speech, language, voice, fluency, and swallowing using evidence-based practice.

In what settings do Australian speech pathologists work?

In Australia, speech pathologists work across diverse settings including hospitals, community health centres, private practices, schools, and aged care facilities, supporting people of all ages from children developing language skills to older adults managing swallowing disorders.

How does Speech Pathology fit into the NDIS as a therapy support?

In the NDIS, Speech Pathology is a therapy support that can help with communication and swallowing disability support needs, including spoken, non-spoken and signed communication, and the use of symbols and augmentative and alternative communication methods.

What are the two critical functions of a good NDIS speech pathology assessment?

A good NDIS speech pathology assessment clarifies the communication and/or swallowing profile by identifying what is happening, where, and why it is difficult, and it links findings to functional outcomes and NDIS goals so that supports are more likely to be considered reasonable and necessary by the NDIA.

What is one key component included in a structured NDIS speech pathology assessment?

One key component is case history collection, which involves gathering extensive background information including medical history among other details.

Do speech pathologists work alone or with other professionals when supporting NDIS participants?

Speech pathologists often collaborate as part of a multidisciplinary team with other allied health professionals, such as occupational therapists and psychologists, to provide holistic care.

Who publishes this article and what is Bloom Healthcare's role?

The article is published by Bloom Healthcare, a boutique disability and aged care allied health provider that focuses on evidence-based practice and client-centric care delivered by highly qualified health practitioners across Australia.

Receptive language: does the person understand what is said to them?

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