



HUNTER NEW ENGLAND
NSW HEALTH

Rural speech pathologists' perceptions of working with allied health assistants: A pilot study

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List of Abbreviations and frequently used terms:

SP: Speech Pathology / Speech Pathologist

AHA: Allied Health Assistant

AH: Allied Health

AHP: Allied Health Professional

SPA: Speech Pathology Association of Australia Ltd. (Australia)

RCSLT: Royal College of Speech and Language Therapists (England)

ASHA: American Speech and Hearing Association (US)

HNE Health: Hunter New England Health, NSW, Australia

NSW Health: New South Wales Health, Australia

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1 Abstract

Background: Speech pathology (SP) has significant recruitment and retention problems particularly in rural and remote areas. Some allied health disciplines address this problem by employing allied health assistants (AHAs) to deliver clinical services.

Aims: To examine rural SPs' perceptions of working with AHAs in providing clinical services.

Method: Semi structured interviews were conducted with eight rural SPs. Questions probed perceptions of role, supervision, budget and resource management, accountability, workload and productivity, skills, training and rural issues. Transcripts of the interviews were analysed to identify key themes.

Results: High agreement was reported regarding gaps in skills and knowledge for SPs regarding AHA supervision and delegation, lack of exposure to AHAs and a need for training in such skills. Participants perceived a lack of understanding of the SP role by management and the wider community as well as poor consultation regarding the introduction of AHAs into the health service. Considerable variation was evident regarding overall perceptions of working with AHAs, and potential tasks they could perform.

Conclusions: SPs need consultation and training with regard to working with and supervising AHAs. Increasing SPs' exposure to AHAs and standardising the role of AHAs may provide a way forward in this workforce redesign.

Key Words: Speech pathology, allied health assistants (AHAs), workforce, rural and remote, perceptions.

2 Executive Summary

Within NSW there is significant activity surrounding Allied Health Assistants (AHAs) and the implementation of AHA programs. The most significant to the current project is the Rural Allied Health Assistant (RAHA) project. The RAHA project is being conducted to examine roles of AHAs, career pathways and training frameworks with the aim of addressing the shortage of rural allied health professionals ^[1]. The current project was undertaken to allow speech pathology (SP) to contribute to this discourse regarding the potential implementation of AHAs in rural allied health services, as the discipline is considerably under-represented in the literature to date ^[2,3].

The current project was conducted with the support of the NSW Institute of Rural Clinical Services and Teaching via a Rural Research Capacity Building Program and Hunter New England Health (HNE Health). It aims to inform and contribute to work being conducted by HNE Health workforce personnel. It is hoped that this research may be used to help shape the implementation of an AHA program for rural SP and potentially other rural allied health services.

The current research describes rural SPs' perceptions to utilising both generic and discipline specific AHAs, and identifies some of the barriers and benefits to implementing this potential workforce redesign. The main barriers include industrial complexities such as budget and resourcing, while the main benefits described include improving therapy intensity and decreasing SP's large clinical caseloads. It is intended that this information be presented to appropriate bodies such as workforce planning, SP discipline managers, allied health/ health service managers, SP training programs, and to Speech Pathology Australia (SPA) to address these issues on a larger scale.

The following recommendations have been made from interpretation of results;

Recommendation One:

All participants identified a gap in skills and knowledge with regard to working with AHAs. It is therefore recommended that area health services provide ongoing training and support for SPs regarding;

- How to most effectively utilise the skills of an AHA
- How to provide supervision to an AHA

Recommendation Two:

Most participants identified a lack of exposure to AHAs. Research shows that exposure to AHAs improves perceptions and skills with regard to working with AHAs. It is therefore recommended that clinical placements with AHAs be considered across NSW Health to increase undergraduate SP students' exposure to AHAs. This will require consultation between NSW Health and tertiary SP program co-ordinators.

Recommendation Three:

Participants reported concern regarding clinical outcomes and patient / client / family concerns regarding working with AHAs as opposed to SPs. It is

recommended that future research takes into consideration other stakeholders such as patients, clients and families, management and AHAs themselves with reference to SP interventions being delivered by an AHA.

Recommendation Four:

SPs perceived poor consultation and consistently reported feeling marginalised and powerless regarding AHA program planning. Therefore, it is recommended that a communication strategy be devised to inform SPs across area health services of the rationale and context of an AHA program. It is also recommended that a participative approach be adopted between the AHS and SP in planning for an AHA program, in order to ensure the needs of SPs and individual services are represented.

Recommendation Five:

Perceptions were not uniform regarding what an AHA can or cannot do within a SP caseload. Also, participants reported there were specific service needs associated with being in a rural or remote region. It is therefore recommended that area health services collaborate with individual services to address specific issues regarding rural practice. The needs of clinicians and the community in these areas can be addressed to create appropriate education packages for SPs regarding:

- Understanding the role planned for SP AHAs in rural areas
- Understanding the job descriptions created for SP AHAs
- The role of the SP with regard to working with AHAs

The results of this study reinforce the findings in the multidisciplinary allied health literature regarding perceptions of working with AHAs. This suggests that results may be applicable to a range of allied health disciplines that do not traditionally utilise AHAs in clinical service provision. Given the current results reflected the existing multidisciplinary findings, it is suggested that literature from other Australian states be accessed to assist in shaping any potential AHA workforce in NSW. Increasing SPs' knowledge of working with and improving exposure to AHAs would likely lead to improved perceptions and more positive workplace uptake of this program.

3 Introduction

There is a national shortage of allied health professionals and this has a greater impact on rural areas in terms of recruiting and retaining staff [4-7]. The NSW Rural Allied Health Workforce study (2009) has documented that there is chronic understaffing and high clinician turnover in rural allied health professions [4], resulting in a loss of skills and experience [8]. SP has well documented recruitment and retention issues, and the literature sites poor variety and a lack of career structure as reasons for high levels of attrition [9]. It is documented that 51% of rural SPs surveyed in the Rural Allied Health Workforce Study intended to leave their jobs within the proceeding two years [4]. It is important to look at issues regarding ongoing recruitment and retention of rural SPs in terms of job satisfaction, stress and attrition in relation to the impacts on service provision. [10, 11]

Speech pathology is on the critical skills shortage list, whereby there is evidence that the SP workforce need exceeds supply [10, 12-17]. As such, maintaining and increasing the SP workforce is vital for the ongoing provision of clinical services. Currently there is limited research regarding how the profession plans to meet this need in the future, and how health services aim to address these probable shortages [10].

Staff retention is a key issue in rural areas for all allied health professions, as it impacts upon the ability to provide sustained and reasonable access to allied health services. [8, 18-20]. There have been studies identifying strategies which have the potential to improve recruitment and retention of allied health professionals. One study by Schoo, Stagnitti, Mercer & Dunbar (2005) indicates these strategies exist over three domains; personal / individual, organisation, and community [18]. Access to ongoing professional education, personal and professional support and strong communication networks, particularly for new and recent graduates, are discussed in terms of the profound impact they have on an individual's intent to stay. The facilitation of a career structure within an organisation has been associated with enhanced job satisfaction and the ability of communities to have effective partnerships with health services are also associated with better retention [18].

Strategies which have been considered to improve recruitment and retention of rural allied health professionals have included increasing the number of rural clinical placements for students, improving education and training for rural clinicians and consideration of alternative service delivery models such as utilising vocationally trained staff including allied health assistants (AHAs) [18]. The emerging roles of AHAs is an area gaining momentum, with significant literature coming from the United Kingdom, United States of America and local papers from Victoria, Western Australia, the Australian Capital Territory and Queensland [3].

Utilising AHAs is an example of a significant workforce redesign which has the potential to improve recruitment and retention of SPs in rural areas by positively contributing to decreasing waiting lists and promoting reasonable workloads [21].

The aim of this workforce redesign is to employ vocationally trained staff to provide clinical support under the supervision of allied health professionals [19]. There is limited literature published regarding SPs utilising AHAs, and even less pertaining to understanding SPs perceptions of working with AHAs.

Utilising generic or discipline specific AHAs is a high priority workforce strategy for NSW Health; however there is minimal research within the state to support the implementation for SP. The speech pathology discipline has been shown to be a significant user of AHA services in other states of Australia and internationally, but the system has not yet been embraced in NSW [22].

In their case study of SPs working through assistants, researchers report that the number of AHAs working with SPs in the UK was expected to grow, but there was very little research on SPs' perceptions regarding this change and the effects that it would have on current working practices [2]. The case study of five SPs used questionnaires and formal interviews with a content analysis to identify key themes. The results of this study showed that the SPs interviewed found working with assistants problematic, despite being well supported in terms of activities and planning time. Some of the difficulties experienced included the need for clinicians to be 'thinking for two', need for improved training for both SPs and AHAs, and management of job satisfaction for SPs [2].

The aim of the current study was to investigate the issues regarding working with AHAs among a cohort of SPs who have had limited access and exposure to AHAs in a rural Australian context. The current study used different methods of data collection and is not a reduplication of the McCartney (2005) study, but reflects on the themes and issues raised within.

The limited research currently available regarding SPs working with AHAs provides little insight into the extent to which this kind of program is likely to be accepted by the profession. The primary aim of the current research is to describe the perceptions of rural SPs to utilising both generic and discipline specific AHAs for clinical service provision. It is also aimed to identify the barriers and benefits to this potential workplace redesign.

4 Background and literature review

The primary aim in the current research is to describe the perceptions of rural SPs to utilising both generic and discipline specific AHAs for clinical service provision, and to identify the barriers and benefits to potential workplace redesign. This research aims to begin a discourse regarding the perceptions of utilising (generic/ profession specific) AHAs for SP within rural areas. The documentation/formalisation of this research will allow SP to participate in future AHA planning and potential implementation. This has important implications for HNE Health workforce planning, and SP as a profession.

Currently there is a clear plan for activities AHAs can perform within physiotherapy, occupational therapy and dietetics, and other Australian states (e.g. WA, VIC, ACT) have SP specific AHA job descriptions. Hunter New England

Health workforce planning has compiled job descriptions and appropriate task lists for AHAs in SP in consultation with SP senior staff. These job descriptions cover a range of clinical settings including adult rehabilitation, community paediatrics and acute settings. Hunter New England Health does not currently employ any SP specific AHAs, and there has been limited exposure of SPs to AHAs within the state.

In addition to the current literature, anecdotal evidence gleaned from rural peer support networks and SP sector meetings have determined some of the issues that are pertinent for rural clinicians in HNE Health. These include large workloads, poor career structure and potential workforce strategies to assist, including AHAs. This project aims to formalise this evidence.

A thorough literature review was conducted to ascertain the existing current research regarding AHAs in Australia and internationally. Given the small amount of literature available with reference to SP and AHAs, the current project is largely based on studies completed with occupational therapy and physiotherapy given their parallels with SP in terms of undergraduate training, work practices and industrial classification. Nursing and medical literature contain pertinent information regarding assistants, changing roles and perceptions of the same, but the professions are vastly different to allied health disciplines. These differences are evident in terms of professional structure with regard to job opportunities, entry into the workplace, work practices, and industrial classifications. There is also wider community knowledge of the role of nursing and medical professions. One of the most significant differences between nursing and allied health in terms of the current research is the practice environment. Allied health professionals often find themselves in professionally isolated roles including sole therapist positions, where the “partners-in-care” model^[23] ensures nursing staff are allocated a team dependent on skill mix^[23-25]. Given these stated differences, medical and nursing literature has not been heavily relied upon.

Five main themes were identified from the literature;

- **Role:** clarity, delineation, job descriptions, discipline specifics
- **Training:** AHAs, SPs, competencies, external facilities
- **Supervision:** delegation, mentorship, new graduates, career opportunities
- **Productivity**
- **Recruitment, retention and industrial issues**

4.1 Role: clarity, delineation, job descriptions, discipline specifics

Given the lack of discipline specific research and literature, the roles of SPs and AHAs are not adequately defined and delineated. This is a significant issue which may impact on SPs’ perceptions of working with AHAs. Speech Pathology Australia (SPA) have identified numerous titles for staff in support roles in the

Parameters of Practice (2007) and recognises the value of these roles within the management of a clinical caseload [26]. The SPA Parameters of Practice specifies roles which are the sole responsibility of the SP and roles which may be successfully delegated to an AHA. This information is also supported by the documentation of the Royal College of Speech and Language Therapists (RCSLT) and is relevant to the development of local policies and procedures with regard to training, employment, supervision, delegation and maintenance of quality service provision [27]. Following on from the concern regarding role delineation are concerns regarding efficacy and supervision, as well as the potential for litigation. These are certainly issues which are addressed in the literature for other disciplines and have a strong bearing on the way that SPs may perceive an AHA program in NSW.

International professional bodies have addressed role delineation and regulation. For example, in the United States, the SP AHA role has been increasingly regulated by state authorities. This requires clarity regarding the differences in ability, training and roles of a SP as opposed to those of a SP assistant. This need for clarity is reflected in the work of the Speech Pathology Association of Australia, who recognises the possibility of unsafe and ineffective service delivery if a clinical governance framework for AHAs is lacking[26]. Speech Pathology Australia recommends a clinical governance framework include definition of the AHA scope of practice, clear position descriptions and risk management plans. To date, there is no such framework for SP [26].

The issue of discipline specific support roles versus the generalist AHA is an important one with little distinction in the literature. Limited evidence is available regarding the role of the non-discipline specific AHA or 'generic' AHA and it is reported that disciplines have created task based descriptions. Discipline specific AHA roles have therefore evolved to fit specific service requirements, rather than being systematically planned [3]. It seems that varied terminology has led to role confusion and a lack of role clarity between AHAs and allied health professionals [3].

The interest in an assistant health workforce over the past decade has resulted in clinician perceptions of pressure from services to utilise AHAs [28]. Goldberg, Williams and Paul-Brown (2002) reported perceived challenges to traditional models of allied health intervention caused feelings of anxiety and stress, pertaining to fears of potential job losses, role replacement or significant role change in allied health professions [21]. These stresses are rarely addressed through a clearly delineated role for AHAs as there are rarely well defined role descriptions [3, 21]. Fear of unknown factors about an assistant workforce may lead to negative rather than positive perceptions.

There are well documented concerns regarding the inappropriate utilisation of AHAs in potentially exceeding or decreasing the scope of the role. There are also concerns that having an inexperienced SP as supervisor may increase this likelihood [3, 21, 26-28]. [Please see theme 3 'Supervision']. Over utilisation or underutilisation of an AHA's skills may result in poor perceptions of the AHA role within the SP team, poor outcomes for patients / clients, and the potential for

ethical, legal and professional issues. This supports the case for a co-ordinated plan for the implementation of an AHA program, and a clearly delineated framework of responsibility [28].

4.2 Formal Training of AHAs: AHAs, SPs, competencies, external facilities

The most significant area of difficulty in researching best practice for planning an AHA program is the lack of a standardised training program and unclear understanding of competencies required for clinical practice^[3]. Given that training for AHAs has no clear minimum standard, training is often a mix of 'on the job' training and vocational education. There are Certificate III and Certificate IV qualifications available in Allied Health Assistance through a number of Registered Training Organisations in Australia (E.g. TAFE), however to date they have not been a mandatory requirement for performing the AHA role. This supports the literature which discusses that AHA roles have traditionally evolved to fit a service's individual needs, and have not been a systematic, planned implementation [3]. To date, research shows no consensus regarding the best way to train AHAs. While the trend seems to lean towards competency based standards, there is poor agreement amongst allied health professionals as to what these competencies should be. A further complicating factor is the issue of discipline specific versus 'general allied health', and for SP, concern for whether these standards are adequate for meeting the increasing complexity of SP caseloads [3, 21, 26-28]. The SPA Parameters of Practice acknowledges the role of support staff in providing SP specific services, but also recognises that the training and experience of these staff is not clearly defined. It is clear that the treating SP must provide appropriate training and supervision to the AHA. It is also clear that the SP ultimately retains all ethical and legal responsibility for the support staff and the tasks that they conduct under the SP's direction [26].

The overarching concern with regard to formal training of AHAs is that without a minimum standard of training required for performing the AHA role, there will continue to be no standardised competencies. While clinicians are not involved in AHA training or are unaware of the competencies that AHAs must achieve, it is not possible to determine if an AHA is equipped to conduct clinical intervention. A recent change to the AHA workforce in Australia has been the addition of increased opportunities for up-skilling existing AHAs through recognition of prior learning and Certificate IV training for new and potential AHAs. There has been increased awareness that this should be recommended training for performing the AHA role. Part of the Certificate IV training includes clinical placements and it is expected that this will increase SPs knowledge of competencies that AHAs need to complete, as well as improving outcomes for AHAs being 'work ready'. Area Health Services are currently conducting recognition of prior learning for existing AHAs to ensure that 'on the job' training and experience is recognised.

As well as AHAs being exposed to clinical settings, the literature addresses the need for SPs to have exposure to AHAs within their undergraduate clinical

placements, as they are graduating with little or no experience in delegating, or effectively using the skills of an AHA [21, 27, 28]. This will have an impact on the training and educational preparation of SP students in the future. However, it remains that without a systematic approach to the training and development of AHAs, and without a system of training and ongoing support for SPs who supervise AHAs, it is not possible to implement a uniform AHA program. This will continue the poor exposure of SP students to AHAs, limiting the ability to develop the skills necessary for successful utilisation [3, 21, 26-28]. Consultation between Area Health Services and tertiary SP programs is needed to address requirements and increase exposure and experience working with AHAs.

4.3 Supervision of AHAs by allied health professionals/ SPs: delegation, mentorship, new graduates, career opportunities

The literature contains little detail regarding supervision of AHAs across roles (e.g. generic versus profession specific), clinical settings, or disciplines. It appears that supervision is largely perceived as an informal arrangement without discipline and/or role specification [3]. Due to the increasing diversity of the SP role, it would be a difficult task to specify supervision ratios between SPs and AHAs in terms of scope of practice across settings (i.e. acute, rehabilitation, community, disability and private sectors). Whilst the SPA Parameters of Practice document encourages the development of 'support structures', it does not specify what this would entail. For example, there is no clarification of whether supervision should be face-to-face, or whether it would involve reflection only versus clinical observation^[26]. The subsequent time commitment for supervision expected of both the SP and the AHA is also unclear. It is important to recognise that the goals of AHA supervision differ to those of supervising a student or colleague, and as such needs to be reflected in job descriptions as well as in the training that SPs receive (see theme 2 – 'training and competencies')^[28-30].

There is a lack of evidence regarding the efficiency and effectiveness of working through an AHA, thus difficult to provide a rationale for clinicians for making delegation decisions. Currently delegation is based heavily on individual opinions, resources, previous experience and guidelines from professional bodies such as the Speech Pathology Association of Australia, Royal College of Speech and Language Therapists (UK) or the American Speech-Hearing Association (US) [26, 31]. This requires further research in order to provide clinicians with a clear decision making framework for task delegation in terms of clinical complexity and the specific clinical setting. However, it is outside the scope of the current project to investigate factors related to delegation of tasks as the project aims to consider the challenges to the implementation of an AHA workforce.

It is not only the training of AHAs which is important to address. There is little evidence to show that SPs are educationally prepared to teach and train AHAs [3, 21]. SPs graduate with little to no exposure to supervision methods (i.e. supervising students or colleagues), and it is acknowledged that the supervision of an AHA would be a very different task given the nature of the roles and

relationships involved. It is acknowledged that supervision would be a vital part of the SP role in an AHA program, but the concern remains that in a climate of increasing clinical demands and decreasing resources, service administrators and managers may not recognise the need for sufficient time for specialist training of SPs, such as training in the skills of delegation and supervision of a staff member not of their own profession [3, 21, 27].

4.4 Productivity (including clinical intensity, client throughput, professional substitution)

It is commonly thought that the introduction of AHAs into SP would lead to increased productivity – whereby the AHA completing lower complexity and repetitive tasks would free up the SPs' time to conduct more complex clinical and non clinical tasks [3]. It is also cited that AHAs can increase the intensity of clinical input. Unfortunately, there are few studies which demonstrate any formal evidence of complexity of roles performed by SPs as opposed to AHAs, and no Australian evidence to demonstrate an increase in therapy intensity[3]. It is documented that allied health professionals in rural Western Australia reported feeling positive about providing clinical services through AHAs when surveyed, and perceived that they gained clinical time. It is documented that these same clinicians reported lack of time and procedures for training, supervision and delegation, which left them reluctant to hand over tasks confidently to an AHA or feeling as if the tasks they delegated were inappropriate for the AHA to conduct[31]. In these eventualities, it is possible for the AHA to feel either underutilised or overwhelmed, resulting in less than optimal clinical outcomes [31].

4.5 Recruitment and retention

In examining recruitment and retention issues in SP, it must be noted the values held in high esteem by the profession. Belcher (2005) has written that SPs highly value professional factors in their recruitment decisions, and it is documented that work value (including social service, positive co-worker relationships, utilisation of individual abilities and feelings of achievement) are most highly treasured values for SPs [32]. This sentiment is reflected in McCartney et al (2005) who addressed SPs' perceptions of working with support staff and found that there is a definite need to address the job satisfaction of clinicians, if not addressed it may have a negative impact on retention which would be more marked in rural areas [2].

Recruitment and retention is a vital issue to address with reference to both SPs and AHAs [13, 33-35]. In the NSW Rural Allied Health Workforce Study [4], it was reported that 51% of rural SPs surveyed intended to leave their jobs in the proceeding two years, citing remuneration, career structure and dissatisfaction with their job as reasons for leaving. The survey did not measure the current utilisation of AHAs in rural areas. It will be an important area to examine in the

near future what effect SP retention rates have on an AHA program, and vice versa.

It has been discussed that the utilisation of AHAs improves exposure of the community to allied health professions, and that this is a known factor for increasing the likelihood of rural people entering allied health professions [36]. Similarly, it is indicated that employment of AHAs does not result in decreasing numbers of qualified SPs in the workforce [28]. In the creation of an AHA program in SP, it is vital that this idea is well understood by service administrators and SPs to alleviate the fear of job loss or replacement that is evident in such a workforce change.

Recruitment and retention difficulties are important to discuss in terms of the other themes in this paper. A lack of SPs in rural areas will have an impact on the supervision and delegation of tasks to an AHA. That is, an AHA may feel pressure (either real or perceived) to provide assessment or therapeutic advice to clients in the absence of a treating SP, which is inappropriate to their role. Poor recruitment or retention of SP staff will have an impact on productivity as an AHA is not able to conduct assessment and diagnosis, and therefore needs the SP to provide therapeutic planning for clients and patients [28].

A point which warrants further investigation is whether the addition of potential career structure and career enhancing skills through an AHA program could improve the recruitment and retention of rural SPs. If ongoing recruitment and retention issues in SP are to be adequately addressed by the health services, then it would be important that an AHA program has some positive implications for SPs themselves. McCartney et al (2005) states that increasing SPs' satisfaction at work is a vital area to address, requiring a shift in focus from caseload and service delivery factors of an AHA program to a focus on the SPs themselves [2].

Given the focus on complexity and intensity of tasks, it is often overlooked that within the introduction of an AHA program comes a paradigm shift for clinicians. Goldberg et al (2002) cites the shift from "service provider to program manager" (p196)[21] which has the potential benefits of providing skills such as collaboration and leadership, and added career structuring [21]. It is understood that some clinicians may not be ready to embrace this particular shift, and the support of health services will be required in allowing lead in time and appropriate training to allow positive change rather than negative enforced change [21].

4.6 Summary

The literature review indicates the need for further research to understand SPs' perceptions of working with AHAs. It also indicates that AHA, consumer, and allied health professionals' satisfaction with different AHA models of practice requires future examination. Target areas include rural and remote practice given the specific issues related to recruitment, retention, demographics and distance, as well as pre-service training and exposure of SPs to working with AHAs.

It is acknowledged in many sources that there has been limited evaluation and research, and that AHA programs to date have been based on practice needs alone. This clearly indicates the need for economic evaluation in terms of productivity gains, research pertaining to appropriate service delivery models, consumer, AHA and allied health professional perceptions and satisfaction with the role, and development of policies to ensure the most efficient and effective services are provided [3, 21, 28].

5 Method

In the current study, a qualitative methodology was employed to ensure a wide range of perceptions were gathered. Semi structured interviews were conducted and thematic description allowed the data to be grouped appropriately into themes. Interview transcripts were subsequently analysed to illustrate experiences. The data was interpreted in terms of the similarities and differences across the cohort, and factors which may have influenced the responses [37].

Participants

Participants were recruited from rural and remote parts of an area health service which has a major metropolitan centre, a mix of several large regional centres and smaller rural and remote communities within its borders. The service covers a geographical area of over 130,000 square kilometres, and has approximately 35 rural or remote SPs working part or full time, and in permanent or temporary positions. Information about the research was distributed via health service email, and interested SPs were invited to contact the researcher directly. It cannot be guaranteed that all SPs received the original email, as recruitment was conducted remotely to ensure there was no perceived coercion on the part of the researcher, as she is a SP colleague employed by the Area Health Service. After indicating interest in participation, all participants were contacted by telephone by the researcher to ascertain their preferred place and time for the interview. It was confirmed that participants had received the participant information statement and any questions regarding the research were addressed. This paper reports on the eight participants interviewed. These participants represented a range of clinical contexts, levels of experience, age and rural settings.

All participants were women, which is consistent with the professional demographics [4]. Seven participants worked in a mixed generalist position but identified that these positions were predominantly community based paediatric services. Six participants worked full time, and were all permanently employed by the Area Health Service (however, this was not an inclusion criterion). One participant expressed interest, but withdrew from the study prior to being interviewed. Years of clinical experience ranged from less than one year to more than 20 years, with half of the participants working between three to five years in a rural or remote setting. For the purpose of maintaining confidentiality, all participants were randomly allocated a number for reporting responses.

Interviews

Interview questions were developed following review of the literature regarding allied health disciplines' experiences with AHAs, across the following seven areas: *role, supervision, budget and resource management issues, accountability, workload and productivity, skills and training, and rural issues*) – please see appendix A.

Semi structured interviews were conducted between May and August 2009. Participants were interviewed individually by the researcher and were asked to describe their experience and perceptions of working with AHAs and how these perceptions were formed. Six interviews were conducted in the participants' individual workplace, one was conducted in a participant's home, and one was conducted in the researcher's workplace. Only the participant and researcher were present at seven of the eight interviews. A participant's child was present at one interview. The interviews were between one to one and a half hours duration. With the consent of the participant, the interviews were recorded via a digital voice recorder (Livescribe), and extensive field notes were made during the interviews. All participants were offered the opportunity to revise and comment on their own transcripts, but all refused this option.

Analysis

All interviews were transcribed fully by the researcher, including all communication events, such as laughing, sighs and self revisions, in order to preserve the context of the conversation for analysis purposes (note that such notations are only included in this paper where necessary to assist the readers' interpretation). The analysis was informed by content and thematic analysis, where inductive coding allowed themes to be interpreted from the data itself, and then compared to theoretical ideas from multidisciplinary literature. In order to understand the nuances of the themes, the codes were applied to the data over several occasions to ensure consistent coding ^[38-41]. The initial coding stage entailed the transcripts being analysed for the seven broad content areas covered in the interview (as above), and further analysis for main themes emerging within each area. The number of times a theme was raised was recorded to evaluate priority. The second stage of coding involved the themes being analysed further by transcripts being entered into N-Vivo^[42] qualitative data analysis software. The participants' responses were coded according to the key themes, and broken down into more specific sub themes.

Ethics

Ethical clearance was granted on February 19th, 2009 from Hunter New England Human Research Ethics committee, reference 08/12/17/4.03.

6 Results

The results of the analysis of interviews are presented in relation to the seven broad areas of questioning. Overall, the extent to which participants' comments reflected a positive attitude to working with AHAs remains unclear, as some clinicians discussed being reserved about making a decision due to factors relating to themes discussed below. One participant expressed how she perceived the overall feeling amongst SPs regarding working with AHAs;

"I think its mixed. Um, I think there are people who are very much against it. I can see why, and can understand that point of view because I think their concerns are similar to mine, um but I wouldn't consider myself against the idea... I'm just reserved" (Participant #8).

Approximately half of the participants perceived the implementation of an AHA program as being a positive change.

Role

There was agreement across all participants about the need for clear role delineation for SPs and AHAs to be created prior to implementation of an AHA program. The reasoning for this delineation varied widely according to whether working with an AHA was perceived as a positive or negative change. Participants who viewed the move towards an assistant workforce as a positive change saw the need for role definition as necessary for effective delegation and ensuring appropriate utilisation of both roles;

"I think it would be quite clear as to what role I was performing as opposed to the allied health assistant...so it wouldn't be that sense of, this person here could do the job that this person can do, they're more supporting this role and making the role easier" (Participant #4).

Participants who perceived an assistant workforce as a negative change saw role delineation as necessary for maintaining the role of the speech pathologist and protecting clients and patients from receiving an inferior service;

"Maybe you could say that would be great, wow, that would be great to share the load without really thinking about the implications in the long run about the clients and how they would be managed and whether the family would be happy with that" and "I think it would be very difficult to monitor patient care. You know if they're not with you, its like having a student isn't it?" (Participant #7).

It was clear from all participants that the role of the SP was broader than that of an AHA. There were definite areas identified within the SP role that an AHA was unable to participate in, particularly assessment and diagnosis;

“They don’t have that training. They’re not a speech pathologist, they’re not the person who’s actually qualified to pick the targets, the therapy targets, to do the assessment, look at the assessment, work out what the therapy targets are going to be” (Participant #7).

The concern that the AHA role might be expanded to replace a SP was raised by most participants in terms of job security, outcomes and efficacy of service, budget and role maintenance;

“If we lost that (vacant SP position) in place of an allied health assistant, we wouldn’t... be the same department. While it would help in the interim, I don’t think it’s the long term solution for the clinic”, and “ I think the worry is that we’ll lose positions, sort of qualified positions in place of allied health assistants”(Participant #3).

The increasingly broad role of rural SPs was discussed by all participants;

“In the middle of nowhere you get everything. Anything and everything.” (Participant #7);

“I think that needs to be acknowledged within a generalist caseload, that jump in between an adult with this a child with that” (Participant # 6); and

“I could have a baby one day, and then I could have a severe phonology client or a literacy client or an aphasic adult all in the same day” (Participant # 8)

The difference in critical thinking skills required of a SP for assessment and diagnosis, as opposed to an AHA were highly valued by all participants. The perception that these skills and the SP role was misunderstood and devalued outside the profession was consistent across the cohort;

“It still amazes me too how often there is, how regularly there is a comment like, ‘Oh, you’ve got a degree!’ Like, ‘oh, did you have to go to uni to do this?’”(Participant #6).

Supervision

Participants were asked how they perceived supervision and monitoring patient outcomes if they were to work through an AHA. All participants responded that on site supervision and structured support were necessary;

“I think any direct client contact there needs to be that supervisory role” (Participant #4);

“There’s a lot of supervision, it seems to be really time consuming...and that’s just ongoing...It’s still hard because she doesn’t have specific speech pathology background” (participant # 3); and

"I think you really need to be willing to take time out of your clinical load to train the aide... to support you and to get used to, you'll need to get used to each other" (participant # 2)

The concern that time taken to train and supervise an AHA would take away time that SPs would be conducting clinical interventions was consistent across all participants, for example;

"The disadvantages I can see are the time that it takes to train or supervise" (Participant # 8);

"I think it would only add more pressure to a setting where they're obviously going to need a little bit of supervision and that sort of thing where an under-resourced clinic is already under enough stress and time demands" (Participant #4); and;

"I would think that they would need close supervision, and they would need to be well trained... that would take quite a bit of time" (Participant #7).

Participants reported that they graduated with no formal supervision skills to supervise SP students or colleagues. It was identified that if an AHA program was part of a SP's role, then formal training would need to be provided by the health service;

"The speech pathologist would need to be able to break down the tasks into achievable steps and into achievable language to do it" (Participant # 8); and

"She's (the speech pathologist) got to have some kind of preparation or orientation herself as to her role in guiding" (Participant #1)

Suggestions of how this training could be implemented included teleconferencing (with particular reference to rural sites), professional development courses and seminars, multidisciplinary learning (e.g. working with a physiotherapy or occupational therapy aide), and to increase undergraduate exposure of students to AHAs while on clinical placements.

Most participants had no exposure to AHAs, either as a student or as a professional. The possibility of working with an AHA while on student placement was raised as a potential way of increasing exposure and experience of SP students to AHAs. It was suggested that having experience delegating to an AHA at this undergraduate level would improve confidence, experience and improve work readiness for working with AHAs.

All participants agreed that new graduate clinicians should not have sole responsibility for supervising an AHA, and that post graduate clinical experience was important before a SP should have this additional responsibility. The perceptions were that new graduates spent their first year;

"Just getting the hang of what they can do and all of that ownership of your specialised area" (Participant # 1);

Managing the day to day clinic demands;

“They’re still mastering their clinical skills, never mind managing other people, they can’t manage their time” (Participant # 7);

and reflections on their own skills;

“I decided I’d give myself at least a year to try to figure out how I’m going” (Participant #2).

It was a consistent perception that post graduate clinical experience was important before a SP should have the additional responsibility of supervising and managing an AHA. It was also raised that without consolidation of their own clinical skills, a new graduate may be in the position of being ‘managed’ by an AHA with more life experience, but also more experience within the clinic role. Following on from this, it was agreed by all participants that strong professional supervision and support from the discipline would be required with the introduction of AHAs in SP.

Budget and Resource management

Participants reported a lack of confidence in budget and resource management in terms of the provision of funding for AHA positions;

“If an assistant can do it then why would you employ a speech pathologist when they’re potentially double the cost? That’s the whole phasing out of speech pathologists that I’m worried about.” (Participant #8)

All participants perceived that a lack of management understanding of the SP role could lead to issues of replacement of SP positions by AHAs;

“If there’s someone there doing the work, are management actually going to be motivated to look for a speech pathologist?” (Participant #3)

However, some clinicians perceived that AHAs could be an augmentation to services already in place with the aim of increasing productivity.

The need for better support and resourcing in order to deliver quality clinical services to patients and clients was consistently raised. Specific issues included physical resourcing which was perceived to potentially result in challenges in extra housing and resources for any other professional including AHAs in some rural centres.

It was largely perceived that this initiative was being driven by a non clinical workforce, with limited involvement of clinicians. It was also perceived that resourcing was being prioritised above the needs of clinicians or clients. These results indicate that the participants perceived a lack of consultation over the

initiation of an AHA program, and therefore felt potentially devalued and disempowered;

"I think people assume that you can just train someone to be a speech pathologist, that four years of training and then multiple years of experience don't actually mean very much. And I think that is a big issue, that to not value or understand that that is a lot of university education, combined with lots of on the job training... It assumes that being a speech pathologist is a really simple thing and that there's nothing very complicated about it at all" (Participant # 7).

It was perceived that the AHA planning was being run from a metropolitan perspective, and that workforce planning was being done without consideration of specific rural issues;

"I know a lot of the Area Professional Directors are based in Newcastle you know, and their issues are very different" (Participant # 7)

Accountability

All participants perceived that it remained the treating SP's responsibility to ensure appropriate treatment was being given and outcomes being met. Some participants expressed concern regarding the efficacy of treatment and difficulty monitoring outcomes;

"if anything went wrong, you would be the person who was responsible, even if you were far from where the action was happening, which would be likely." (Participant #7)

Others perceived that by introducing AHAs, more therapy could be provided to those clients who needed more intensive services;

"I think a lot of my frustration at times is that I can't offer what I would like to...because of all the restraints of time and resources, so if I had someone there who was ...helping along the way... well I would be able to offer my clients a better service, which would then make me happier." (Participant #4)

Workload and Productivity

Perceptions varied regarding tasks that an AHA could be delegated, ranging from tasks of an administrative nature,

"I think they're a good idea, they'll reduce kind of admin kind of workloads and things" (Participant #5)

To being involved in goal setting, discharge planning and building a clinical caseload under the supervision of a qualified SP;

"I think ...one of the strengths of having the roles is... perhaps a chance to service more complex populations more efficiently" (Participant # 8);

"she would put half of our programs together for us...we want to work on this, and she'd just get it all, and it was done. And you know, we might do it once and she'd keep doing it for the rest of the days because we couldn't go up and see that person every day... It worked really well with the nursing staff as well" (Participant #3); and

"I think they could be involved in conducting reviews on clients that... fairly straightforward clients that we're just monitoring, I think they could have a pretty good role in that. Parent education would be another area and training as well, running those sessions that we do that are fairly structured anyway" (Participant # 4).

There was agreement amongst all participants that an AHA should never have responsibility for assessment and diagnosis.

Participants reported concern that potential workload benefits provided by having an AHA may be offset by the time required for training, supervision, mentoring, and monitoring the outcomes achieved by the AHA. It was also raised that some clinical settings would be more appropriate to implement AHA, where there would be low level repetitive tasks for an AHA to conduct.

Skills and Training

Most participants were not aware of the training formats and competencies involved in AHA training, and identified that they would need this knowledge if working with AHA. The perception of 'on the job' skills was not uniform - some participants perceived that on the job training would sharpen an AHA's skills to the specific needs of the clinical setting, and training time would be recouped in productivity gains.

Rural Issues

Participants perceived that the role of the SP in a rural area was different from that of a metropolitan SP, in that they often worked in professional isolation, had limited ability to specialise, and distances impacted on supervision, access to professional development and access of clients to the service;

"The distances between the support, the ability to support and supervise somebody like that is always a problem in rural settings" (Participant #7).

Given the role of the SP is perceived differently, it was clear that the role of the AHA would differ in rural areas from metropolitan areas.

7 Discussion

Little is known about SPs perceptions of working with AHAs and an aim of the current study was to provide some research in this area, with particular reference to rural and remote areas. Participants reported a wide range of perceptions of utilisation of AHAs. This supports the finding that further education and consultation is needed regarding the role of AHAs in rural areas.

SPs perceive a gap in the skills and knowledge which will be required to work successfully with AHAs. Interviews revealed a lack of exposure to AHAs and a lack of formal training in supervision and delegation skills. Participants also did not perceive ownership or adequate consultation over the planning of this redesign, despite senior SPs being involved in producing task lists to shape the role description of an AHA. A lack of understanding of the SP role by management and the wider community was also a consistent perception. Poor agreement was demonstrated regarding overall perceptions of working with AHAs. The importance of a SP's training and critical thinking skills was highly valued by all participants, and it was agreed that it would be inappropriate to replace a SP with an AHA. The potential for AHAs being introduced prior to these issues being clarified caused concern for participants. The themes which arose in the current study were consistent with literature from other disciplines such as physiotherapy and occupational therapy [28, 43, 44].

The results indicate that having little or no exposure to working with AHAs is one clear barrier to progressing this workforce reform. The current results indicate that it is more likely to be exposure to AHAs, than years of clinical experience, which leads to positive perceptions regarding AHAs. This exposure could be either on the job or in university training and clinical placements. Lack of exposure to AHAs is a contributing factor to ongoing negative perceptions of SPs to utilising AHAs. Lack of clarity regarding expectations and roles is another contributing factor to ongoing negative perceptions to SPs utilising AHAs. It is interesting to note that the level of rurality was not a direct indicator of positive or negative perceptions of working with AHAs.

Although this study was limited to one region and a small sample size, it has presented an in-depth study of the perceptions of participants in an area of substantial geographic diversity. It is suggested that future research should test for variation by geographic region across NSW. This study alone is not able to represent the discipline's perceptions as a whole, but rather highlights the issues of importance to SPs and begins to involve the discipline in workforce planning for the future.

In workforce redesign, it is known that human factors often present the most significant challenges. Goldberg et al (2002) cites a range of challenges which SPs may face in working through workforce redesign, the most significant challenge to be natural human resistance to change. Resistance to change due to attachment to traditional therapeutic models has also been cited in the literature regarding generic and discipline specific AHAs [21].

The literature recognises that many AHA programs have been developed in a reactive manner to situations including workforce shortages and crises within health services. In these cases AHA roles have 'evolved' to fit the specific service rather than having effective pre-planning. Areas of concern for the participants in the current study included professional issues such as valuing the SP role, professional accountability and outcomes for patients and clients. It is clear that if these values are perceived to be threatened, it would be detrimental to the introduction of any AHA program. Subsequently, implementation of an AHA program without adequate planning and consultation would be unsatisfactory for the participants and the discipline.

A communication strategy with SPs would be beneficial to improve awareness of the rationales and context of an AHA program. Education of SPs may improve awareness of the range of possibilities for AHAs, and expose them to a range of programs which are available in other Australian states and internationally.

Results indicate that employers may need to acknowledge the potential negative consequences (at least initially) of implementing an AHA program in terms of productivity and time, and provide support for clinicians during this change. In the current study, some participants perceived that training an AHA to deliver SP intervention may result in poor clinical outcomes, which would result in increased stress on the treating clinician. As McLaughlin et al (2008) discusses; a significant cause for stress for SPs is compromising quality and quantity of clinical care necessitated by managing of time and resources. It is understandable then, that without assurances of increased management support, SPs could negatively perceive a workforce change which may, initially at least, increase rather than decrease their workloads, and negatively contribute to existing work related stress ^[11].

The current study indicates that the participants were not aware of forecast shortages to the SP workforce. They also were not aware of initiatives for increasing numbers of allied health professionals, and for improving productivity ^[45]. It is potentially due to inadequate communication between the Area Health Services and SP discipline that the current AHA initiatives have not been made clearer in their intent. It is suggested that workforce planning needs to engage and communicate with SPs regarding this point. Given the opportunity, SPs could contribute valuable options specific to the discipline. Similarly, ensuring concerns regarding job security are addressed as well as being transparent in the planning process will be vital to the success of this workforce redesign.

8 Conclusions

The current research describes themes in rural SPs perceptions of utilising AHAs and identifies some of the barriers and benefits to this potential workforce redesign.

The results of the current study strongly reinforce the findings in the multidisciplinary allied health literature regarding perceptions of allied health

professionals working with AHAs. The themes have been consistent with other allied health disciplines who traditionally work with AHAs, and the barriers and areas of professional concern are the same. Furthermore, this study has been able to introduce the SP discipline into the discourse regarding the utilisation of AHAs for clinical service provision.

It is acknowledged that there has been limited evaluation and research and that AHA programs to date have been based on practice needs alone. This clearly indicates the need for economic evaluation in terms of productivity gains. Research is needed regarding the most appropriate service delivery models for such gains to be made. Consumer, AHA and AHP perceptions and satisfaction with the AHA role have not yet been conducted and are warranted. It will be necessary to develop policies surrounding the program to ensure the most efficient and effective services are provided [3, 21, 26]

As a move towards involving SPs in the discourse surrounding the planning of an AHA model, and as the outcome of this pilot project, five recommendations have been made concerning the consideration of an AHA program for SP in NSW.

Recommendation One:

All participants identified a gap in skills and knowledge with regard to working with AHAs. It is therefore recommended that area health services provide ongoing training and support for SPs regarding;

- How to most effectively utilise the skills of an AHA
- How to provide supervision to an AHA

Recommendation Two:

Most participants identified a lack of exposure to AHAs. Research shows that exposure to AHAs improves perceptions and skills with regard to working with AHAs. It is therefore recommended that clinical placements with AHAs be considered across NSW Health to increase undergraduate SP students' exposure to AHAs. This will require consultation between NSW Health and tertiary SP program co-ordinators.

Recommendation Three:

Participants reported concern regarding clinical outcomes and patient / client / family concerns regarding working with AHAs as opposed to SPs. It is recommended that future research takes into consideration other stakeholders such as patients, clients and families, management and AHAs themselves with reference to SP interventions being delivered by an AHA.

Recommendation Four:

SPs perceived poor consultation and consistently reported feeling marginalised and powerless regarding AHA program planning. Therefore, it is recommended that a communication strategy be devised to inform SPs across area health services of the rationale and context of an AHA program. It is also recommended that a participative approach be adopted between the AHS and SP in planning for an AHA program, in order to ensure the needs of SPs and individual services are represented.

Recommendation Five:

Perceptions were not uniform regarding what an AHA can or cannot do within a SP caseload. Also, participants reported service needs associated with being in a rural or remote region. It is therefore recommended that area health services collaborate with individual services to address specific issues regarding rural practice. The needs of clinicians and the community in these areas can be addressed to create appropriate education packages for SPs regarding:

- Understanding the role planned for SP AHAs in rural areas
- Understanding the job descriptions created for SP AHAs
- The role of the SP with regard to working with AHAs

The results of this study reinforce the findings in the multidisciplinary allied health literature regarding perceptions of working with AHAs. This suggests that results may be applicable to a range of allied health disciplines that do not traditionally utilise AHAs in clinical service provision. Given the current results reflected the existing multidisciplinary findings, it is suggested that literature from other Australian states be accessed to assist in shaping any potential AHA workforce in NSW. Increasing SPs' knowledge of working with and improving exposure to AHAs would likely lead to improved perceptions and more positive workplace uptake of this program.

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10 Appendices

Appendix A: Interview Questions

1. What is your area of work?
 - a. (acute / rehab / community adult / inpatient paediatrics / community paediatric / mixed generalist / disability)
2. What is your postcode?
3. Are you
 - a. Full time / part time /
 - b. Permanent / temporary / casual
4. How many years have you worked as a speech pathologist?
5. How many years have you worked as a speech pathologist in a rural area?

Experience

1. What do you think about Allied Health Assistants in speech pathology?
2. Tell me about any previous experience you have had working with Allied Health Assistants (if any)? Were there positive things about this? Negative things?
3. Has working with an Allied Health Assistant ever been discussed or considered within your department / area of work? What sort of things do people say when this topic comes up? What do you think about what 'they' say?

Tasks

4. In your area of work, which tasks could be performed by an Allied Health Assistant?
5. How do you see sharing of administration tasks with an Allied Health Assistant?
6. If this happened as you describe, how do you see it changing your role?

Skills and Training

7. What skills would an Allied Health Assistant need to have to work successfully with speech pathology in your area of work?
8. What skills do you feel would be necessary for a speech pathologist to have in working with and supervising an Allied Health Assistant?
9. Where could these skills be taught / learned (E.g. University / clinical placements / on the job)? Which would be the most practical in your situation?
10. What support do you think you would need for supervising and working with an Allied Health Assistant?

Main issues

11. What do you see as the potential strengths and weaknesses of working with an Allied Health Assistant?

12. How do you think working with an Allied Health Assistant would impact on your work?

NB: If the participant says they don't ever want to work with an AHA, will ask:

13. What are the main issues which make you feel this way?

14. Are these issues able to be addressed? How?

Values and Beliefs

15. How do you perceive your role as a speech pathologist in your area of work?

16. How do you perceive your role as a speech pathologist in your community?

17. Do you think this perception would change if you were working with an Allied Health Assistant? How? Why do you think this would be?

18. Do you think that working with an Allied Health Assistant would change your current feelings of job satisfaction and job security? In what way? Why is this important to you?

Implementation

19. What are your ideas about how supervision of an Allied Health Assistant would be successfully conducted given your large geographical area / large caseloads / part time basis?

20. Do you think there would be issues with the standards of care for patients? What sort of things would need to be considered?

21. How could you monitor standards of care with patients / clients working with an Allied Health Assistant?

Industrial

22. How do you perceive your current job security?

23. How do you see your current role changing if you were to start working with an Allied Health Assistant?

24. How do you feel about that?

Appendix B: Participant Information Statement



Research Project – Rural speech pathologists perceptions of working with Allied Health Assistants

Speech pathology is a profession in significant demand, with well documented recruitment and retention issues particularly in rural and remote areas. One of the strategies that have been successfully implemented within allied health disciplines in Western Australia, Tasmania, the ACT and Victoria is the utilisation of Allied Health Assistants (AHAs) to assist in delivery of clinical services. Speech Pathologists have been shown to be significant users of AHA services in other Australian states and internationally, but the system has not yet been embraced by the discipline in NSW.

There are currently staff who have roles as Allied Health Assistants, but may be classified as physiotherapy assistants, diet aides, occupational therapy aides, therapy assistants, rehab assistants or enrolled nurses. There are currently limited speech pathology specific assistants in NSW.

What is the research about?

The research project aims to identify the perceptions of rural speech pathologists to working with Allied Health Assistants (AHAs). The project is being conducted through Hunter New England Health and the Institute of Rural Clinical Services and Teaching. The current research aims to describe rural and remote speech pathologists' perceptions of working with Allied Health Assistants. The information gained from the interviews will increase understanding of how rural speech pathologists perceive their job changing, job security, how they could utilise AHAs and what skills would be necessary for both speech pathologists and AHAs. The pilot project is to be 2 years in duration, aiming for completion and publication of results in 2010.

Why am I being asked to participate?

As you are a rural speech pathologist within NSW, I would like to invite you to participate in an interview to discuss your perceptions of working with AHAs.

What will I be asked to do?

You will be asked to participate in a one on one interview. The interview will take about 1 hour in which you will be asked questions about your previous experience working with Allied Health Assistants (if any), any training/educational requirements for working with AHAs, and your perceptions of the issues involved with working with AHAs. Interviews will be conducted face to face if at a location of your choice at a mutually suitable time. Interviews will be recorded onto digital voice recorder. You may ask for recording to be stopped, and have sections edited or erased as you wish at any time during the interview. You will be given the opportunity to review, edit or erase the own audio recording and the written transcript of your interview if you wish.

What will happen to the information that is collected?

Information which you give may be able to identify you; however every step will be taken to de-identify your information. Any information which is potentially identifiable will not be used in any published report. All information gathered will be securely stored and only available to the research team. The information which you provide will be accessed, used and stored in accordance with Commonwealth Privacy Laws and the NSW Health Records and Information Privacy Act 2002.

Voluntary participating

Participation is voluntary and your information will be kept strictly confidential. You can choose to withdraw your consent for the use of your information at any time. Participation or otherwise in the project will not affect your relationship with NSW Health.

Complaints

This research has been approved by Hunter New England Area Health Service Lead Research Ethics committee of Hunter New England Health (Reference 08/12/17/4.03). Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to Dr. Nicole Gerrand, Professional Officer (Research Governance and Ethics), Hunter New England Human Research Ethics Committee, Hunter New England Health, Locked Bag 1, New Lambton NSW 2305, telephone (02) 49214950, email HNEHREC@hnehealth.nsw.gov.au.

If you have any questions about the project, please contact Rachael O'Brien on (02) 49392249.

Rachael O'Brien
Speech Pathologist