Resistance, paradox and professional identity in speech-language pathologists’ perceptions of working with assistants.

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B Sp Path

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Management
University of Newcastle
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This research was supported by an Australian Government Research Training Program (RTP) Scholarship
Declarations

Statement of Originality

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision.

The thesis contains published scholarly work of which I am a co-author. For each such work, a written statement endorsed by the other authors, attesting to my contribution to the joint work has been included.

The thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University’s Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

Signed: Dated:

(Rachael O’Brien)
Acknowledgments

I wish to thank my fabulous supervisory team, Rebecca Mitchell, Nicole Byrne and Alison Ferguson. You are brilliant and empathetic women who have continually and generously inspired, consoled, taught, supported and guided me through the process of completing my PhD. You have opened doors to opportunities previously unknown, and maintained your grace and sense of humour throughout. I’ve so enjoyed the opportunity of completing my PhD – you’ve all taught me so much, and I am so very grateful for the good fortune of working with you all.

For my wonderful Mum and Dad. Thank you for fostering a deep love of reading for longer than I can remember, and for valuing learning so highly. Thank you for looking after the boys which allowed me to work, as well as for meals-on-wheels, cups of tea, listening to paper ideas, and for taking pride in what I was trying to achieve. Mum, thanks for always providing the ‘soft option’ and Dad for understanding my ‘twisted little academic bent’. I absolutely couldn’t have done this without both of you, and your never-ending love and support. This thesis is as much yours as it is mine.

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11.3 Additional contribution 3 – Oral presentation to the Allied Health national conference 2017

11.3.1 Full citation

11.3.2 Abstract

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11.4.1 Full citation

11.4.2 Contribution

11.4.3 Abstract

12 Appendices

12.1 Appendix 1: Ethics approvals and documentation

12.1.1 Approval HNEHREC: Reference # 11/03/16/5.06 (7th March 2011)

12.1.2 Amendment HNEHREC: Reference # 11/03/16/5.06 (9th December 2011)

12.1.3 Renewal HNEHREC: Reference # 11/03/16/5.06 (14th March 2014)

12.1.4 Registration of external approval University of Newcastle: Reference # H-2009-0225 (8th November 2017)

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12.3 Appendix 3: Participant consent forms

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12.4 Copyright permissions

12.4.1 International Journal of Speech-Language Pathology

12.4.2 Scandinavian Journal of Caring Sciences

12.4.3 Journal of Clinical Practice in Speech-Language Pathology

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1 List of publications included in the thesis

Paper 1 (Pilot)


Paper 2 (Perceptions)


Paper 3 (Resistance)


Paper 4 (Paradox)


https://doi.org/10.1111/scs.12437.

Please note, this paper was first published online 19th May 2017. It is referenced in Paper 5 and additional contributions 2 and 4 as (O’Brien, Mitchell & Byrne, 2017).
Paper 5 (Professional identity)

O’Brien, R., Mitchell, R., & Byrne, N. (Accepted). The role of the speech-language pathology professional identity as a response to a workforce redesign. *Journal of Clinical Practice in Speech-Language Pathology* 20(2).

Paper 6 (Value added)

2 Additional contributions included in the thesis

The following additional contributions are referred to in the thesis. They were designed to increase the reach of the research by making it widely available within and outside of the speech-language pathology profession and ensure communication with practitioners.

**Additional contribution 1: Assistant literature review**


**Additional contribution 2: Poster presentation**


**Additional contribution 3: Oral presentation**


**Additional contribution 4: Poster presentation**

3 Additional publications

The following additional publications are relevant to the thesis and are referred to in discussion but are not included in it.

Additional Paper 1


Additional Paper 2

Byrne, N., & O’Brien, R. (2017). Speech Language Pathology students’ perceptions of factors related to entry and retention for Aboriginal students (Manuscript submitted for publication)
4 Abstract

Over the past decade, research has been emerging regarding assistants in speech-language pathology, particularly in the UK, US and Canada, however, there is minimal information within NSW to support the implementation for the profession. The limited literature available for assistants in speech-language pathology has indicated some reluctance within the profession to utilise this workforce, despite recognition of some of the potential benefits. Similarly, most of this research has not directly investigated the principles underlying the perceptions of professionals. The present research investigates speech-language pathologists’ (SLPs’) perceptions of working with assistants and focuses on how these perceptions were formed. It examines factors such as consumer focus and the role of the larger health organisation in the formation of such perceptions. While assistants are utilised in the profession internationally and in some states of Australia, it is a workforce redesign that is yet to be embraced as usual practice by all SLPs. A preliminary step in resolving continuing ambivalence over assistants in speech-language pathology is to develop a greater understanding of how SLPs perceive assistants, how this impacts upon their own perceptions of self in terms of professional identity, roles and value within the organisation, and how the implementation of assistants may contribute to professionals, the profession, as well as to consumers and the community.

This qualitative study aimed to provide rich subjective accounts of professional perceptions of a workforce redesign, with a focus on perceptions of individual experiences. The study comprises data from in-depth, semi-structured interviews conducted with 20 speech-language pathologists from various local health districts (LHDs) across NSW, Australia. The interviews collected information from practising SLPs and asked about experience and perceptions of working with assistants, role, as well as feelings of value within the health organisation and community. The participants were SLPs with between 1-25+ years’ experience, currently working in NSW, Australia. Participants were purposively sampled which allowed a range of clinical caseloads, work patterns, age and clinical experience. The principles of interpretative phenomenological analysis were employed to allow deep exploration of perceptions and experiences, as well as principles derived from specific
relevant frameworks from Smith, Flowers and Larkin (2009) and Liamputtong and Ezzy (2005).

The findings of this research emerged from deep analysis of interviews. The research finds that participants highly value their position as a speech-language pathologist and use this as a marker for their own as well as other groups’ status within the larger organisation. This research presents participants’ perceptions of a workforce change involving the introduction of assistants in an area without current policies guiding their utilisation. It illustrates how SLPs not currently working with assistants may view the workforce change, and how working with assistants may impact on their understanding of their current role and status within the organisation. This research emphasises the need for greater understanding of the construction and maintenance of professional identities in a changing workforce.

The findings of this study suggest that while working with assistants is a workforce model which has benefits for individual clinicians, professions, consumers, and organisations, real or perceived professional identity threat is a significant source of resistance to such change. Similarly, the findings suggest that a major source of professional identity formation amongst participants includes their relationships and advocacy role with their patients and clients, who are often perceived as vulnerable. These relationships are perceived to be threatened by the introduction of assistants, and as a result, participants perceived that the profession was at risk of losing the strongly held value of consumer focus.

For this thesis, empirical research has been undertaken into SLPs’ perceptions regarding assistants. The findings have been disseminated through six papers (as well as four additional contributions including literature review, oral presentations, and posters). This thesis integrates the papers and research output into the overall change management and identity literature and proposes future planning strategies for professions and organisations.

The findings of this research have the potential to inform future workforce planning regarding the assistant workforce across health professions; what factors precede resistance, what resistance may be expected, and how to mitigate such resistance. Additionally, it discusses the potential for professions and professional organisations to be more, not less
inclusive of a vocational tier of their workforce and identifies that an assistant workforce provides a non-traditional pathway into professions. This, in turn, has the potential to provide greater workforce diversity, allowing better reflexivity and responsivity to consumer need.
## 5 Glossary of terms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>AH</td>
<td>Allied Health</td>
</tr>
<tr>
<td>AHA</td>
<td>Allied Health Assistant</td>
</tr>
<tr>
<td>AHP</td>
<td>Allied Health Professional</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>ASHA</td>
<td>American Speech-Hearing Association</td>
</tr>
<tr>
<td>HNE</td>
<td>Hunter New England</td>
</tr>
<tr>
<td>HWA</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>IJSLP</td>
<td>International Journal of Speech-Language Pathology</td>
</tr>
<tr>
<td>IPA</td>
<td>Interpretative Phenomenological Analysis</td>
</tr>
<tr>
<td>JCPSP</td>
<td>Journal of Clinical Practice in Speech-Language Pathology</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>LNR NEAF</td>
<td>Low and Negligible Risk National Ethics Application Form</td>
</tr>
<tr>
<td>NEAF</td>
<td>National Ethics Application Form</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>OTA</td>
<td>Occupational Therapy Australia</td>
</tr>
<tr>
<td>PT</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>RCSLT</td>
<td>Royal College of Speech and Language Therapists</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SJCS</td>
<td>Scandinavian Journal of Caring Sciences</td>
</tr>
<tr>
<td>SLP</td>
<td>Speech-Language Pathologist</td>
</tr>
<tr>
<td>SP</td>
<td>Speech Pathologist</td>
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<tr>
<td>SPA</td>
<td>Speech Pathology Australia</td>
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</table>
6 Synopsis

This thesis by publication includes six core papers and four additional intellectual contributions that report on an investigation of a substantial workforce change in the speech-language pathology profession. The specific aim of this research was to address the question of how speech-language pathologists perceive and respond to working with assistants in an area without widespread utilisation of assistants, and how consumer focus and professional identity factors impact on such perceptions. At the time of completion (24th March 2018), three papers had been published and one was under review in peer-reviewed journals. Two papers had been published in national and international conference proceedings respectively and also presented as oral papers. The additional contributions had been presented to scholarly and practitioner audiences at national and international conferences with the aim of increasing the reach and impact of the study findings. This thesis will link the papers to the aims and overall findings and discuss the significance therein.

The introduction section of this thesis provides an overview of the health workforce context relevant to the introduction of assistants, including the global shortage of appropriately skilled health workers and the drivers for workforce change, including changing community need and decreasing resources. It further discusses the dynamics and processes surrounding the implementation of this important workforce change, drawing on literature from a range of allied and related professions including medicine and nursing. It provides a rationale for why assistants are becoming more widely recognised as a valuable resource in healthcare services internationally, and why resistance to their utilisation continues to be documented. The introduction will outline the research purpose, aims, and questions. It will also describe the methodology of interpretative phenomenological analysis (IPA) and why this was chosen as the research method. The significance of the research will be discussed, as well as the contribution to knowledge.

The section below provides an overview linking the series of published papers and research output to the overall thesis. It will begin with an explanation of the purpose and aims of the
study, followed by research questions and discussion of the overall methodology. The clinical and theoretical implications will then be discussed.

6.1 Paper 1: Pilot


Working with assistants is a workforce redesign which has been widely adopted in health services, and it is recognised that it allows a range of types and levels of ability to contribute to an overall skill mix which is beneficial to health consumers and organisations (Buchan & Dal Poz, 2002). The speech-language pathology profession has utilised assistants internationally, but it has not yet been fully adopted in all states of Australia (O’Brien et al., 2013). Resistance to working with assistants continues to be documented in allied health professions, and factors that determine how assistants are utilised as well as how professionals perceive this workforce remain unclear. Identifying this as a need for further information, the research presented in Paper 1 (Pilot) explored the perceptions of eight speech-language pathologists in a rural area where assistants were not yet utilised, and where there were no policies guiding their employment or use. The aim of this paper was to explore current perceptions of Australian speech-language pathology professionals regarding assistants where they had not been directly exposed to this workforce change.

By analysing the accounts of practising rural SLPs, this paper identified a wide range of perceptions regarding the potential impact of assistants and subsequently proposed a model of inter-relationships between three domains; professional, organisational and economic. Each domain was elaborated within the context of the SLPs’ role. The professional domain emphasises values and qualities expected of an SLP; the organisational domain relates to the role of the SLP in the larger health organisation and the organisation’s role in the workforce redesign. The economic domain relates to resource management, including concerns about funding positions, substitution and replacement and physical requirements to practice. The study analysis recognised that while each theme emerged individually, it
was the inter-relationships across domains that indicated the overall complexity of perceptions. Both positive and negative conditions across domains emerged, as well as pivotal points where greater transparency of purpose between profession and organisation would be beneficial. Mixed perceptions regarding assistants were interpreted as potentially impacting significantly on the uptake and sustainability of such a workforce redesign. The findings showed a measure of fear of the unknown, and this publication employed theory in change management to draw conclusions regarding the importance of understanding and being able to appropriately respond to perceptions of potential loss and risk is important in minimising resistance to change (Kotter & Schlesinger, 2008).

Analysis of accounts indicated that overall perceptions were varied amongst the cohort, and by extension indicated the potential for inconsistent uptake and effectiveness of the redesign. Several pivotal points were identified requiring further clarification in order to allow for more positive perceptions of working with assistants; consultation between profession and organisation, clear expectations and roles, with clarification of overall goals and purpose of the redesign.

*Paper 1* was exploratory in nature and findings suggested that perceptions were influenced by previous exposure to assistants; that is, SLPs with previous exposure or experience working with assistants were more likely to have more positive overall perceptions. The small sample size and geographical reach were identified as a limitation of the study, and so for *Paper 2 (Perceptions)* and subsequent papers, the number of participants and geographical reach was increased. However, the analysis in *Paper 1* provided valuable direction regarding perceptions and the domains over which they existed. This allowed comparison with the interprofessional collaboration and change management bodies of literature and provided future direction for the research. The ambivalence in participants’ perceptions is acknowledged as an important basis for future research and led to further probing of participant accounts for clarification across the positive and negative conditions (*Paper 2*), as well as to further examine the human challenges identified – that is, resistance to change (*Paper 3*) and threatened professional identity (*Paper 4, additional contributions; Poster presentation 1 and Oral presentation 1*).
6.2 Paper 2: Perceptions


In Paper 2 (Perceptions) the geographical reach of the study was extended across NSW and the number of participants was increased from eight to twenty. Bach, Kessler & Heron’s (2007) model of empowerment and degradation was applied to participant accounts in order to investigate SLPs’ perceived barriers and facilitators to working with assistants and also whether the consequences of the introduction of the assistant role would be empowering or degrading for SLPs.

Against the background of changing health policy and workforce structure, Paper 2 discussed these two concepts in relation to the perceptions of speech-language pathology professionals who were working in established clinical service delivery models. The findings extend current understanding of professional responses to assistants. This paper argued that assistants may be perceived as enhancing the autonomy of individual providers to meet the needs of consumers, as well as increasing workload variety and complexity and as such be seen as empowering. This paper built on extant models of responses to assistants by suggesting that empowerment and degradation can co-exist in a workforce redesign event both within and across stakeholder or individual perspectives. An important contribution was to suggest that a professional may perceive a specific workforce redesign as both degrading and empowering as a result of outcomes to their specific role. That is, both positive and negative aspects may co-exist in the situation. Additionally, the perception of a workforce redesign being empowering, or degrading may differ across those in the relationship; the professional may perceive the situation as being degrading, whilst the assistant may perceive it as empowering, or vice versa.
A further contribution of this paper was to apply the concepts of empowerment and degradation as work and employment-centred dimensions; where the work-centred dimension is based on the notion of work organisation and task orientation of the group (e.g. delegation), and the employment-centred dimension is based on conditions, treatment and benefits for the employee. A novel aspect of this paper related to the finding that empowerment and degradation across the work and employment-centred dimensions may present a paradox for both the assistant and professional roles. The finding of paradoxical perceptions is explored in greater detail in Paper 4 (Paradox). In terms of the work-centred dimension, the professional role may be empowered through the relief provided by assistants taking on tasks of lower complexity; however such delegation may also degrade via dilution of the professional role (O’Brien et al., 2013). In terms of the employment-centred dimension, this study found that the professional role may be empowered by the complementary skills brought to the context by the assistant role and concurrently be degraded by the additional management responsibility that is inherent in supervising an assistant. Application of the concepts of empowerment and degradation to this unique population demonstrated the potential tensions arising between positive and negative conditions in the same workforce redesign event. It highlighted the awareness of the professional group’s existence and contributes to knowledge of the impact of professional identity in a workforce change.

Drawing on this typology, the data presented in Paper 2 suggested that perceptions of empowerment resulting from workforce redesign could have powerful positive outcomes for organisations. There are significant practical applications that flow from this typology. For example, the importance of understanding the factors that contribute to perceptions of either empowerment or degradation in order to enable positive workforce change. Perceptions of empowerment and degradation similarly bring to light the issue of professional boundaries and protection by occupational groups (Bach et al., 2007; Nancarrow & Borthwick, 2005). Protection of professional boundaries has the purpose of maintaining or improving professional power or dominance, societal status, and retaining desirable tasks in a role while delegating to others the less attractive ones (Nancarrow & Borthwick, 2005). As the introduction and utilisation of assistants increase across health
services, a thorough knowledge of the relationships across the boundaries between professionals and assistants will be necessary given the fragile and dynamic nature of professional boundaries (Bach et al., 2007; Nancarrow & Borthwick, 2005). The identification of how shifts in the division of labour between professionals and assistants lead to empowerment or degradation of roles in the workplace contributes to understanding the consequences of these new roles (Bach et al., 2007). The exploration of perceptions of empowerment and degradation in Paper 2 highlight the tensions existing between these perceptions within the professional group. The analysis also indicates the importance of resistance to change in such perceptions. The importance of understanding resistance and the findings in Paper 2 led to the more in-depth examination of the role of resistance in Paper 3 in perceptions of working with assistants.

6.3 Paper 3: Resistance


The importance of understanding resistance and the findings in Paper 2 led to the more in-depth examination of the role of resistance in perceptions of working with assistants. Review of the literature showed that little attention to date had been paid to resistance in knowledge workers, a group to which speech-language pathology belongs. In Paper 3 the role of resistance in participant accounts was analysed. It was found that professional identity arose as an issue which led to further exploration and reporting of same in Paper 5 (Professional Identity). Paper 3, however, proposed that professional identity construction and threat have the potential to motivate resistance to a workforce redesign and discussed the importance of understanding both the identified factors that contribute as well as how this is realised in resistance. This paper argues that ambivalence may lead to resistance and discusses the importance of understanding such ambivalence.
The research discussed in *Paper 3* and *Paper 4* explored perceptions using the social identity perspective (Hornsey, 2008), which is discussed more fully in *Paper 3*. The acceptance of a vocational tier of the workforce and its meaning in relation to existing professional identities of professionals reinforces the social identity perspective, whereby status within the complex health workforce hierarchy is drawn to some extent from protection of professional boundaries (Ashforth & Mael, 1989).

The findings of *Paper 3* extended upon the discussion of empowerment and degradation where empowerment accounted for positive perceptions and degradation accounted for negative perceptions. It was found that despite tensions between the positive and negative overall perceptions, perceptions of professional identity including values and behaviour were relatively consistent. This paper builds upon extant knowledge by suggesting that the meanings of the workforce redesign ascribed to those outside the profession, particularly organisational management, were seen as being at odds with the consumer-focused ethos of the profession. In this context then, SLPs’ resistance to working with assistants may be a way of strengthening their own client centred values and opposing what they perceive to be organisational goals based on economic rationalism. A theoretical contribution of this paper is to pose that resistance is not a negative response to the workforce redesign; rather than the level of commitment to the group and the differentiation between the profession and other groups in the work organisation contribute to understanding the complexity of resistance. This paper contributes to the study of professional identity and resistance in knowledge workers by illustrating the identity construction of SLPs and proposes that real or perceived threat to this identity may serve as an antecedent to resistance. A clinical application of such findings for organisations is to be cognizant of the importance of professional boundaries and individual professions’ need for distinctiveness in planning workforce redesign.

*Paper 3* empirically examined how resistance to a workforce redesign is influenced by social and professional identity. It proposed that resistance in the research context was less a result of fear of unknown factors, but rather the participants’ considered assessment of the impact of the redesign on themselves and their clients, given their access to information regarding the redesign. These findings led to further examination of the identity of the
professional group, ambivalence of perceptions and potential impact on consumers, which are discussed in Paper 4.

6.4 Paper 4: Paradox


*Paper 2* presented the preliminary findings relating to perceptions of empowerment and degradation, which led to a more detailed exploration of the role of paradox in participant perceptions in *Paper 4*. Considering the results discussed in both *Papers 2* and *3* regarding ambivalence in perceptions of working with assistants, *Paper 4* focuses on the role of professional resistance in relation to such polarisation. *Paper 4* advances the existing knowledge by identifying a number of factors which potentially influence perceptions, either positively or negatively. These factors included drivers for change, professional inclusion and strategic forward planning, and role clarity.

With previous literature identifying that workforce redesign attempts are often unsuccessful secondary to stakeholders being unsure of benefits of change, this paper aimed to understand the perceptions that engender professional resistance to working with assistants and to examine identity factors that may serve to lessen such resistance. The paper contributes to the literature in workforce redesign, identity and subgroups in an organisational context, by providing a clearer understanding of perceptions that trigger resistance, leading to strategies to minimise such resistance. The findings show that most clinicians were willing to work with assistants and were readily able to think of ways in which assistants could benefit health consumers, health services, and clinicians themselves. However, all clinicians discussed issues impinging on the successful uptake of such a workforce change. These issues included the need for protection of professional boundaries, which was largely presented as being for the protection of consumers and their clinical outcomes.
The results presented in the paper demonstrate that there was a polarisation of perceptions across key themes of assistants’ influence on professional roles, tasks undertaken and relationships. Consumers as a focus were discussed as a core value for SLPs, and this was reflected in terms of influencing perceptions. If consumer focus was perceived as a driver for the workforce change, then the overall redesign of working with assistants was perceived more positively. Conversely, if the redesign was seen as being driven from an economic perspective, then perceptions were likely to be more negative. Such identification is valuable in practical terms given the small amount of research available concerning the interaction of polarised perspectives and the outcomes of same.

This paper offers both an increased understanding of factors leading to resistance and a way in which such resistance may be lessened. It proposes that the framing of the workforce redesign is vital in how it is ultimately perceived by professionals. Being cognizant of the strength and importance of professional values such as consumer focus and professional autonomy may lead to framing the redesign from the perspective of the consumer. Such a focus may allow more satisfactory outcomes for all stakeholders. It also offers a contribution to documenting the cultural evolution of an allied health profession, where work at the profession’s boundaries is examined. The increased autonomy of allied health professions since the 1970s is important in terms of perceptions of threatened boundaries and autonomy presented by a vocational tier of the workforce.

The paper affirms the importance of understanding ambivalence in order to address concerns of professionals, positively influence perceptions, and minimise resistance. These results are significant in that they align with or confirm previous findings related to the polarisation of responses to a workforce redesign in a novel context. It contributes to the literature in change management by identifying the importance of professional inclusion and role clarity, decreasing the risks of perceptions of degradation of roles and quality of services. A number of factors that accounted for the different types of reactions were identified, as well as implications for what the findings mean for practitioners and leaders.

The findings of this study were found to be of importance to the speech-language pathology profession, and as such were presented as a poster at the Speech Pathology Australia
national conference in 2017 (Additional contribution 2) in order to access over 1000 SLP delegates from Australia and internationally [O’Brien, R., Mitchell, R., & Byrne, N. (2017). Paradoxical perceptions towards the introduction of assistants in speech-language pathology and potential impact on consumers. Poster presentation at the Speech Pathology Australia National Conference – working and investing in future innovations. May 2017, Sydney, Australia]. The findings also have applicability to a wider health audience, leading to the research findings being presented to the Allied Health national conference in 2017, which attracted a national and international cohort of over 1000 delegates from allied and related health professions – [O’Brien, R., Mitchell, R., & Byrne, N. (2017). Speech-language pathologists’ paradoxical perceptions towards assistants and consumer focus. Oral presentation to the 12th National Allied Health conference. August 2017, Sydney Australia] (Additional contribution 3). This oral paper was important to extend the reach of the research beyond speech-language pathology to a wider allied and related health audience.

6.5 Paper 5: Professional Identity


The tensions between positive and negative perceptions provided the stimulus to further explore the professional identity which appeared to be relatively consistent across the cohort. The professional identity construction and consistency within the participants’ resistance led to further investigation in Paper 5. Exploration of ambivalence and paradoxical perceptions not only highlighted the tensions between positive and negative but also identified conditions where there was agreement. Throughout the research, the professional identity of the cohort has been shown to be stable and strong, whether or not participants identified as typical members of the professional group. This led to a more in-depth exploration of the professional identity of SLPs, and how this identity impacted upon perceptions of working with assistants. The tensions between positive and negative perceptions provided the stimulus to further explore the professional identity which appears to be relatively consistent across the cohort. The speech-language pathology profession is a
beneficial context in which to explore issues of professional identity construction. The profession is well established, though relatively new in comparison to other health disciplines (Godsey, 2011), is a small discipline and uniquely straddles both health and education sectors. All of these issues contribute to the importance of exploring professional identity construction and threat.

Paper 5 identified the presence of a distinct set of values, beliefs and behaviours which was characteristic of the speech-language pathology professional identity, as well as the participants’ perceptions of threat to this identity subsequent to the introduction of assistants.

In Paper 3, it was discussed that the real or perceived threat to SLPs’ professional identity may have been in the form of a threat to the distinctiveness of the speech-language pathology group within the organisational hierarchy. The professional identity construction and consistency within the participants’ resistance led to further investigation in Paper 5. Given the importance of positive employment relationships between professions, professionals and organisations, the need for greater exploration of the professional identity of employees and their professional groups is highlighted. The interest in an assistant workforce over the past decade has had the result of some clinicians perceiving a ‘push’ from employing organisations to utilise assistants. The research findings have explored SLPs’ perceptions of working with assistants and have acknowledged the anxiety resulting from fears for job security or significant role change. It is suggested that strategies such as clear role delineation would be a positive step toward alleviating such fears.

This paper’s contribution is towards a greater understanding of the role of professional identity in workforce redesign. Participants differentiated between being an employee of an organisation and being a member of a professional group, where professional identification is ascribed higher significance. Where professional identity threat was perceived, the meanings ascribed to others outside of the professional group, (e.g. managers and workforce planners) included having an economic focus at the expense of consumer need, a lack of understanding of the speech-language pathology role and subsequent devaluation of professional expertise. The group identity reflected the core values of the profession,
including consumer focus and clinical autonomy, which is consistent with the findings of Paper 4.

Paper 4 offers insight into the way professionals may respond to a perceived professional identity threat. The results of this paper indicated that the introduction of assistants who may share a boundary with SLPs may be perceived as lessening the sharpness of such boundaries, and as such, lessening the distinctiveness of the professional role. It is concluded that real or perceived threat to professional identity is a basis for resistance to a workforce redesign.

The findings of this study were of importance to SLPs and were incorporated into a poster presentation (Additional contribution 4) to the Speech Pathology Australia national conference – working and investing in future innovations in 2017. Over 1000 national and international SLP delegates attended the conference [O’Brien, R., Mitchell, R., & Byrne, N. (2017). Speech-language pathologists’ professional identity in response to working with assistants. Poster presentation at the Speech Pathology Australia National Conference. May 2017, Sydney, Australia].

6.6 Paper 6: Value-added


The previous papers had a focus on the perceptions of SLPs, and how these perceptions were formed. Participant accounts included the concern that there was little evidence available about assistants, and as such SLPs had a poor understanding of assistants’ training, qualifications and the value they could bring to the profession. Similarly, participant accounts indicated a limited awareness of the value that assistants could bring to the profession, their own practice and to consumers. The importance of employees having the correct information needed to provide input into workforce redesign has been identified (Kotter & Schlesinger, 2008). This knowledge led to Paper 6, which discussed assistant training, skills and tasks they are able to undertake, as well as the speech-language
pathology contexts in which they are able to work. The paper presents the demographic differences between SLPs and assistants, acknowledging the profession’s lack of diversity, and how working with assistants may aide the profession to provide more culturally appropriate services to consumers. Similarly, it considers the possibility of working as an assistant to be considered as an alternative career path into speech-language pathology. This paper reinforces the importance of looking to international professional associations for the evidence base for working with assistants. For example, in the United States the speech-language pathology assistant role has been increasingly regulated by state authorities, and in the UK and Canada, assistants are recognised as associate members of the profession, and are therefore bound by their respective associations’ codes of ethics (Royal College of Speech and Language Therapists, 2017).

6.7 Publication and research impact

The research sought to contribute to theory across fields including sociology and organisational psychology, with the papers focused on paradox, professional level resistance and professional identity. It also sought a significant impact on speech-language pathology and broader health workforce policies and decisions. This led the researcher to seek publication in journals that were read by speech-language pathology clinicians and leaders. Though the publications included in this thesis are not in traditional management journals, each of the journals targeted has health workforce included in its scope and has published important papers addressing similar organisational issues. The research impact and importance of each of these targeted journals is discussed specific to each paper in chapter 9.

6.8 Integration of the overall thesis concepts

The concepts discussed in each of these papers and academic contributions are presented in Table 1. This allows comparison of the relationships between the concepts and identifies the complexity involved in perceptions of a workforce redesign.
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**Table 1: Integration of concepts throughout the thesis contributions**

The table illustrates the progression within the thesis from understanding the workforce redesign from the principles of change management to exploring in greater depth the impact of other factors, such as resistance, professional identity and consumer focus. Overall, this highlights the complexity of the inter-relationship between these factors, as well as the capacity for perceptions to be positively or negatively influenced depending on chosen workforce approach. Further research into the numerous factors involved in perceptions of workforce redesign has the potential to affect positive, rather than enforced change, with benefits for stakeholders including consumers, professions, professionals and organisations.
7 Literature review

The following literature review presents the health workforce context, which provides the background for the research. Firstly, it will illustrate how the current state of the health system in Australia has led to the increasing utilisation of less qualified but suitably skilled workers including assistant roles. While the current research concerns allied health, and most notably the discipline of speech-language pathology, it is important to gain an understanding of where allied health is placed in the context of the Australian health workforce.

Published Papers 1 and 2 reported on the data collection and early qualitative analysis of participants’ perceptions. From that analysis, the findings emerged from resistance, paradox and professional identity. Papers 3, 4 and 5 reported on the further exploration of these issues in relation to the data. The following literature review examines the published literature in relation to the Australian healthcare context in which the data collection took place. The literature review in relation to the emergent findings around resistance, paradox and professional identity is presented within the published Papers 3, 4 and 5.

7.1 Australian health system

The key principle of the Australian health system is that the population is able to have access to health services regardless of ability to pay (Healy, Sharman, & Lokuge, 2006). The health system is largely funded through taxes collected by the Commonwealth Government, while the States and Territories have an administrative role in the functional running of hospitals and provision of health services. Given the division of financial and administrative responsibilities, all changes to the health system require an elevated level of negotiation between the Commonwealth and States / Territories (Australian Institute of Health and Welfare, 2016; Healy et al., 2006). As well as the public sector, there is a large private sector which includes medical, nursing and allied health services in acute and non-acute facilities (Freed, Turbitt, & Allen, 2017; Nancarrow et al., 2017; Saunders & Carter, 2017). The overlap of the private sector with public health is actively encouraged by the Australian government, who have inducements for consumers to purchase private health
insurance (McDonald & Duckett, 2017). In 2008 the Council of Australian Governments (COAG) agreed to a national activity-based funding approach, whereby funding public health services is based on the activities undertaken with consumers – that is, health services are paid according to the number and mix of patients treated (Eagar, 2011; Munyisia, Reid, & Yu, 2017). A more recent shift in funding in Australia is the National Disability Insurance Scheme (NDIS) which aims to take a lifelong approach by providing individual insurance to people with permanent and significant disabilities (Foster, Henman, Tilse, Fleming, Allen & Harrington, 2016). This funding allows clinicians to register either as sole traders or non-government organisations to become NDIS providers, whereby they are paid through NDIS funding to provide services to individuals who are insured under the NDIS (Speech Pathology Australia, 2016a).

In a 2016 study of the performance of the Australian health system in comparison with four other countries (US, UK, Canada and New Zealand), it was found that while health expenditure as a proportion of gross domestic product increased in all countries in the study, Australia showed the lowest increment (Martins, 2016). All five countries were shown to differ in the organisation and use of resources. Australia and Canada were the most similar in terms of provision of health services (e.g. universal health cover), but with differences in the use of doctor and hospital services. New Zealand and the UK also provided universal health cover but had lower numbers of doctors per capita, with New Zealand having the lowest utilisation of medical technologies (Martins, 2016). The US is the only country of the five studied to not provide universal health coverage, and it spent more on pharmaceutical drugs and expensive technologies than the other countries. It has the highest health expenditure but the lowest life and health expectancy (Martins, 2016).

7.1.1 Demographics and characteristics of the Australian health workforce

The definition for ‘Health Workforce’ for the purposes of this project is defined as ‘all those professionals who work in the health sector, State, Commonwealth and privately funded in: acute health care, rehabilitation, aboriginal health care, pharmacy, care for people with disability, young people, maternity care, care for families, mental health care, care for people with alcohol and drug issues, aged care, care for people who are dying’
Health professions make up 32% of employment within the Australian health industry (the other groups include managers, administration, support staff, such as cleaners and tradespeople etc) with labour costs being the largest proportion of health costs (Duckett & Willcox, 2015). Health care workers account for approximately 4.3% of the total Australian workforce (Duckett & Willcox, 2015). The National Health Workforce Taskforce has indicated that the number of people employed in health services in Australia is forecast to increase and that the health workforce is growing at a faster rate than the general Australian workforce (National Health Workforce Taskforce, 2009).

The health workforce is ageing with decreased workforce participation rates (Productivity Commission, 2013). Workforce participation for the purposes of this thesis is the extent that members of the Australian population are able to work on a full-time, part-time or casual basis. Having recognised that there will be fewer Australians of working age, reform will be required to encourage more people to enter or re-join the health workforce. The health workforce is experiencing generational change, e.g. it has been discussed that after 2010 workers aged between 55-64 will outnumber workers aged 20-29 (Spinks & Moore, 2007); is increasingly female (e.g. in 2014 the two largest health professions, nursing/midwifery and medicine, female participation was 89% and 39% respectively) (Australian Institute of Health and Welfare, 2016), and working fewer hours (Duckett & Willcox, 2015). Given these changes, there may be more people working in the health workforce, but increased numbers of people are needed to fill more part-time positions (National Health Workforce Taskforce, 2008). The increasing feminisation of the health workforce means that other significant factors are influencing workforce participation including marital status, child raising and carer responsibilities. Similarly, the labour market provides greater options for positions outside of health, which directly impacts on people available to meet health workforce supply (Health Workforce Australia, 2011; National Health Workforce Taskforce, 2008).

It has been identified that Australian health services do not have a sustainable workforce supply to continue to provide necessary services and are part of a larger global workforce shortage (Buchan, Naccarella, & Brooks, 2011). Projected shortages are a result of a
number of factors affecting both the way in which health services are provided and the way the community will need them. These supply and demand factors are a complex interaction including demographics of the health workforce and larger population, disease/illness patterns, and design of the health workforce according to professional and legislative demands (National Health Workforce Taskforce, 2009). A further complicating factor is that workforce shortages are not nationally uniform but depend on the profession and location, and also occur in the wider context of an international health workforce shortage (National Health Workforce Taskforce, 2009). Health workforce shortages across medicine, nursing and allied health have been identified in all states and territories of Australia (Kilpatrick, Le, Johns, Millar, & Routley, 2007). However, it is more recently acknowledged that rather than focusing on increasing the number of specific professionals in the workforce, a more effective method of workforce planning is to focus on the skills required in order to meet consumer need (Duckett & Willcox, 2015).

7.1.2 Health of Australians

The Australian population generally experiences good health outcomes, with improved life expectancy rates and more years of living free of disability or health condition impacting on quality of life (Australian Institute of Health and Welfare, 2016; Productivity Commission, 2015). However, some significant problems have emerged regarding the Australian health system. These problems include the sustainability of current health spending to continue to meet rising demand (with government health spending increasing significantly over the past decades) and the division of financial and governance arrangements between the Commonwealth and State / Territory Governments. Other significant issues include unequal access and subsequent health status of rural and metropolitan communities (for example, the mortality rate of people living in remote and very remote areas was 1.4 times higher than people living in metropolitan centres in 2009-2011) (Australian Institute of Health and Welfare, 2016). Aboriginal and Torres Strait Islander people continue to experience health disadvantage across a number of health indicators, including lower life expectancy and higher rates of diabetes. Indigenous Australians are 1.5 times more likely to experience disability, and Indigenous women are twice as likely to die from complications due to pregnancy and childbirth than non-Indigenous women (Australian Institute of Health
Health spending has been increasing in Australia over the past years and is expected to continue to increase as a result of growing public demand for services. Australian health spending in 2013-2014 was estimated at $155 billion, of which two-thirds was derived from governments (Australian Institute of Health and Welfare, 2016).

The sustainability of the health workforce is a priority (Australian Institute of Health and Welfare, 2016), requiring consideration of new models of healthcare delivery and preparation of the health workforce to respond to the changing health needs of the community (Health Workforce Australia, 2012). Considerations include health workforce imbalances and shortages in terms of the ageing population, the parallel ageing health workforce with falling workforce participation, skill imbalances and strategies to address these issues (Health Workforce Australia, 2011). This has necessitated a focus shift from planning for future growth and design of the workforce to working from the needs and outcomes required of the population and addressing how these needs may be met (Health Workforce Australia, 2012). Failure to reform the systems which train and employ the health workforce may result in a mismatch between available workforce skills and community need. This mismatch will result in a lack of adequate care for the community, particularly those in vulnerable populations including the elderly, those with chronic conditions or mental illness, and Aboriginal and Torres Strait Islander people (Australian Institute of Health and Welfare, 2016).

### 7.2 Supply and demand in the Australian health workforce

Factors affecting the supply and demand of the Australian Health workforce include increasing demand for health workers, competition for labour both internationally and with other sectors within Australia, and the education and training system that has limited ability to meet the needs of the health system in a timely manner (National Health Workforce Taskforce, 2009). Duckett & Willcox (2015) discuss the difficulties in ensuring a balance of health workforce supply and demand, including low mobility of health professionals - for example, over-supply in some areas and under-supply in others, largely evidenced as recruitment and retention difficulties in rural areas. Importantly, it is discussed that professional responses to workforce innovation and reform impact on the uptake of
programs which may address consumer need (Duckett & Willcox, 2015). The work of the Productivity Commission (2005) recognises that growth in health expenditure and the resultant need for health workforce reform occurs largely due to factors including advances in technology, changing community expectations and health inflation (Productivity Commission, 2005). In comparison with the US, UK, Canada and New Zealand, it was shown that there was an increased number of health professionals employed in Australia during the study period of 2001 to 2011, with Australia and New Zealand having the highest amount of inpatient care, along with more nurses per capita than the comparison countries (Martins, 2016).

7.2.1  **Factors contributing to health workforce demand:**

7.2.1.1 **Population growth**

The Australian health system reform will address population growth in order to create a sustainable health system for the future. Population growth may be viewed as a chance to renew and refresh the health system to best meet changing population needs, however, financial constraints must also be considered, such as accessing appropriate funding for services (Australian Institute of Health and Welfare, 2016). The time between population growth and implementation of new health infrastructure must be considered – if the time lag is too great, then population growth over this time has the potential to heavily burden existing services. Another factor for consideration regarding population growth is the geographical distribution of the community and the availability of appropriate health services (Russell et al., 2013). If population growth is significantly faster than health service implementation it may have a negative impact on the health and well-being of the community. To continue in the current health model and simply increase numbers of workers would not only fail to meet changing community needs but also be economically inappropriate.

7.2.1.2 **The ageing population**

The Australian population is ageing, which will increase health expenditure and demand. It is estimated that over 6.4 million people will be aged over 65 in Australia by the year 2051.
(Healy et al., 2006), with an increase of approximately 4 million people over the age of 75 years between 2012 and 2060 (Productivity Commission, 2013). People aged over 65 years are more likely to use health services such as general practitioners, require more medication and longer hospital stays (Bartlett, Wang, Hay, & Pang, 2017; Productivity Commission, 2013). Ageing impacts on the changing care needs and health spending is approximately four times higher for people aged over 65 than that of people aged under 65 years (Productivity Commission, 2013). It is discussed that an ageing population is not the main determinant of health spending, but rather one of a suite of determinants; including new medical technologies, increased costs of services and higher consumer expectations of treatment (Department of the Prime Minister and Cabinet, 2014; Segal & Bolton, 2009). It was found that Australia had the highest life expectancy, second highest levels of education and income in comparison to the UK, US, Canada and New Zealand (Martins, 2016). Similarly, World Health Organization estimates show that Australians have the longest disability-free years among the five countries, with the US having the lowest (World Health Organization, 2014).

7.2.1.3 Changing burden of disease

The incidence and pattern of disease are changing in Australia, which directly impacts on health service provision (Australian Institute of Health and Welfare, 2016). The incidence of chronic conditions such as diabetes, anxiety and arthritis is increasing and is linked to an ageing population and lifestyle factors such as smoking and obesity. Chronic conditions require a change of focus of health services to primary and secondary prevention in order to slow their growth in the community (Foley, 2011). There is also an increased awareness and need for early intervention services for children with special needs (Guralnick, 2017). To compound the changing illness patterns, it is documented that disease treatments are becoming more expensive (Garling, 2008). The cost of a first-time stroke in Australia in health costs and lost productivity has been calculated as approximately $100,000AUD (Kim et al., 2017), and cardiovascular disease (including stroke and coronary heart disease) cost $7.9 billion in 2008 (Foster & Mitchell, 2013). It is estimated that by 2050 in Australia, 7400 new dementia diagnoses will be made each week, which is important considering that health and aged care spending for people with dementia was $4.9 billion in
2009-10 and that dementia is anticipated to require greater health spending than all other health conditions by 2060 (Keast, 2015).

7.2.1.4 Changing public health priorities

Given that disease patterns have changed, the focus of the health system has moved from unpredictable acute illnesses to predictable chronic conditions (Duckett & Willcox, 2015). This requires the health system to have a role in empowering the population to look after their own health and wellbeing, encourage self-management, and for health professionals to work in partnership with consumers to optimise health outcomes. There is a move for a greater proportion of health spending to be invested in population-based prevention programs (such as smoking reduction or responsible consumption of alcohol) to enable effective management before illnesses develop, or early management in the illness progression (Australian Institute of Health and Welfare, 2016). A significant challenge for the US, Canada, NZ, but most especially Australia is bridging the gap between the health of Indigenous and non-Indigenous populations (Martins, 2016)

7.2.1.5 Advances in technology

Technological advances in health services are able to provide improvements in quality and quantity of life (Department of the Prime Minister and Cabinet, 2014; Willeme & Dumont, 2015), however, require changes in workforce demands (Duckett & Willcox, 2015). Such demands include new skills and new service delivery models, with resulting impacts on workforce structure, including the implementation of new roles (Armstrong, Gillespie, Leeder, Rubin, & Russell, 2007; Productivity Commission, 2005). As technology continues to evolve, a full assessment of what impact this will have on the health workforce is desirable.

7.2.1.6 Consumer and workforce expectations

The Australian health system in its current format was designed in the 1950s when demands and needs of the community were different and more focused on acute care (Foley, 2011). Community needs and expectations have changed and the focus is now on
chronic conditions as well as primary and preventative care (Segal & Bolton, 2009). The role of the healthcare consumer has changed and has had a significant effect on the health system by driving necessary reform. Consumers are now more empowered than ever before regarding their health care and are more knowledgeable about their own health or illness given the availability of information through sources such as the internet and the media (Australian Institute of Health and Welfare, 2016). This knowledge enables them to engage their health care providers in partnership towards their treatment and health outcomes, rather than having their treatment options decided for them.

7.2.2  **Factors contributing to health workforce supply**

7.2.2.1  **Competing demands for labour**

Australia is part of a global economy and is therefore exposed to competition from international labour markets for the workforce. The global shortage of health care workers means that individuals with the skills and qualifications to work in the health sector are in high demand (Zurn, Dal Poz, Stilwell, & Adams, 2004). The demand for Australian healthcare workers exists internationally, as well as within Australia across State/Territory borders (National Health Workforce Taskforce, 2009). National and international recognition of qualifications is increasing, allowing for greater mobility of the skilled labour force (Duckett & Willcox, 2015). The occurrence of occupational spillage is evident where people with in-demand skills leave the sector they trained in to work in other employment such as the private health sector (National Health Workforce Taskforce, 2009).

7.2.2.2  **A shrinking workforce pool and changing workforce intentions and availability**

The working-age population is becoming smaller as a result of the Baby Boomer generation reaching retirement age, as well as generational shifts in attitudes to the priority of work as compared with other commitments (Segal & Bolton, 2009). Health professionals tend to retire between 60-65 years of age, and with decreasing working hours in the years preceding this (Duckett & Willcox, 2015). With numbers of people aged over 60 being forecast to increase to 22.9% in the year 2021, the workforce is facing a significant loss
through reduced hours and retirements. There will also be a significant decrease in people between the ages of 20-49 years who make up a substantial proportion of the workforce pool. There is a consistent trend across health professions to decrease working hours for a variety of reasons, including (but not limited to) overseas migration due to personal, career or economic reasons, child raising and family commitments (National Health Workforce Taskforce, 2009). Strategies to increase the available labour force include broadening the range of people available in the workforce, including women, older workers and under-represented groups (Campbell et al., 2014).

7.2.2.3 Reliance on international health professionals

Working in Australia is an attractive option for internationally trained health professionals, and Australia has relied on migration to supplement the domestic health workforce (Duckett & Willcox, 2015). There are a number of practical and ethical issues involved in this reliance: The practical being that Australia has not gained self-sufficiency in its health workforce supply, and the ethical being that as part of a global market, migration of health workers to a prosperous country such as Australia may leave developing countries in a state of health workforce crisis (Campbell et al., 2014).

7.2.2.4 Education and training of health workforce professionals

Australian health roles have remained relatively conservative in their scope of practice, with only changes such as extended, changed or new roles being recognised as part of the recent health care reform (Duckett & Willcox, 2015). The education and training of the health workforce will need to match community need, which will entail innovation in terms of roles and delivery of health services (Health Workforce Australia, 2012).

It is acknowledged that it takes considerable time from beginning a health degree to workforce outcomes, given long education and training times (3 years for a nursing degree, 4 years for most allied health professions, and 5-6 years for dentistry and most medical programs) (Duckett & Willcox, 2015). It is therefore important that education and training facilities and employing health organisations have greater co-ordination in their future
planning to ensure appropriate numbers, as well as skill sets, are available (Department of the Prime Minister and Cabinet, 2014; Zurn et al., 2004).

7.3 Models of care

Health workforce changes are focused on the development and progression of new models of care, facilitation of interprofessional practice and to make the health workforce sustainable in order to meet increasing demands resulting from changing population demographics and health needs (Australian Institute of Health and Welfare, 2016). This, in turn, aims to create a responsive health system able to meet the changing needs of the Australian population. The trend towards devolution of traditional roles and boundaries and increased focus on providing appropriate skill mix has been widespread in the health services (Buchan & Dal Poz, 2002; Duckett & Willcox, 2015). The dilemma of decreasing workforce availability coupled with increasing consumer need has necessitated the focus on a changed structure to traditional health services. Government policy and strategy have placed the health consumer at the centre of their own treatment and there has been increasing reliance on workers in vocationally trained assistant roles (Health Workforce Australia, 2012).

7.3.1 Effective service delivery and interprofessional approaches

Working in interprofessional teams comprising of practitioners from various clinical disciplines is becoming more common in healthcare provision, as a way to increase effective delivery of care (Mitchell et al., 2016; Zwarenstein, Goldman, & Reeves, 2009). Positive outcomes of such teams can include reduced service duplication, improved clinical outcomes for clients, increased innovation and problem-solving (Zwarenstein et al., 2009). However, barriers to interprofessional approaches have been well documented including health policies not considering the importance of underlying professional differences (McNeil, 2014), which may contribute to conflict and poor team dynamics (Mitchell et al., 2016). Walshe and Shortell (2004) discuss ‘professional protectionism’ as being professional self-interest prioritised above consumer needs, while Lizarondo, Kumar, Hyde and Skidmore (2010) discuss issues such as professional status, security and professional
identity being challenged by role boundaries which are not well defined. Nancarrow and Borthwick (2005) discuss that professions may act in ways to ensure the maintenance of their group status in society by controlling professional behaviour and tasks, as well as limiting entry to the profession. Zurn and colleagues (2004) discuss the actions of professional associations who, through their representation of a profession, attempt to increase the standing of the profession in society and increase influence and income. It is discussed that professions need to be willing to share power in order to function positively as a team and provide holistic care. While professions engage in professional boundary protection with the intention of increasing their power or status, effective team working will be elusive (Reeves, Lewin, Espin, & Zwarenstein, 2010).

Role restrictions and regulation for health professions are in place with the intention of protecting the safety of consumers accessing health services (Australian Health Practitioner Regulation Agency, n.d.). It ensures that health professionals are appropriately skilled and qualified to undertake specific tasks. However, role restriction and regulation may also be viewed as overly cautious in terms of patient safety. The community may be denied access to services due to workforce shortages and unmet health demands, when tasks may be safely provided by a health worker other than the professionals who have traditionally performed them (Australian Government Department of Health and Ageing, 2008).

As previously discussed, the changing health needs of the population require a shift in the way workforce planning is conceptualised. Traditionally workforce planning has been conducted by looking forward from the current pool of professions and health workers and increasing their number, however, this has been shown to be inadequate to address impending shortages (Health Workforce Australia, 2012). While it is important to ensure adequate skill mix and number of professionals trained to meet this need, a change in focus is necessary from increasing graduate numbers to addressing the skills or tasks to be delivered (Duckett & Willcox, 2015). A more effective workforce planning method would involve ‘working backwards’ from identified health outcomes and need, to how these needs may be met. This change in focus has been the impetus for looking to vocational roles to perform a selection of tasks traditionally conducted by tertiary trained health professionals.
It has been demonstrated that the current system of healthcare is not adequately meeting the current and future needs of the Australian population, and there is a clear need for workforce redesign. Alternative designs which have been considered include new models of care and reconsideration of traditional roles within the health workforce. The provision of timely, high-quality health services to the community requires a workforce with the appropriate skills and training to do so. In the current climate of increasing demand and changing focus of health services, role redesign is intended to make the best use of available skill and numbers of staff. Changing skill mix in the workforce is an important strategy which may improve the existing health care system, as well as address workforce shortages (Bosley & Dale, 2008).

Strategies which have been considered to improve recruitment and retention of health professionals have included increasing student placements, improving education and training and consideration of alternative service delivery models such as utilising vocationally trained staff including assistants (Schoo, Stagnitti, Mercer, & Dunbar, 2005). Internationally, health workforce reforms have included strategies such as skill mix changes and the creation of new roles such as healthcare assistants and support workers which allow professionally qualified staff to delegate tasks of lower complexity (Buchan & Dal Poz, 2002; Nancarrow & Borthwick, 2005). Papers arising from the current research will explore the concept of tertiary qualified professionals working with vocationally trained assistants in greater detail. Please see Chapter 9 – published papers.

### 7.3.2 Changing the health workforce skill mix – advanced practice

One method of changing the skill mix in the health workforce has been to create new roles. One of these new roles is that of the advanced practitioner, or extended scope practitioner within nursing or the allied health professions. The advanced practice role for allied health professions has been implemented in part to increase the flexibility of the health workforce, and to create the ability of non-medical team members to conduct tasks traditionally performed by other professions (McPherson et al., 2006). McPherson and colleagues (2006) discuss the problematic use of the term ‘extended scope practice’, and there remains scant evidence to date regarding the health outcomes, cost-effectiveness, agreed on definition,
and lack of formalised education and training for clinicians to be considered ‘extended’ or ‘advanced’. Drivers of this type of role can be categorised into two groups: service or profession based (McPherson et al., 2006). Service-based drivers are, for example, limits of funding, skill shortages and alternative models of care, while profession-based drivers include the need for career pathways, job security and satisfaction which potentially lead to better recruitment and retention. There is no agreed definition of advanced practice, however, it is agreed to have a clinical component, formal preparation, and be beyond the general scope of practice of a given profession (McPherson et al., 2006; Sibbald, Shen, & Mcbride, 2004). It is recognised that since clinical work is constantly changing, tasks which may be ‘advanced’ may change to be within the general scope of practice of a profession over time. This being considered, however; advanced practice roles have the potential to move a profession forward and be responsive to changing service and community needs.

7.3.3 Changing the health workforce skill mix – assistants

Another important new role is that of support staff or assistants. The emerging roles of support staff are gaining momentum internationally, with literature coming from the UK, Canada, the U.S. and some Australian papers; however, the pace of local reform has been slower than comparable countries (Lowe, Grimmer-Somers, Kumar, & Young, 2008). Utilising suitably skilled, vocationally trained staff to provide clinical services is an example of a workforce redesign which has the potential to improve health outcomes for consumers. It has been shown that consumer satisfaction with health services increases when working with assistants, including allied health assistants, nurse practitioners and health support workers (Lizarondo, Kumar, Hyde, & Skidmore, 2010). There is also the potential to make positions more attractive to professionals because they may be afforded the ability to focus more on complex tasks and needs of their clients. The provision of positive challenges associated with working with assistants and additional career structure has the potential to improve recruitment and retention of skilled clinicians (Lizarondo et al., 2010; McLaughlin, Adamson, Lincoln, Pallant, & Cooper, 2010). Working with assistants may also positively contribute to decreasing waiting lists and promoting reasonable workloads (Goldberg, Williams, & Paul-Brown, 2002).
The assistant role in allied health professions is one of several positions considered as support staff. The aim of redesigning services by utilising assistants is to employ vocationally trained staff to provide clinical support under the supervision of allied health professionals (Queensland Health, 2016). Poor understanding of the efficiency and effectiveness of new roles such as that of the allied health assistant have contributed to professions being reluctant to relinquish traditional service delivery models and embrace new innovations (Nancarrow & Borthwick, 2005). The published papers arising from the current research explore perceptions of professionals to working with assistants, including their perceptions relating to delegating tasks, supervision and role boundaries, in greater detail. Please see chapter 9 – published papers.

7.4 Australian allied health workforce

The professions which are broadly referred to as allied health in the Australian health workforce include, but are not limited to; audiology, dietetics, exercise physiology, music therapy, occupational therapy, physiotherapy, psychology, social work, and speech-language pathology (Australian Institute of Health and Welfare, 2012). These professions undertake tertiary training which includes clinical components.

While it is recognised that reliable workforce data on the Australian allied health professions is lacking (Nancarrow et al., 2017), it is known that allied health professionals make up approximately 20% of the health workforce in Australia (Philip, 2015). Nancarrow and colleagues (2017) conducted an environmental scan of 27 allied health professions in Victoria, Australia, and found that more than 80% of the allied health professions profiled were female, and half of the professions reported that a third of their workforce is aged under 30 years (Nancarrow et al., 2017), and are generally younger than the health workforce as a whole. Allied health professions are an important part of the provision of Australia’s health services including primary and preventative care, chronic disease management, acute and community health (Philip, 2015). They work across a range of services including acute/sub-acute, community health, aged care, education, palliative care and specialist services including mental health and drug and alcohol services. Allied health services work with medical and nursing professions, and are in both public and private
sectors, charitable organisations, a range of government departments including disability and education settings, as well as other facilities such as tertiary education.

Staff retention is a key issue for all allied health professions (Naccarella, 2015), as it impacts upon the ability to provide sustained and reasonable access to allied health services. There has been significant research into retaining the current allied health workforce, as well as strategies such as diversifying the populations who may choose to enter allied health professions, such as people from culturally and linguistically diverse backgrounds (Byrne, 2007, 2015).

7.5 Australian speech-language pathology profession

Speech-language pathology is an allied health profession in Australia with clinicians working across a wide range of settings. Speech-language pathologists (SLPs) are clinicians who work with people across the lifespan, with a range of either developmental or acquired disorders affecting communication, voice or swallowing (Speech Pathology Australia, 2015). Speech-language pathologists work with paediatric and adult caseloads, in settings including but not limited to, hospitals, community health settings, group homes, residential aged care facilities, education settings such as preschools and special education units, rehabilitation services, correctional institutions, mental health settings and universities (Speech Pathology Australia, 2015). The practice areas in the speech-language pathology scope of practice include speech, language, fluency, multi-modal communication, voice and dysphagia (swallowing) (Speech Pathology Australia, 2015).

7.5.1 Speech-language pathology profession and training in Australia

In Australia, SLPs were originally called ‘speech therapists’ or ‘speech correctionists’ and the current title of ‘speech pathologist’ / ‘speech-language pathologist’ did not come into wider use (including changing the name of some university degrees) until the 1990s. The title ‘speech pathologist / ‘speech-language pathologist’ implies that the clinician not only provides speech therapy to clients and patients but is also responsible for the diagnosis and management of disorders relevant to speech pathology (Byrne, 2007). There is evidence to suggest a lack of public awareness of the role of speech-language pathologists. An
Australian survey of 400 members of the general public showed that 41% of people lacked awareness of the role of the speech-language pathologist (Parsons, Bowman, & Iacono, 1983). A UK study conducted a questionnaire with 651 school and college students at a point where they were selecting degree courses and found that one-third of participants had no knowledge of speech-language pathology, with males being significantly less familiar with it than females (Greenwood, Wright, & Bithell, 2006). In an Australian study of students studying related allied health degrees, it was found that participants reported a lack of knowledge of the speech-language pathology profession at the point of selecting a course of study (Byrne, 2010). There is also evidence to suggest that colleagues who share a working relationship with speech-language pathology also have limited knowledge of the role of the SLP (Lesser & Hassip, 1986).

Speech-language pathology training is via a university degree at either a Bachelor or Masters level (Speech Pathology Australia, 2017b), with clinical components. The profession is comparatively young in Australia, with speech-pathology having a longer history in the UK and US. In Australia, training was historically a diploma level course, however, training changed to a 3-year Bachelor level course as the profession expanded and the scope of practice increased (Speech Pathology Australia, 2017c). Currently, the undergraduate training is a 4-year Bachelor-level degree. The university speech-language pathology programs need to meet comprehensive accreditation requirements with Speech Pathology Australia (SPA), the national peak body for the profession in Australia (Speech Pathology Australia, 2017a). This accreditation is to ensure that graduates meet the professional competencies in order to work as a practising speech-language pathologist. While individual membership of SPA is not mandatory for SLPs in Australia (necessary only to be eligible for membership to work as a SLP), it is increasingly preferred by employers; for example, SLPs must be members of SPA to access private rebates such as health funds for clients / Medicare (Speech Pathology Australia, 2017d).

7.5.2 Registration/membership of Speech Pathology Australia

Speech-language pathology is currently not a registered profession in Australia, so SLPs are not required to be registered with the Australian Health Professions Regulation
Authority (AHPRA). Disciplines who are required to be registered with AHPRA include, but are not limited to; Occupational Therapy, Physiotherapy, Psychology, Podiatry, Optometry, Chinese Medicine, and Aboriginal and Torres Strait Islander Health Practice (Australian Health Practitioner Regulation Agency, n.d.). Speech-language pathology is a self-regulated profession, meaning that membership of SPA is a method by which consumers can ensure that a clinician has the necessary levels of training and practice to be working as a SLP in Australia (Speech Pathology Australia, 2017d). Speech Pathology Australia has a self-regulation scheme ensuring that SLPs have an ongoing commitment to professional development and practice recency.

Speech Pathology Australia is the peak body for the profession in Australia, and despite membership not being mandatory, SPA represented over 8000 members in 2017 (Speech Pathology Australia, 2017c). The speech-language pathology profession was represented by Speech Pathology Australia and the Speech Pathologists Board of Queensland in their submission to the Australian Health Practitioner Regulation Agency to become a nationally registered profession under the National Accreditation and Registration Scheme (The Speech Pathology Association of Australia Limited and Speech Pathologists Board of Queensland, 2009). Speech-language pathology was ultimately not included in the scheme as it was decided that there was not adequate evidence of public safety concerns resulting from speech-language pathology intervention (Cimoli, 2011). The original submission discussed risks posed to public safety by individuals who do not possess the appropriate professional competencies to conduct speech-language pathology intervention. The importance of public trust in the speech-language pathology profession will continue to increase while demand for service increases. SLPs work with people with communication and swallowing disorders, and such populations can be vulnerable. While speech-language pathology remains unregulated, the public cannot be guaranteed safe and competent services from suitably qualified clinicians (Cimoli, 2011).

7.5.3 **Speech-language pathology workforce in Australia**

The findings of the Speech Pathology Australia General Membership Survey (Lambier & Atherton, 2003) were found to be generalisable to the Australian speech-language
pathology workforce, and demographics have shown little change in the period since then. The general membership survey (2003) highlighted that speech-language pathology is a homogenous profession with 96.1% of respondents being female, while more recent information from Health Workforce Australia (based on census data), showed that 97.5% of speech-language pathologists in Australia are female (Health Workforce Australia, 2014). Less than 10% of speech-language pathologists in Australia are aged 55 years and over, showing a young overall age profile, and the average working hours per week was 30.3 in 2011 (Health Workforce Australia, 2014). The membership survey (2003) reported that 85.2% of respondents were born in Australia, while in the 2011 data this dropped slightly to 82.9% (Health Workforce Australia, 2014). The membership survey showed that state governments were the largest employing bodies (Lambier & Atherton, 2003), while more recently, the private sector employed 57% of speech-language pathologists (Health Workforce Australia, 2014). Speech-language pathology is increasingly sought after through the NDIS as well as in other private sector settings. This is driving demand for more clinicians working in private practice or non-government organisations than in public services; It was found that in 2011 for the first time there were more SLPs Australia-wide working in the private sector than in the public sector (Health Workforce Australia, 2014).

### 7.5.4 Recruitment and retention in speech-language pathology

Speech-language pathology 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 (McLaughlin et al., 2010). In their 2010 study of turnover and intent to leave among Australian speech pathologists, McLaughlin and colleagues discussed that of their participants 31% indicated the likelihood that they would leave their current job in the following 12 months, and 13% reported the likelihood that they would leave the profession in the same time period. Given the increasing need for speech-language pathology services, these statistics are cause for concern for the profession. It is important to look at issues regarding ongoing recruitment and retention of SLPs in terms of job satisfaction, stress and attrition in relation to the impacts on service provision (Iacono, Johnson, Humphreys, & McAllister, 2007). The general assumption is that SLPs leave positions or the profession in order to raise children, however, it appears that SLPs are more likely to remain in the
profession if they have young children (McLaughlin et al., 2010). It was demonstrated that it is more likely to be other variables which contribute to turnover and attrition, such as high levels of administration time, low levels of perceived job security, and speech-language pathology not meeting professional needs (McLaughlin et al., 2010).

7.5.5 **Utilisation of assistants in Australia**

Maintaining and increasing the speech-language pathology workforce is vital for the ongoing provision of clinical services. Speech Pathology Australia acknowledges that increasing graduate numbers and international recruitment will not be adequate to meet this workforce shortage, and support initiatives to address this need including changing the scope of current practice to allow clinicians to delegate tasks traditionally performed by qualified SLPs (Speech Pathology Australia, 2016).

Utilising generic or discipline-specific assistants is a high priority workforce strategy for NSW Health; however, there is limited literature published regarding SLPs working with assistants, and even less pertaining to understanding SLPs’ perceptions of working with assistants. There is therefore minimal evidence to support the implementation of assistants for speech-language pathology. The speech-language pathology discipline has been shown to be a significant user of assistant services in some states of Australia (e.g. Victoria and Western Australia), and internationally (e.g. The UK, US and Canada), but the system has not yet been embraced in NSW. The limited research currently available regarding SLPs working with assistants provides little insight into professional acceptance of this vocationally trained group (i.e. assistants). Speech Pathology Australia supports the utilisation of assistants for speech-language pathology specific work (Speech Pathology Australia, 2014), but currently, assistants are not considered part of the speech-language pathology workforce. The primary aim of the current research is to describe the perceptions of SLPs to working with assistants for clinical service provision.

A review of the literature regarding assistants in allied health revealed only a small amount of literature available with specific reference to speech-language pathology. Studies completed with occupational therapy and physiotherapy have been considered given their parallels with the speech-language pathology profession 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 particularly in terms of professional structure and work practices. Given the lack of discipline-specific research, it was found that the roles of the assistants and SLP working together were poorly defined, potentially impacting on SLPs’ perceptions of working with assistants. This literature review has been included in this thesis as additional contribution 1 (O’Brien, R. (2010). Rural speech pathologists’ perceptions of working with allied health assistants: A pilot study. Maitland: Institute of Rural Clinical Services and Teaching).

7.6 Limitations of previous literature

The existing research cited in this literature review has significantly contributed to knowledge of why health services are endorsing changed service delivery models, including interprofessional approaches and vocational tiers of the workforce being implemented to share occupational boundaries with professional tiers. A significant limitation of this literature which led to undertaking the current research was the exclusion of the speech-language pathology profession from such investigation. These studies present a number of limitations. Some of the studies discussed have focused on how the profession has resisted the introduction of assistants and have viewed such resistance as a negative response. Thomas and Davies (2005) note that there has been a relatively small amount of research attention paid to the role of identity in resistance, and the tendency to frame resistance as negative may account for this lack of research.

Data regarding the implementation of an assistant workforce has also often been collected after assistants have been implemented (e.g. McCartney et al., 2005). Collecting data at these times would be relying on the memory of participants of their perceptions, and the time difference between pre- and post-implementation may influence participants’ recollection either positively or negatively. Research based on perceptions prior to a workforce redesign is necessary to develop the evidence of what factors influence perceptions, how resistance is experienced, and what factors may mitigate such resistance, impacting on accepted rather than enforced workforce change. Workforce research with a
longitudinal perspective is necessary to develop the evidence for strategic, long-term workforce planning.

Most research undertaken regarding an assistant workforce has been concrete in nature, focusing on aspects of the division of labour, such as delegation of tasks and activities, and role delineation. The results of such research do not allow for a detailed understanding of the development of perceptions and the impact of personal factors such as status and professional identity. When the research focuses on task delineation, the research becomes limited to one, or at most, a few related disciplines. It is difficult to extrapolate then to different professions with a different clinical focus. For example, physiotherapy has a physical focus and division of tasks between an assistant and a physiotherapist may be considered reasonably straightforward. In a discipline such as speech-language pathology where there is less of a physical clinical focus and more focus on cognitive tasks, there may be less clarity in task delineation.

A key argument of this thesis is that SLPs’ identities are shaped by their expectations and experience of their professional group (Mackey, 2007). This experience includes professional training, qualifications and socialisation. It includes agreed standards of practice and behaviour which are strongly encouraged by employing organizations (McNeil, Mitchell, & Parker, 2013). It is felt that the current research has implications beyond speech-language pathology; that results are equally applicable to other allied and related health contexts. There are also implications beyond health services; there are clear examples of technically versus professionally qualified roles where there is potential for one part of the workforce to constitute a cheaper option. Examples in the health sector include technical roles being implemented in professions such as medicine, nursing and dentistry (e.g. Kracher et al., 2017), but there are also examples in other sectors such as education (e.g. Willis, 2017). By analysing SLPs’ perceptions of the expected standards of practice and behaviour, this thesis seeks to understand how the introduction of a vocationally trained occupational group may present a threat to this sense of identity, and in turn, the impact it has on resistance.
7.7 Summary

The changes evident in the health of the Australian population (e.g. the ageing population, increased chronic disease management and higher consumer expectations) are contributing to a change in the way health services are needed and being delivered. The increasing demand for services combined with a need for sustainable health workforce and spending indicates that the health system in Australia requires a workforce that is flexible, adaptable and innovative to address these changing demands. The utilisation of an assistant workforce has been adopted by other professions such as occupational therapy, physiotherapy, nursing and medicine, but is slow to be utilised by speech-language pathology, particularly in NSW.

Assistant roles have traditionally evolved to fit a service’s individual needs, and have not been a systematic, planned implementation (Lowe et al., 2008). The comparatively slow acceptance of such reform in Australia may be attributed in part to barriers presented by professional boundaries and relatively static models of health service delivery. This thesis hypothesises that poor understanding of the motives behind such workforce reform may contribute to professional reluctance to change traditional ways of working. National workforce reform policies, as well as Speech Pathology Australia, supports the introduction of an assistant workforce and as such new roles and models of care have the potential to provide a wider range and amount of speech-language pathology service to those who need it. Working with assistants has the potential to decrease long waiting times and to contribute to meeting growing service demands across the scope of speech-language pathology services (Goldberg et al., 2002). There is also the unexplored area of whether working with assistants may add to a positive career path for speech-language pathologists. Ensuring that the health workforce is suitably qualified and skilled is essential to achieve safe health services that are of a high quality (Wylie, McAllister, Davidson, & Marshall, 2013). The innovative creation of assistant roles within speech-language pathology has the potential to create a financially viable, sustainable and highly skilled workforce that is able to meet the needs of the community. While the move towards an assistant workforce in speech-language pathology is gathering momentum, it is not without issue. Speech-language pathology has been notably absent from the discourse regarding working with
assistants, and there is a paucity of research and evidence to demonstrate effectiveness, efficiency and appropriate outcomes for consumers of these services. This thesis identifies SLPs’ perceptions of working with assistants, as well as factors contributing to these perceptions.

Inherent in any potential change to the profession are the clinical obligations to patients, clients and the community, alongside the fiscal constraints and need for workforce sustainability of the employing organisation. Before it is able to be claimed that working with assistants is a solution to workforce supply shortages and increased clinical demand in the SLP profession, the profession itself and employing organisations need a clear understanding of the perceptions of SLPs to this workforce change. Perceptions of working with assistants require further research in order to fully evaluate professional practices and services, and the possibility of expanding these services to meet demonstrated need. However, the focus on the need for workforce redesign has not explored in detail the perceptions of clinicians currently working in an established clinical model (O’Brien et al., 2013). It is important to research perceptions of practising clinicians to a workforce redesign as there is potential for negative perceptions to impact on uptake of new innovations (Kotter & Schlesinger, 2008).

Health services policy and workforce planning have a focus on increasing the assistant workforce to meet increasing healthcare demand in a climate of diminishing resources. The rhetoric surrounding the professional perspective concentrates on ensuring clinical outcomes continue to be met and profession-specific skills continue to be maintained. In contrast, most studies tend to focus on organisational aspects, broadly investigating issues including division of labour, delegation and supervision. It is necessary to explore what working with vocationally trained assistants means to professionals, what impact it has on their perceptions of their own professional identity, and how their status within the larger organisation may be impacted. With this aim in mind, we have utilised a group of Australian SLPs from an area without extant policies and procedures regarding working with assistants, and minimal opportunity for experience with such a workforce group. In particular, the factors that impact on the development of perceptions were of interest and has wider applicability to other disciplines and professions.
7.8 Research questions

The purpose of this research is to explore and generate an understanding of SLPs’ perceptions of working with vocationally trained assistants. It is of interest to examine the underlying principles which contribute to the formation of such perceptions. In addition, the study aims to gain a preliminary understanding of the professional identity of SLPs, what factors contribute to its formation, and what impact this has on perceptions of working with assistants. The exploratory nature of the research led to the use of a qualitative methodology, specifically interpretative phenomenological analysis, which will be discussed in detail in the following sections.

This research has several aims. Firstly, it is important to establish how participants perceive the introduction of assistants into their profession as well into their individual workplaces. It is important to the research that participants discuss their perceptions in their own words, drawing from their own experience of the profession. This research also aims to explore the meaning that SLPs ascribe to the introduction of assistants, according to whether they fit with extant literature in the area of workforce change.

As a result, this thesis aims to answer the following research questions;

1. What are the perceptions of SLPs in NSW, Australia, to working with assistants?
2. What meaning is ascribed to the implementation of assistants by SLPs?
3. What factors contribute to the perceptions of SLPs to working with assistants?

A further three questions emerged from the findings of the early stage analysis, namely;

4. How is resistance to a workforce redesign realised in SLPs’ perceptions of working with assistants?
5. What meanings do SLPs ascribe to their professional identity? and
6. How does professional identity formation impact on SLPs’ perceptions of working with assistants?
8 Methodology and method

This section describes the methodology and methods used in this research. It discusses the reasons for using a qualitative approach and why interpretative phenomenological analysis informed the approach to the qualitative analysis of participant perceptions. The nature of qualitative research in relation to this project is discussed, along with a detailed description of the research process including design, sampling strategies, ethical considerations, and research limitations.

8.1 Research approach

The nature of the research questions lent itself to using a variety of methods; consideration was given to quantitative and also mixed methods approaches. A qualitative methodology was ultimately chosen as the overall approach to the research, as it allows the opportunity for in-depth exploration of the phenomena, through a person’s individual perspective, with respect to the context in which it occurs (Denzin & Lincoln, 2005). Given the aim of the current research is to inform policymakers and practitioners of the issues involved in the introduction of an assistant workforce in speech-language pathology, qualitative methods allowed a deep exploration and understanding of participants’ perceptions of their experience (Smith et al., 2009). Interpretative phenomenological analysis (IPA) was deemed as the most appropriate approach to the research, as it allows flexibility across data collection and analysis. It is an approach which is participant-oriented, where participants are encouraged to provide their personal perspectives on their lived experience and perceptions in their own terms, as opposed to according to pre-defined categories. In the present study, the experience in question was SLPs and assistants working together, and any previous experience which may have led to these perspectives.

This research required a methodology which allowed reflexivity; the formulation of questions allowing the participant to lead the conversation, and flexibility for the researcher to ask questions within the participant’s account. Yielding in-depth accounts provided rich data to help explain why SLPs perceive the introduction of assistants in the way they do.
8.2 Research theory and paradigms

The dominant way of thinking about research over the past two decades has been through what Morgan (2007) describes as the ‘metaphysical paradigm’ which examines paradigms viewed as epistemological stances (such as positivism and constructivism) in terms of their metaphysical concerns, which include but are not limited to ontological, epistemological and methodological assumptions (Morgan, 2007). Ontology is the nature of reality; epistemology is how knowledge is gained and the relationship between this knowledge and the knower; methodology is the approach or process of research (as distinct from methods, which are the technical tools used in research) (Creswell, 2012). Within this paradigm, there is a top-down approach where ontology affects epistemology, which in turn affects methodology (Morgan, 2007). Traditionally two approaches have dominated the research community: quantitative and qualitative. These metaphysical concerns have and continue to provide the overall structure for thinking about the nature of research and create a dichotomy between qualitative and quantitative methods by forcing researchers to adopt a measure of allegiance to one stance while rejecting others (Creswell & Plano Clark, 2010).

Quantitative research is orientated with the positivist/postpositivist paradigm, which sees reality as objective and predictable, the researcher as independent of the phenomenon being researched, and is value-free and unbiased. Results from research within this paradigm are generally analysed using statistical methods and presented in numeric form (Creswell & Plano Clark, 2007). Qualitative research is orientated with the constructivist paradigm (also known as naturalistic inquiry), which sees reality as subjective - the researcher interacts with the study phenomenon and acknowledges the values and biases that he or she brings to the data collection and interpretation (Smith et al., 2009). Qualitative results are generally analysed using thematic strategies and presented in narrative form. There has been significant conflict between the qualitative and quantitative communities (Morgan, 2007). A significant issue for the research community is how important these metaphysical concerns are in planning and conducting research, as they focus on abstract concepts rather than providing a framework for making practical choices in research design (Morgan, 2007).
8.3 Consideration of other research approaches

In consideration of the most appropriate research approach for this study, a number of qualitative approaches were considered. Following is a brief discussion of these approaches, and the rationales for why they were not employed in conducting this research.

Ethnography is the study and interpretation of a group and its shared culture, where the researcher is immersed in the natural setting of the group. It is a form of social research that examines what people do or say in context (Hammersley & Atkinson, 2007). Ethnography requires the researcher to observe the actions and interactions of the group over a period of time. It requires the researcher to become immersed in a particular group’s culture while focusing on what happens in context. In the current research, the researcher is a practising SLP and therefore a member of the professional group being studied - this would have made ethnography a viable option. However, ethnography is concerned with culture and not with individual experience and perceptions. While the study of the profession and as such, the professional culture was deemed important, the focus on the individuals and their lived experience was that which was of primary concern in the research. The participants were not (to the researcher’s knowledge) aware of the participation of their colleagues, and did not share a common environment, despite similarities across work settings and caseloads. Given these factors, ethnography was not pursued as the approach to the research.

Grounded theory is a qualitative approach to research which, similar to ethnography, examines participants in their own context. One key aim of grounded theory is to generate theory from the data collected (Urquhart, 2013). However, it was not the intention of this research to generate theory around working with assistants, and similarly, participants did not come to a fixed, agreed point in their understanding and perceptions of working with assistants. Given these limitations, grounded theory was not utilised for this research.

8.4 Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) was deemed as the most appropriate approach to the research and was chosen to encourage participants to provide their personal perspectives on SLPs and assistants working together and any previous experience which
may have led to these perspectives. It was necessary that the approach allowed exploration of the similarities and differences in perceptions of the same phenomenon.

IPA has its origins in psychological research but is gathering momentum as an appropriate methodology for use in other health, social and human sciences (Smith et al., 2009). It is a qualitative approach which examines how people make sense of their life experience, what happens when this lived experience takes on a certain significance and the reflective process that occurs regarding the significance of what is happening (Smith et al., 2009). This method allows the researcher to consider first the importance of the topic and hence the potential impact of the results.

IPA is based on 3 major theoretical axes; phenomenology, hermeneutics and ideography (Smith et al., 2009). Phenomenology is the study of experience, with an interest in what the experience of being human is like and how this is examined and comprehended. Hermeneutics is the study of interpretation, more specifically, the methods and purposes of interpretation itself. Ideography is concerned with the particular – specifically the detail and depth of presented analysis. These key concepts within the philosophy of knowledge have informed IPA, as it attempts to gain an understanding of the lived experience by looking in detail at how someone makes sense of an experience in their life (phenomenology). The researcher’s role in this process is to interpret the participant’s account with the outcome of understanding the experience; hence the final account produced is the joint reflection of both the participant and the researcher (hermeneutics). Finally, IPA research is focused on the particular, which generally leads to small, homogenous sample sizes allowing the researcher to get a deeper understanding of the experience of each individual involved (ideography) (Brocki & Wearden, 2006). It is central to IPA that the experience is expressed and understood in its own terms and not according to predefined categories. It is not concerned with ‘cause and effect’, but exploring meaning and context, leading to better assumptions and more understanding of the complexity of experience (Brocki & Wearden, 2006). Addressing what people perceive and express about their experience is a way of showing how they derive meaning from their individual experience. It is important from this perspective that the research design refrains from applying a predetermined set of
values on to individual experience (Smith et al., 2009). The experience of interest to IPA is one where:

“ordinary everyday experience becomes ‘an experience’ of importance as the person reflects on the significance of what has happened and engages in considerable ‘hot cognition’ in trying to make sense of it” (Smith et al., 2009b p33).

The current research consisted of individual semi-structured interviews with participants who were SLPs from LHDs within NSW, Australia. Their perception of an assistant workforce within speech-language pathology was the central experience of interest to the research. The semi-structured interviews were chosen to allow the researcher and participants to have a rapport, which in turn encouraged free and reflective accounts, resulting in deeper data. At this point it was thought that the use of highly structured interviews or questionnaires would have limited the data collected to less rich accounts, negatively impacting on analysis. The exploratory nature of this research required rich accounts and thick description to ascertain the variables within the phenomena. The interviews were designed to explore the participant perceptions, examining agreement and disagreement within and across participant accounts (Smith et al., 2009).

The interviews were based on an interview schedule prepared following a literature review of allied health professionals working with assistants (Additional contribution 1) which resulted in the identification of several key areas including; role, supervision, budget and resource management, professional accountability, workload and productivity, skills and training. The aim of developing the schedule was to be cognisant of issues which may be important to the participants, allowing the researcher to be more attentive and flexible within the interview (Smith et al., 2009). The interview schedules were comprehensive in the questions available to ask, but not all questions were asked of each participant and the participants themselves were invited to lead the discussion to enable them to give their own account and perceptions (Smith et al., 2009). The interview schedule evolved to reflect the increased knowledge gathered from participants throughout the research process (Please see Paper 1, appendix A for an example of an interview schedule).
8.4.1 *Sampling and recruitment*

The current research design started with a narrow focus limited to rural or remote SLPs from one local health district (LHD) within NSW, Australia. However, data collection and analysis revealed that the enquiry needed to take a broader focus to examine perceptions of working with assistants of SLPs in a broader geographical reach. It was important to address this wider cohort in order to examine factors which were instrumental in forming perceptions and to investigate similarities and differences across the cohort.

Purposive sampling techniques are used in IPA. These techniques require the researcher to use their judgement to select participants based on the likely relevance of the information to be gained from their experience of the phenomenon, and what this can contribute to answering the research question (Smith et al., 2009). Purposive sampling aims to access populations that have the information necessary for answering the research question, but that vary across several dimensions. The sample size for purposive sampling is generally small in order to get greater depth of information from each case and the method of selecting a sample is based on subjective (but expert) judgement in purposive sampling.

For phase one of the research, participants were recruited from rural and remote parts of Hunter New England LHD, which has a major metropolitan centre, a mix of several large regional centres and smaller rural and remote communities within its borders. The district covers a geographical area of over 130,000 square kilometres, and approximately 35 rural or remote SLPs were working in the area at the time of recruitment. Information about the research was distributed via health service email and interested SLPs were invited to contact the researcher directly. Recruitment was conducted remotely to eliminate any perceived coercion, given the researcher is a working SLP in the same LHD. After registering interest in participating, participants were contacted by the researcher to arrange an interview. Nine SLPs initially expressed interest in participating, but one withdrew due to ill health.

For phase two of the research, the geographic reach of recruitment was widened to include LHDs across NSW Health. Details of the research were provided to service managers from LHDs across NSW, and all were invited to participate. Five LHDs elected to be involved,
with SLPs from three LHDs other than Hunter New England participating in the research. An independent SLP disseminated research information via email to senior SLPs in the participating LHDs, who distributed the information to their SLP staff. SLPs interested in participating in the research contacted the researcher directly and were offered an interview either face to face or via telephone depending on their location. Twelve SLPs volunteered to participate in phase two, with a total of twenty participants across the two phases.

8.4.2 Participants

To ensure that a range of perceptions was gathered, the qualitative data was collected from different sample groups; rural and remote SLPs from Hunter New England LHD, and rural, regional and metropolitan SLPs from across NSW Health. Seventeen women and three men were interviewed, who represented a range of caseloads, years of experience, and work patterns within their employing organisation. The participants’ years of experience ranged from less than one year to more than twenty-five years. Caseloads included mixed generalist, community paediatric, adult acute and rehabilitation, and community adult including brain injury rehabilitation. Most participants were permanent employees of NSW Health, but some were employed on a temporary basis.

8.4.3 Research tools

In-depth interviews

The most prevalent method of data collection in IPA is the use of semi-structured interviews following an interview schedule designed to be non-directive. These interviews are most commonly conducted face to face with participants (Brocki & Wearden, 2006; Smith et al., 2009). The interviews are designed to yield rich, detailed first-person accounts of experiences, and as such participants are granted the opportunity to speak freely and reflectively (Smith et al., 2009). IPA allows for dialogue between participants and the interviewer, and initial interview questions can be modified in response to participants. This method also allows the researcher to continually revise and refine the problem as knowledge about the topic increases. However, as Brocki & Weardon (2006) discuss, this makes it difficult for authors to provide details of interview schedule construction, leading
to potential difficulty for the reader in making a judgement about the quality of the interview conducted and subsequent data obtained (Brocki & Wearden, 2006).

In-depth, semi-structured interviews were conducted between the researcher and participants. Most interviews were conducted face-to-face, however where distances between researcher and participant were prohibitive, interviews were conducted via telephone. The interviews were between 60 to 90 minutes duration. With the consent of the participants, the interviews were recorded via 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.

The in-depth interviews were conducted to elicit and develop concepts to understand the perceptions of working with assistants and how these perceptions were formed. They were conducted to elicit responses relating to the natural workplace environment, as opposed to an experimental environment, in order to understand the phenomena of perceptions of working with assistants and how they are formed (Smith et al., 2009). The interviews entailed a question set which was considered a continuous iterative cycle; as an understanding of the issues and concepts increased, a further understanding of emphasis and experiences was gained. It was felt that a quantitative approach would not allow the researcher to qualify experiences in the interview phases, as the aim of these studies was not to seek statistical significance.

An introductory statement was made at the commencement of each interview indicating that while some of the interviews were question and answer format (for example, gathering demographic data), the participants would also be asked to describe their experience and perceptions of working with assistants and how they felt those perceptions were formed. The semi-structured interview technique was used to allow participants to discuss issues which were important to them in terms of the topic, rather than be directed by the researcher (Liamputtong & Ezzy, 2005a; Smith et al., 2009). It was anticipated that this method may identify issues which had not already been identified in the literature. This technique was intended to be as naturalistic as possible to allow open discussion between the interviewer and participant.
8.4.4 **Data analysis**

There is no single prescribed method of analysis within IPA, but rather processes and principles which may be employed in a flexible manner (Smith et al., 2009). A “healthy flexibility” is described regarding the analytic process within IPA, rather than a single prescriptive method for analysis (Smith et al., 2009). Despite this, Smith and colleagues (2009) propose a series of steps in the process of analysis within an IPA study which is not intended as a linear process, but a way to encourage engagement with the participant’s presentation of their experience. These steps include reading and re-reading the data, initial noting, development of emergent themes and searching for connections across these themes, moving to the next case and looking for patterns across cases (Smith et al., 2009).

All interviews in phase one 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 thesis where necessary to assist the readers’ interpretation). For the subsequent interviews in phase two, the interviews were transcribed by an external party, then reviewed and checked against the recordings by the researcher.

The analysis is concerned with the way an individual derives meaning from an experience, but it is also central to IPA that the experience and knowledge of the researcher impact on their interpretation of participant accounts. It is important then that the researcher engages in constant reflective practice throughout data analysis (Smith et al., 2009). 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 on several occasions to ensure consistent coding (Liamputtong & Ezzy, 2005).

The initial coding stage entailed the analysis of the transcripts for the broad content areas covered in the interview and further analysis of main themes emerging within each area. The number of times a theme was raised was recorded to evaluate priority. The second stage of coding further analysed themes by entering transcripts into N-Vivo (QSR
International, 2012) qualitative data analysis software. The participants’ responses were coded according to the key themes and broken down into more specific sub-themes.

8.4.5 **Rigour and validity**

Rigour and validity are concepts which are somewhat difficult to define in qualitative research. Creswell and Plano Clark (2011) discuss qualitative validity as beneficial in determining whether the researcher’s account of the research is accurate, trustworthy and credible (Creswell & Plano Clark, 2011). They discuss several techniques which can be used in qualitative research to ensure rigour and validity, including member checking, triangulation, reporting of disconfirming evidence, and peer review (Creswell & Plano Clark, 2011).

Several techniques were utilised in order to provide a credible study and confidence in the research contribution. Iterative questioning was utilised, meaning that any information which was unclear was further questioned and clarified during the interview process. The interviews were conducted by the researcher who is a practising SLP, providing a high level of shared professional language and understanding. It was important to the research that researcher bias was acknowledged. That is, the researcher’s prior knowledge and own beliefs and values were recognised. One method by which this was managed was by including a non-SLP as the researcher’s primary academic supervisor. This added a non-speech-language pathology perspective to the research, providing the opportunity for challenge and review. Reflective field notes were taken after each interview was completed, allowing critical self-reflection in relation to data gathering, research approach and design (Ortlipp, 2008).

Continual memos were created during analysis to allow transparency. Inter-rater reliability and checking of agreement and consensus were continually undertaken with the researcher and two of three academic supervisors. One supervisor was not directly involved in data analysis so was able to provide scrutiny during and post analysis. Some excerpts of data in the analysis process were published in a highly ranked peer-reviewed paper, allowing readers access to raw data. All participants in the study were offered the opportunity to check their transcripts for accuracy, but none elected to do so.
The findings of the research have been widely disseminated to SLPs, as well as wider allied and related health audiences in both practical and theoretical forums. The findings have also been disseminated to non-health related professionals including economics and sociological forums. The research has been subject to high-level peer review throughout the process, with peer review conducted on papers prior to publication and presentation.

8.5 Ethics approvals

Please see Appendix 12.1 for documentation of ethics approvals.

On the 19th February 2009, the Hunter New England Human Research Ethics committee (HNE HREC) approved phase one of the studies (HNE HREC Ref 08/12/17/4.03). Phase one was registered as a Research Higher Degree with the University of Newcastle Human Research Ethics Committee on the 20th July 2009 and was granted external approval on the 12th August 2009 (H-2009-0225). An amendment regarding upgrading from a pilot study to a Research Higher Degree and expansion of recruitment was granted from the HNE HREC on the 5th November 2009.

For phase one, the identified participant group were SLPs working in rural areas of Hunter New England LHD. It was identified that speech-language pathology is a homogenous profession, with 97% of the discipline being female, with poor representation of people from non-English speaking backgrounds, from Aboriginal or Torres Strait Islander descent, or from culturally and linguistically diverse backgrounds. Permission to conduct this research with this participant group was granted. Ethical approval was sought and gained through the University of Newcastle and Hunter New England Human Research Ethics Committee to use the phase one data in the main body of the research.

For phase two of the research, ethical approval was gained to recruit more participants from Hunter New England LHD, as well as from other geographical areas including Murrumbidgee, Southern NSW, Northern NSW (Hastings Macleay), Northern NSW (Tweed Byron), and the Mid North Coast LHDs. Following consultation with HNE HREC research governance officer, a Low and Negligible Risk National Ethics Application Form (LNR NEAF) was submitted to the HNE HREC on the 15th February 2011, and approval
was gained on the 7th March 2011 (HNE HREC Ref No 11/03/16/5.06). Site-specific assessments were submitted to research governance officers at each LHD after this initial approval, as there was a change in NSW Health from Area Health Services to LHDs, which potentially entailed changes in approval processes. During this process, contact was maintained between the researcher and the senior SLPs in each LHD to ensure they were aware of the project and willing for their staff to be involved. For both phases of the research, recruitment was conducted remotely to ensure there was no perceived coercion on the part of the researcher (being a practising SLP and a NSW Health employee).

This research is concerned with health service management and utilises a relatively broad literature base. As such, profession specific literature has been drawn from the speech-language pathology profession, as well as from wider allied health fields with an existing history of working with assistants, such as physiotherapy, occupational therapy and podiatry. Theoretically, this study draws heavily from the fields of sociology, organisational psychology and behaviour.

Publishing the results was decided upon with consideration of the value of the work’s interdisciplinary nature. Several factors were considered when deciding upon a publishing destination for the various papers, including impact factor, audience and reach, as well as the scope of the individual journals. The selection of publishing outlets and their status will be discussed prior to each paper.

The thesis now proceeds to the published papers arising from the research. It will begin by examining the issues relevant to working SLPs in Paper 1, an exploratory paper investigating rural SLPs’ perceptions of working with allied health assistants.
9 Published papers

9.1 Paper 1 – Rural Speech-language pathologists’ perceptions of working with allied health assistants

9.1.1 Statement of contribution of others

Statement of contribution of co-authors

We, Rebecca Mitchell, Nicole Byrne, Alison Ferguson and Rachael O’Brien attest that PhD candidate Rachael O’Brien had the primary and lead role in the study concept, design, data collection and analysis, preparation and final revision of the publication entitled:


Rebecca Mitchell (Co-author)
Date: 4th July 2017

Nicole Byrne (Co-author)
Date: 4th July 2017

Alison Ferguson (Co-author)
Date: 4th July 2017

Rachael O’Brien (PhD Candidate)
Date: 4th July 2017

Suzanne Ryan (Assistant Dean Research Training – Faculty of Business and Law)
Date: [Signature] 19 July 2017.
In chapter seven, the overall health context was discussed, including the need and drivers for an assistant workforce in allied health and more specifically, in speech-language pathology. Working with assistant roles has been a focus for workforce reform for the Australian and international health workforce. The increased utilisation of assistants increases the skill mix of the health workforce and aims to contribute to meeting future health demands of the population while allowing for sustainable delivery of allied health services. Assistants are utilised internationally and in some states of Australia in speech-language pathology and are an economically viable option for increasing service provision.

While the literature regarding assistants contributes to the understanding of their utilisation in the larger context of the allied health workforce, there is little research to date which specifically addresses the perceptions of speech-language pathologists. There is therefore little evidence on which to base decisions such as how, when and why their introduction into the discipline in Australia should occur. Speech Pathology Australia has been supportive of working with assistants for some time; stating that working with assistants is a viable model for sustainable service provision, and flexible role boundaries are one way to extend the speech-language pathology scope of practice in order to best meet the needs of consumers (Speech Pathology Australia, 2016). Given the professional differences across states within Australia (for example, registration, work contexts such as health and education, and the current utilisation of assistants) it remains that there are different perceptions of working with assistants within the discipline.

The purpose of Paper 1 was to identify the main themes and issues regarding the planning and implementation of a successful assistant program for the speech-language pathology profession. The need for a planned and organised implementation is clear, as the literature recognises that many assistant programs have been developed in a reactive manner in response to situations including workforce shortages and crises within health services (Lowe et al., 2008). However, limited studies with specific reference to the discipline of speech-language pathology have been conducted and have largely been based on disciplines such as physiotherapy and occupational therapy. While there are definite
parallels in terms of work environments and wide-ranging roles, discipline-specific research is required due to the specific clinical tasks conducted by speech-language pathologists, as well as the characteristics specific to the discipline such as demographic and workforce issues.

This paper contributes to the overall thesis by introducing the SLP profession into the discourse surrounding working with assistants. It highlights the ambivalence in perceptions of working with assistants and the importance of understanding such perceptions, both in relation to the speech-language pathology profession and to a broader range of professions who similarly have a limited exposure and history of working with assistants. By exploring perceptions and their antecedents, this thesis argues that when perceptions are understood, pivotal points can be identified, allowing transparent communication between stakeholders, and a more positive perception of a workforce redesign may potentially ensue.

Part of the purpose of the current research and the focus of this paper was to compile perceptions of rural and remote SLPs to working with assistants. It explores the perceptions of SLPs in an area where assistants are not yet utilised by the profession, and where there are no policies outlining their use or guiding delegation. It aims to identify the barriers and enablers perceived by working clinicians to such a workforce change. The participants in the study were from rural or remote areas within Hunter New England LHD in NSW, Australia. It is the intention of this research to provide local evidence which will allow employing health organisations and the speech-language pathology discipline to participate in national workforce planning and design.

9.1.3 Criteria for journal selection

International Journal of Speech-Language Pathology (IJSLP) is an international scholarly journal which explores clinical and theoretical issues relating to any area of the speech-language pathology scope of practice. IJSLP publishes 6 issues per year of high-quality, original research. Other widely read speech-pathology journals have a specific clinical focus (e.g. AAC, Dysphagia and Journal of Voice), but IJSLP has a profession-wide focus, making it a widely read professional journal. All submissions are subject to editorial screening prior to a rigorous double-blind peer review process by expert referees. IJSLP
had an impact factor of 1.179 (2016). It is ranked 18/25 in Audiology and Speech-Language Pathology, 50/180 in Linguistics, 79/135 in Rehabilitation (IJS LP, 2017). These measures indicate the high quality and impact of this journal to the speech-language pathology profession. The IJS LP is published by the Speech Pathology Association of Australia (SPA), the national peak professional body for speech-language pathologists, and the journal is distributed to over 8000 members of SPA in Australia.

IJS LP was a logical choice as a publishing outlet for Paper 1: Rural speech-language pathologists’ perceptions of working with allied health assistants and Paper 6: What value can assistants bring to speech-language pathology practice? IJS LP had identified in earlier issues the challenge facing the speech-language pathology profession of responding equitably to increasing and changing consumer need in an environment of decreasing resources (Wylie et al., 2013). This paper responds to such a challenge and identifies that the increased utilisation of an assistant workforce working with SLPs could be an alternative to traditional service delivery models. Paper 1 was exploratory in nature and aimed to begin a professional discourse surrounding assistants and what their implementation meant in terms of impact on (e.g.) existing roles and boundaries, and the relevance to individuals and the profession.

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9.1.4 Full citation

9.1.5 Publication


Rural speech-language pathologists’ perceptions of working with allied health assistants

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Abstract
Workforce shortages are forecast for speech-language pathology in Australia, and will have a more significant impact on rural and remote areas than on metropolitan areas. Allied health (AH) disciplines such as physiotherapy and occupational therapy address the problem of workforce shortages and growing clinical demand by employing allied health assistants (AHAs) to provide clinical and administrative support to AH professionals. Currently, speech-language pathologists (SLPs) don’t work with discipline-specific allied health assistants in all states of Australia (e.g., New South Wales). This paper aims to provide insight into the perceptions of SLPs in one Australian state (NSW) regarding working with AHAs. Semi-structured interviews were conducted with eight rural SLPs. Qualitative analysis indicated that participants perceived they had deficits in skills and knowledge required to work with AHAs and identified further training needs. Participants perceived the SLP role to be misunderstood and were concerned about poor consultation regarding the introduction of AHAs into the profession. Ambivalence was evident in overall perceptions of working with AHAs, and tasks performed. While previous research identified benefits of working with AHAs, results from this study suggest that significant professional, economic, and organizational issues need addressing before such a change should be implemented in speech-language pathology.

Keywords: Speech-language pathology, pathologists, allied health assistants (AHAs), workforce, rural and remote, perceptions.

Introduction
The increasing international demand for speech-language pathology services presents the profession with the challenge of responding in an appropriate and equitable manner (Wylie, McAllister, Davidson, & Marshall, 2013). Wylie et al. (2013) assert that, to meet this challenge, profound changes in the profession must be considered, including the possibility of increased utilization of others to implement speech-language pathology services (Wylie et al., 2013). Responding to decreasing resources and workforce supply has led to the international trend of utilizing allied health assistants (AHAs) for delivering speech-language pathology services as an alternative to traditional service delivery models. Assistants have been used in countries including the US, UK, and Canada to extend the services provided by qualified speech-language pathologists (SLPs), allowing for more effective caseload management and increased access to services for consumers (Lubinski, 2012). In the US, the first assistant initiatives began in 1967 with the committee on supportive personnel being established to develop professional guidelines regarding the use of support staff (Paul-Brown & Goldberg, 2001). Similarly in the UK, the government has challenged the National Health Service to re-design the skill mix of the health workforce to become less focused on traditional roles and move toward providing the right mix of skills to meet consumer needs (Sibbald, Shen, & McBride, 2004). Speech-language pathology in the UK has responded to this challenge by working with assistants who undertake the more routine aspects of the traditional speech-language pathologist role (Davies & van der Gaag, 1992). The Canadian Association of Speech-language Pathologists and Audiologists (CASPLA) is the peak body for SLPs and audiologists in Canada, and since 2006 has had a supportive personnel membership category including a code of ethics (Canadian Association of Speech-Language Pathologists and Audiologists, 2010). In Australia, the speech-language pathology profession has utilized AHA services in some states, but the system has not yet been implemented in New South Wales (Chief Health Professions Office, 2008), and reform is at a
slower overall pace in Australia than comparable countries (Health Workforce Australia, 2011).

Workforce and service delivery

Australian Allied Health (AH) professions do not have a sustainable workforce supply, and are part of a larger global health workforce shortage (e.g., Buchan & Dal Poz, 2002; Buchan, Naccarella, & Brooks, 2011). The speech-language pathology profession is on the skilled occupation list (Australian Government, 2011) and there is evidence that the current workforce need exceeds supply (Iacono, Johnson, Humphreys, & McAllister, 2007). Demand for speech-language pathology services is increasing as a result of a complex interaction of factors including an ageing population (Australian Government, 2010), increased incidence of chronic disease (National Health Workforce Taskforce, 2000), increasing awareness of the importance of early intervention (Paul-Brown & Goldberg, 2001), and population growth (Health Workforce Australia, 2011). National workforce shortages have been forecast for the speech-language pathology profession in Australia (Speech Pathology Australia, 2005), and will have a more significant impact on rural service provision which is already unequal to that provided in urban areas (Duckett, 2007). Barriers to accessing speech-language pathology services in rural areas have been identified as a lack of or limited choice of clinicians, distance and associated travel costs, poor public transport, long waiting times, and poor awareness of speech-language pathology services (O’Callaghan, McAllister, & Wilson, 2005). Maintaining and increasing the speech-language pathology workforce is necessary for the ongoing provision of clinical services (Speech Pathology Australia, 2005). It is currently unclear how the profession plans to meet demand for services in the future, and how health services aim to address these shortages (Iacono et al., 2007).

Utilizing AHAs

The workforce re-design of utilizing vocationally trained staff such as AHAs to provide direct client care and indirect support (such as administration) has been found to improve recruitment and retention of AH professionals in rural and remote areas by leading to reduced caseload burden (Nancarrow & Mackey, 2005) creating more time for AH professionals to concentrate on complex tasks (Lizarondo, Kumar, Hyde, & Skidmore, 2010; Schoo, Stagnitti, Mercer, & Dunbar, 2005). This impacts on the ability to provide sustained, timely, and appropriate access to AH services for people in these communities (Australian Health Workforce Advisory Committee, 2006). Recent international research has shown the positive contribution of AHAs to clinical outcomes, patient satisfaction and role satisfaction for AH professionals (Lizarondo et al., 2010). For example, Conti, LaMartina, Pete, and Vitthuhn (2007) demonstrated improved clinical outcomes for patients including reduced ventilator days and reduced skin breakdown rates after the introduction of a physical therapy assistant (Conti et al., 2007). In a study by Nancarrow and Mackey (2005), patients reported increased satisfaction with the amount of time spent with them by staff members, and occupational therapy staff reported reduced burden on themselves, facilitated by the introduction of an occupational therapy assistant (Nancarrow & Mackey, 2005).

However, there is evidence that the implementation of this workforce change is not without difficulties, including confusion regarding role boundaries, professional status and job security, as well as the perception that AHAs represent a cheaper AH workforce (Lizarondo et al., 2010). In a study of podiatrists and foot care assistants, Farnon and Nancarrow (2003) reported confusion regarding supervision and role boundaries, resulting in underutilization of assistants. In a study by Nancarrow and Mackey (2005), occupational therapists perceived a loss of job satisfaction from delegating clinical tasks, and were concerned that assistants may be seen as a cheap alternative to an occupational therapist (Nancarrow & Mackey, 2005). Ellis and Connell (2001) identified that the unstructured nature of assistant training was a concern for physiotherapists given that it included varied methods and timing, and was generally inadequately resource (Ellis & Connell, 2001). The multidisciplinary literature shows that supervision and accountability are areas requiring clarity for the implementation and successful uptake of an assistant workforce.

Research into AHAs in speech-language pathology

Utilizing AHAs is an example of a significant workforce re-design which may have the potential to improve recruitment and retention of SLPs in rural areas by positively contributing to decreasing waiting lists and promoting reasonable workloads (Goldberg, Williams, & Paul-Brown, 2002). Little research has been undertaken regarding the use of assistants and subsequent effect on workpractices within the speech-language pathology profession. McCartney, Boyle, Bannatyne, Jessiman, Campbell, Kelsey, et al. (2005) explored the perceptions of five SLPs who had experience working with assistants. The findings indicated that the SLPs had varied opinions regarding working with assistants, and identified both advantages (such as increasing client access to services and allowing SLPs to concentrate on more complex tasks) and disadvantages (including time demands of the SLP and role boundary issues) to working with assistants. The opinions were gained from clinicians who were employed specifically to work with assistants, and were similar to those expressed more than 10 years
previously in a study which identified conservative attitudes in SLPs regarding sharing skills with assistants (Davies & van der Gaag, 1992). McCartney et al. (2005) identified that attitudes of SLPs may affect the progression of skill mix changes such as utilizing assistants (McCartney et al., 2005).

The limited research currently available regarding SLPs working with AHAs provides little insight into professional acceptance of this vocationally trained group (i.e., AHAs). By identifying some of the perceived disadvantages associated with AHAs, as well as some of the recognized advantages, this research provides one of the first explorations of a significant healthcare change in speech-language pathology service provision. Given the significant issues associated with the introduction of vocationally-trained assistants identified in previous research (including the perception that AHAs are a cheaper way of providing services, unclear role boundaries and unrealistic expectations of the scope of the AHA role) (Lizarondo et al., 2010) and the reluctance to utilize this additional resource internationally (McCartney et al., 2005), understanding these perceptions is pivotal. Based on the literature in change management, an understanding of, and response to perceptions regarding potential loss and risk, is important in minimizing resistance to change (Kotter & Schlesinger, 2008).

This paper presents a first exploratory step aimed at understanding the perceptions of SLPs in an area without relevant policies guiding AHA utilization, as to date there is minimal published research that has investigated the perceptions of such a population. Discrepancies between perceptions and actualities may influence the way the assistant workforce is utilized within the profession, and this sample is able to provide a starting point for this workforce redesign and service change. This research also allows the speech-language pathology profession to participate in the discourse regarding AHAs, which will benefit the profession and employing organizations.

Method

Ethical clearance was granted from Hunter New England Human Research Ethics committee, reference # 08/12/17/4.03.

Participants

Eight rural or remote SLPs participated in this study. This paper uses the Australian Standard Geographical Classification (ASGC) Remoteness Areas which is a geographical tool measuring access to goods and services based on road distance to the nearest five service centres of specific sizes. It reflects distances to small as well as large service centres, and does not take into consideration socio-economic factors or population size. For the purpose of the current study, clinicians were considered as being rural or remote if they worked in areas classified other than metropolitan (Australian Institute of Health and Welfare, 2004). The participants represented a range of clinical contexts, levels of experience, age, and rural settings.

All participants were female, which is consistent with professional demographics (Speech Pathology Australia and Speech Pathologists Board of Queensland, 2009). Six participants were generalist clinicians with an adult component representing between 5–20% of their clinical caseload. One clinician worked therapeutically with adults with minimal paediatric case management, and one clinician worked only with a paediatric caseload. While clinicians working only with an adult population were under-represented, participation from generalist clinicians was representative of the caseloads in the area. Six participants worked full time, and all were permanently employed by the Local Health District (however, this was not an inclusion criterion). Years of clinical experience ranged from less than 1 year to more than 20 years, with half of the participants having worked between 3–5 years in a rural or remote setting. For the purposes of maintaining confidentiality, all participants were randomly allocated a number for reporting responses.

Five participants reported previous experience working with AHAs. Two participants reported this experience occurred while working in the disability sector; one while on an interstate student placement and the other while working in a short-term locum position. One participant had worked with living skills assistants within a brain injury rehabilitation setting, however reported very minimal contact over 2-year period. One participant had provided some training to federally funded respite carers working with adults with speech and language needs, and one participant had worked with a SLP-specific AHA while on a hospital locum position in the UK. This small sample size allowed deep exploration of participants’ perceptions of working with AHAs (Smith, Flowers, & Larkin, 2009). Electing to utilize a sample of participants from only one local health district allowed exploration of perceptions of working with AHAs in an area prior to the introduction of policies guiding their use.

Procedures

An email invitation from an independent SLP was sent to all rural or remote SLPs working in one local health district in NSW (n = ~35) identified by the speech-language pathology area profession director. Interested SLPs were invited to contact the first named researcher directly. Nine SLPs responded, but one withdrew due to ill health.

Individual semi-structured interviews were conducted with eight SLPs to elicit their perceptions and/or experiences of working with AHAs (Smith et al., 2009). The interview schedule included questions which were generally open-ended, non directive, and
allowed participants to provide their perspectives in their own terms, and not according to pre-determined categories (see for example the Appendix) (Smith et al., 2009). Participants were interviewed individually by the first named researcher and were asked to describe their experience and perceptions of working with AHAws 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 first named researcher’s workplace. The interviews were 60-90 minutes in duration. Participant consent was gained to record the interviews via a digital voice recorder, and extensive field notes were made during the interviews. Participants were offered the opportunity to review their own transcripts; however, none accepted the offer.

Analysis

All interviews were transcribed fully by the first named researcher. Analysis was conducted by utilizing qualitative analytic procedures for interpretative phenomenological analysis (IPA), which involves examining how people make sense of experiences (Smith et al., 2009). The analytic process in IPA is an iterative and inductive cycle where emergent patterns are identified from the data to illustrate key perceptions and experiences. The current study utilized the following analytic strategies: First, each written transcript was read numerous times by the first named researcher, and corresponding field notes and audio recordings were examined. Researcher observations and initial impressions were noted in order to bracket pre-existing beliefs regarding AHAws in speech-language pathology. This close knowledge of the transcripts allowed an understanding of the context and how perceptions were expressed. Second, the researcher identified sections of data which were assigned codes to reflect their meaning, and codes were then compared across participant accounts to identify emergent patterns. The codes which were related, based on knowledge of previous literature, were combined into categories (for example; the codes boundaries, delineation, and job descriptions combined under the category Role), and similar categories allowed identification of three super-ordinate themes (Professional, Economic, and Organizational). Analysis involved constant comparison and testing of codes and categories to the data by the researchers (Joffe & Yardley, 2004). Rigor of coding was established through independent coding of half the data by two of the researchers, with inter-rater reliability of 90%. Subsequent coding was continued by the first named researcher.

Findings and discussion

Three inter-related themes emerged from the participants’ accounts: Professional, Economic, and Organizational. The Professional theme emerged from participants’ professional loyalty, shared values (Reeves, Lewin, Espin, & Zwarenstein, 2010), and emphasis on the qualities required of a SLP including empathy and a desire to help others (Byrne, 2007). This is significant to the current study as it has been shown that poor job security, increased administration time, and perceived decreased benefits of being in the profession are strongly associated with intent to leave speech-language pathology (McLaughlin, Adamson, Lincoln, Pallant, & Cooper, 2010). This theme represents participants’ perceptions of job security and potential role change. The Economic theme encompasses perceptions regarding budget and resource management relating to funding positions, physical requirements to practice such as clinical space, computers, and car access, and a perceived effect of resource limitations on practice. Perceptions in this theme relate back to the introduction of assistants as a cheaper workforce and fears of substitution or replacement of qualified SLPs (Goldberg et al., 2002). The Organizational theme considers perceptions relating to policies and processes of the employing organization, and the impact this has on participants performing well in their jobs. It considers the need for SLPs to have an evidence-base regarding service delivery models, and the importance of retaining treatment efficacy (Goldberg et al., 2002). Four participants perceived the implementation of an AHA program as being a positive change; however, four discussed reservations about this possibility. The themes in which participants identified concerns or positive outcomes are illustrated in Figure 1.

Professional theme

The professional theme encompasses participants’ responses in terms of their professional training and preparation, professional loyalty, and factors such as providing a high quality of care, making a difference in the lives of clients and patients, and the rewards associated with specific caseloads. The perception that the SLP role and skills were misunderstood and devalued by management and the wider community was consistent across participant accounts (n = 8). The increasingly broad role of rural SLPs was discussed by all participants, and the difference in critical thinking skills required of a SLP as opposed to an AHA were highly valued. All participants identified that assessment and diagnosis were inappropriate tasks to delegate to an AHA, and that it remained the treating SLP’s responsibility to ensure appropriate treatment provision and clinical outcomes were achieved. This is consistent with various international guidelines regarding AHAws in speech-language pathology (e.g., American Speech-Language and Hearing Association, 1996; Canadian Association of Speech-Language Pathologists and Audiologists, 2010; Royal
College of Speech and Language Therapists, 2003). The majority of participants \( n = 6 \) perceived that working with assistants had the potential to extend the amount or types of services being offered:

One of the strengths of having the roles is perhaps a chance to service more complex populations more efficiently (Participant #1).

The need for clear role delineation of both SLPs and AHAs was discussed by all participants, and the reasoning for this delineation varied according to whether working with an AHA was perceived as a positive or negative change. Those with negative overall perceptions \( n = 4 \) saw role delineation as necessary for protection of the SLPs role and ensuring quality service provision:

It assumes that being a speech pathologist is a really simple thing and there’s nothing very complicated about it at all … So, you know, could you not just hand them (clients) over to an aide? No, I wouldn’t. I would think that professionally that would be negligent (participant #7).

Those with positive overall perceptions \( n = 4 \) saw it as a way of ensuring appropriate utilization of complementary roles:

I think it would be quite clear as to what role I was performing as opposed to the allied health assistant … (participant #4).

**Economic theme**

The economic theme encompasses participants’ responses in terms of cost and physical resources. For example, cost comparison between a SLP and an AHA salary, clinical resource restraints, and physical environment issues including distances between clinic sites and access to clinical space, cars, computers, and desks:

It’s an issue of where the funding is coming from. I’d rather see that funding go back to speech pathology, rather than speech pathology aides (Participant #6).

Some participants \( n = 2 \) saw advantages in AHAs being a cheaper workforce, such as increasing service options and coverage (e.g., adding new groups or outreach services). However, the majority of participants \( n = 6 \) perceived that AHAs being seen as a cheaper alternative to qualified SLPs was a disadvantage to their implementation. This is consistent with the findings of Nancarrow and Mackey (2005), who reported that occupational therapists were concerned about assistants being seen as a cheaper alternative to qualified occupational therapists. In contrast, the results of McCartney et al. (2005) show that having access to assistants as a cheaper workforce was perceived by SLPs as a benefit to the profession. In a randomized control trial and economic evaluation conducted with school children with language impairment, Boyle, McCartney, Forbes, and O’Hare (2007) showed that assistants represent an effective means of providing speech-language pathology services if well supported and trained (Boyle et al., 2007). Further economic evaluation would be beneficial across clinical settings and contexts.

**Organizational theme**

The organizational theme highlighted the importance of management supportiveness, and the perceived conflict between efficient recruitment and
organizational financial constraints. There was a sense from the participants that the implementation of AHAs would not allow SLPs to focus on more specialized clinical work or act as additional resources, given the amount of SLPs' time and resources that would be needed to train and supervise AHAs, as expressed by the following participant:

I was anticipating that I would do more of the direct speech therapy work and work alongside her ... but I find that I'm doing more training more than anything else (participant # 3).

Some participants perceive greater costs than benefits of introducing AHAs, which indicates that employers may need to acknowledge the potential negative consequences (at least initially) of implementing AHAs in terms of productivity and time, and provide support for clinicians during this time of change. These results may also indicate that the participants and the employing organization may have different understanding and assessment of the re-design (Kotter & Schlesinger, 2008). In the current study, some participants (n = 4) perceived that training an AHA to deliver speech-language pathology intervention may result in poor clinical outcomes, which would result in increased stress on the treating clinician. As McLaughlin, Lincoln, and Adamson (2008) assert, a significant cause for stress for SLPs is the compromise of quality and quantity of clinical care necessitated by managing of time and resources. It is understandable then that, without assurances of increased management support, SLPs 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 (McLaughlin et al., 2008).

Inter-relationships of professional, economic, and organizational themes

Findings from this study indicate that, while the professional, economic, and organizational issues emerged as individual themes, it is not possible to make conclusive statements regarding their impact without considering the inter-relationships between them. The SLPs perceived both advantages and disadvantages to working with AHAs, which is consistent with the multidisciplinary literature regarding the assistant workforce in AH professions (Lizarondo et al., 2010). Participants’ overall perceptions of working with AHAs were important in determining the type of tasks they identified as being appropriate for AHAs to conduct (please see Table I.)

Professional and organizational

An area of professional and organizational overlap was professional preparation and training and the requirements of employing organizations regarding supervisory relationships. All participants perceived that on-site supervision and structured support were necessary for AHAs and that their undergraduate preparation did not include training in the skills to provide supervision to students or colleagues. These

<table>
<thead>
<tr>
<th>Perceived advantages</th>
<th>Perceived disadvantages</th>
</tr>
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<tbody>
<tr>
<td>Reduce administrative workload</td>
<td>Limited management understanding of SLP role</td>
</tr>
<tr>
<td>Allow SLP to see more clients</td>
<td>Consumers perceive that AHA has equivalent training to the SLP</td>
</tr>
<tr>
<td>Decrease waiting lists</td>
<td>Training and supervision time impacts on SLP's clinical time</td>
</tr>
<tr>
<td>Clients receive more one on one time</td>
<td>New graduate SLPs delegating to and supervising AHAs</td>
</tr>
<tr>
<td>Promote the SLP role</td>
<td>AHAs have limited training in SLP skills</td>
</tr>
<tr>
<td>Increase outreach services</td>
<td>AHAs not bound by Code of Ethics</td>
</tr>
<tr>
<td>Enable expanded therapy provision (e.g., groups)</td>
<td>AHAs intended as a replacement/substitute for SLPs</td>
</tr>
<tr>
<td>Increase culturally-appropriate services (e.g., Aboriginal</td>
<td>Extending the AHA role inappropriately</td>
</tr>
<tr>
<td>health worker working with SLPs</td>
<td>Reducing the focus on parent/carer responsibility to participate in the therapy process</td>
</tr>
<tr>
<td>Clear guidelines regarding role boundaries and tasks</td>
<td>Mixed caseload requires wide range of skills and training</td>
</tr>
<tr>
<td>Discipline specific AHA role preferable to generic AHA role</td>
<td>Management focus on budget and resource management rather than clinical outcomes—AHA potentially a ‘cheaper alternative’ to SLP</td>
</tr>
<tr>
<td>Specific tasks for AHAs to conduct across settings/contexts</td>
<td>SLPs not taught supervision and delegation skills</td>
</tr>
<tr>
<td>Support for the SLP</td>
<td>Clinical placements for AHA students at expense of SLP student placements</td>
</tr>
<tr>
<td></td>
<td>Potential for SLPs working with AHAs to deskil in basic therapy provision</td>
</tr>
<tr>
<td></td>
<td>Potential for lack of supervision in rural areas as clinicians often offsite</td>
</tr>
<tr>
<td></td>
<td>Lack of existing office and clinical space to house AHAs</td>
</tr>
<tr>
<td></td>
<td>Potential loss of job satisfaction for SLPs</td>
</tr>
</tbody>
</table>

SLP, speech-language pathologist; AHA, allied health assistant.
results reflect the findings of Mackey and Nancarrow (2005), who discuss the need for clarification of supervisory relationships in occupational therapy given supervisory skills do not form part of undergraduate preparation.

There was consensus that participants did not perceive adequate consultation over the planning of this re-design, despite senior SLPs being involved in producing task lists to shape the role description of an AHA. These findings suggest that increased consultation and communication between SLPs and their employing organization may be beneficial.

**Professional and economic**

Participants \((n = 6)\) reported a lack of confidence in budget and resource management in terms of the provision of funding for AHA positions. Concerns were raised that if a SLP position was unable to be filled, then this might be an impecunious for managers to employ an AHA from a resource and budget perspective, rather than based on clinical need:

> If there’s someone there doing the work, are management actually going to be motivated to look for a speech pathologist? Or are they going to think, oh no, we’re right, we’ve got someone sitting at that desk, or someone answering that phone (participant # 3).

All participants agreed that the role of the SLP was broader than that of an AHA, and that it would be inappropriate to substitute an AHA for a SLP; however, concerns regarding job security were evident. This reflects the inter-professional collaboration literature, where it has been demonstrated that having clear understanding of roles in a team is a requirement of successful collaboration (Suter, Aamdi, Arthur, Parboosingh, Taylor, & Dutenschlander, 2009). One area of divergence from the literature is that some participants in the current study did not recognize assistants as contributing members of a collaborative healthcare team, but as intended replacements for therapists or carers. These findings support the notion that further education and consultation is needed regarding the role of AHAs in speech-language pathology.

**Economic and organisational**

Some clinicians \((n = 6)\) perceived that AHAs could be an augmentation to services already in place with the aim of increasing productivity; however, the need for better support and resourcing in order to deliver quality clinical services to patients and clients was consistently raised. Specific issues included a general lack of physical space in many rural centres which would impact on the ability of services to employ additional staff.

If you were to suggest AHAs to the clinicians at (large rural centre) they’d ultimately see it as a great idea, but ‘no’ would be the answer because they can’t find a desk for themselves, let alone having someone else there (participant # 4).

**Professional, economic and organisational**

It was largely perceived \((n = 5)\) that the initiative to introduce AHAs was being driven by a non-clinical workforce, and that budget and resourcing was being prioritized above the needs of clinicians or clients. It was also perceived \((n = 4)\) that the planning was from a metropolitan perspective, without consideration of specific rural issues. Participants \((n = 4)\) were concerned that their employing organization did not have sufficient evidence in terms of clinical outcomes to employ AHAs, and wondered whether the organization’s attempt to increase service provision through the utilization of AHAs could in fact lead to wasted SLP time and poorer outcomes for clients and patients.

The concern that the AHA role might be intended as a substitute for a SLP was raised by most participants \((n = 7)\) in terms of job security, therapy outcomes, budget, and role maintenance. All participants perceived that new graduate clinicians should have sole responsibility for supervising an AHA as, 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, and experience within the clinic role:

If you had an allied health assistant who had been in the role for a long time and had a bit of ..., ownership of the role, they could make it quite difficult for somebody new (participant # 8).

These findings have implications for SLPs who may in future have the responsibility for supervising and delegating to an AHA. Current differences in opinion reflect potential for inconsistent uptake of this workforce re-design in the short-term and have negative implications for appropriate utilization of AHAs. Discourse with the profession may increase SLPS' perception of being adequately consulted and increase transparency of the planning process.

Participants who had experience working with AHAs \((n = 4)\) were more likely to suggest that there was a definite role for AHAs within speech-language pathology, and were more willing to suggest a wider, more clinically based range of tasks which they would be comfortable to delegate. The results suggest that having little or no exposure to working with AHAs is more likely to lead to a negative perception of this workforce reform, and that it is exposure to AHAs, rather than years of clinical experience, which leads to positive perceptions regarding AHAs. Lack of clarity regarding expectations and roles is another factor which may contribute to negative perceptions of working with AHAs. The current findings suggest
that clinicians working in a rural area had mixed perceptions of working with AHAs.

There was ambivalence in seven of the eight SLPs' perceptions of working with AHAs, as they were able to identify both advantages and disadvantages to the workforce change. They were also able to identify key criteria for the successful introduction of AHAs into the profession in NSW. The results of the present research in terms of the advantages and disadvantages, and the barriers and facilitators involved for working with AHAs, are consistent with previous research in this area. McCartney (1999) examined collaboration between professional groups and found that barriers occurred across the domains of function (goals and purpose of the system/organization), structure (the permanent features of a system/organization, e.g., management structures), processes (dynamics of system/organization behaviour), and environment (the larger context) (McCartney, 1999).

Using these definitions of functional and structural domains, Hartas (2004) explored teachers' and SLPs' perceptions of collaboration, and identified that factors such as professional interaction and status, rigid organizational structures, and time constraints impacted on successful collaboration. The facilitators discussed by Hartas (2004) include the need for time provision not only for collaboration itself, but also to negotiate and create a collective conceptualization of collaborative working, to increase the status of collaboration within the organization. Similarly, McCartney et al. (2005) reported that participants identified the need for time provision for planning, supervision, training and support, role differentiation for stakeholders, and ensuring job satisfaction for SLPs. In considering the findings from the current and previous research, it may be surmised that the goals and purpose of SLPs' work are perceived as different than that of an assistant; and professional models of collaboration and social differences between AHAs and SLPs may underlie some perceptions and present functional barriers to successful collaboration. Potential role change and differences in autonomy may present structural barriers to successful collaboration if not managed well prior to implementation (McCartney, 1999). Identifying the differences between the two professional groups may decrease the confusion created by assumptions and practices (McCartney, 1999).

While there was perception of the advantages, this was coupled with an understanding of the potential risks involved in such a workforce change. In workforce re-design, it is known that human factors often present the most significant challenges (Goldberg et al., 2002). The perception that professional identity and job security may be threatened by the introduction of AHAs in speech-language pathology would have an effect on how willing clinicians are to work with AHAs. These perceptions may lead to what Nancarrow and Borthwick (2005) discuss as maintenance of professional group status, where a profession controls professional behaviour and tasks which are seen as their exclusive responsibility (Nancarrow & Borthwick, 2005). Goldberg et al. (2002) propose that the most significant challenge to workforce re-design is natural human resistance to change. Kotter and Schlesinger (2008) propose four common reasons that people resist change which are; a desire not to lose something of value, a misunderstanding of the change and its implications, a belief that the change does not make sense for the organization, and a low tolerance for change (Kotter & Schlesinger, 2008, p. 132). The current findings illustrate a measure of fear of unknown factors regarding working with AHAs, and concern about losing valuable clinical and professional interests. This reinforces the need for employing organizations to acknowledge the stressful aspects for clinicians inherent in workforce re-design, to communicate the reasons for the change, and to involve SLPs in the design and implementation (Goldberg et al., 2002; Kotter & Schlesinger, 2008).

Limitations and future directions

This paper highlights the complexity of perceptions and the variations across the participant group, which confirms the need for further research regarding AHAs in speech-language pathology. A limitation of the current study was the small sample size in one geographical location. Further research is warranted to ascertain the ability to transfer the current results to the larger Australian speech-language pathology population, given that only one participant worked primarily with adults, which is a setting in which AHAs are typically utilized. Future research may also include a longitudinal study with this unique sample to ascertain whether perceptions change after exposure to working with AHAs. It will be beneficial to compare the current results with perceptions of SLPs from different geographical locations with relevant policies and guidelines in place in order to identify similarity and divergence in perceptions.

The findings indicate that, without clarification of professional, economic, and organizational issues perceived by the participants, the successful uptake of this workforce re-design may be compromised (Kotter & Schlesinger, 2008). This indicates that further research is needed regarding clinical outcomes and economic viability of SLPs working with AHAs, as well as considering perceptions in terms of stakeholders; that is, clinicians, services, and clients. It is suggested that the speech-language pathology profession engage with workforce planners to define the scope of AHA input into speech-language pathology and the policies which govern their use. This will ensure unresolved professional, economic, and organizational concerns are addressed prior to implementation of this workforce change. SLPs could contribute valuable information to ensure AHAs are utilized effectively to maximize services available and maintain clinical outcomes.
Having AHAs in the speech-language pathology profession has the potential to provide a wider range and amount of services to people who need it, may decrease waiting times and contribute to meeting the growing demand. This workforce innovation has the potential to create a financially viable, sustainable, and skilled workforce designed to meet the needs of the community. Further research is warranted to investigate contexts where the use of AHAs has resulted in good outcomes for clients and staff, as this may inform service delivery models and examples of best practice for the future development of this workforce re-design.

Conclusion
This study aimed to advance the multidisciplinary literature regarding professionals working with AHAs, by including evidence from the speech-language pathology profession. Given the current findings reinforce and extend the multidisciplinary AH literature (see for example, Lizarondo et al., 2010), results may be applicable to other AH disciplines that do not traditionally utilize AHAs in clinical service provision.

This study introduces the Australian speech-language pathology profession into the discourse regarding the utilization of AHAs. It presents a necessary first step in enabling a positive, rather than enforced, workforce change which aims to mitigate the shortage of SLPs in Australia and internationally. This research is required to develop strategies to respond to workforce shortages and increasing need for speech-language pathology services. Speech Pathology Australia, the national peak body for speech-language pathology, supports the implementation of an assistant workforce (Speech Pathology Australia, 2007), but mixed perceptions exist with practising clinicians. The presence of positive perceptions of this workforce change is vital to ensuring its sustainability, and will have implications for how willing SLPs may be to working with AHAs in the future (Sutter et al., 2009). Focusing on perceptions of SLPS may facilitate a better engagement between the profession and employing organizations, and lead to clearer understanding of the context and intent of this workforce re-design.

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Appendix: Sample interview questions

- What do you think about allied health assistants (AHAs) in speech-language pathology?
- Can you tell me about any previous experience you have had working with AHAs (if any)? (Prompts) Were there positive things about this? Negative things?
- In your area of work, what sort of tasks could be performed by an AHA?
- How do you see sharing of administration tasks with an AHA?
- If this happened as you describe, do you see it changing your role?
- What skills would an AHA need to have to work with you in your area of work?
- What skills do you feel you would need to work with an AHA?
- What supports do you think you would need for working with an AHA?
9.2  Paper 2 - Speech-language pathologists’ perceptions of working with allied health assistants

9.2.1  Statement of contribution of others

Statement of contribution of co-authors

We, Rebecca Mitchell, Nicole Byrne and Rachael O’Brien attest that PhD candidate Rachael O’Brien had the primary and lead role in the study concept, design, data collection and analysis, preparation and final revision of the publication entitled;


Rebecca Mitchell (Co-author)
Date: 4th July 2017

Nicole Byrne (Co-author)
Date: 4th July 2017

Rachael O’Brien (PhD Candidate)
Date: 4th July 2017

Suzanne Ryan (Assistant Dean Research Training – Faculty of Business and Law)
Date: 17 July 2017
9.2.2 Introduction

The research began by investigating the perceptions of rural speech-language pathologists to working with allied health assistants in a rural Australian health context. The results of this study indicated that perceptions were complex and varied, so the study was then widened to explore the perceptions of speech-language pathologists in metropolitan areas. Clinicians from rural, remote and metropolitan regions of NSW Health were interviewed to explore their perceptions of working with assistants, and what they perceived to be the barriers and enablers to such a workforce change.

Ongoing limited understanding of the explanation for consequences of the introduction of assistants will likely lead to constrained capacity to influence the success of assistant roles. It is therefore important to understand the likely consequences of a workforce redesign so that strategies can be put in place prior to implementation. The literature relating to the sociology of professions indicates the relevance of understanding and responding to clinicians’ needs including perceptions of potential loss and risk (Kotter & Schlesinger, 2008). However, there is a limited exploration of the perceptions of professional groups prior to implementation of assistants and the factors contributing to such perceptions.

Participants were asked about their perceptions of working with assistants and what factors they felt influenced these perceptions. In order to pursue work-centred issues, participants were asked (for example), about tasks they would be comfortable delegating to an assistant, and how they perceived this may impact on professional boundaries. Employment-centred issues were explored by asking participants (for example), their perceptions of job security and satisfaction, and whether they felt the introduction of assistants would impact upon these feelings. Underpinning responses to intended change to public health policy and workforce structure, two contrasting, but commonly co-occurring, perspectives arise concerning the consequences of assistants being introduced into professions; empowerment and degradation (Bach et al., 2007).

Despite the existence of a strong sense of shared professional identity, participants did not have a shared overall perception of working with assistants. However, participant perceptions did fit into the model of empowerment and degradation. Tension exists
between empowering factors (for example, development of a new role, changed career path and increased caseload complexity) and degrading factors (for example, erosion of traditional skills and tasks, and lack of wholistic management of patients and clients) of working with assistants. For example, while some participants were willing to work with assistants and perceived this is an opportunity to increase the value and distinctiveness of the professional role, others felt that by delegating tasks traditionally performed by SLPs, that the professional role would be undermined or diluted. This goes some way towards explaining the tension which exists within the overall perceptions of working with assistants. This tension will be discussed in terms of the factors existing at opposing ends of the empowerment/degradation paradox.

9.2.3 Criteria for conference selection

The Centre of Full Employment and Equity (CofFEE) is a research centre based at the University of Newcastle and Charles Darwin University, which promotes research aimed at restoring full employment and achieving an equitable economy. ‘Reconstructing a Full Employment Narrative’ was hosted by CofFEE, which also incorporated the 14th Path to Full Employment conference and the 19th National Conference on Unemployment. This was an international conference where papers were subject to peer review prior to acceptance. This was an appropriate outlet for Paper 2: Speech-language pathologists’ perceptions of working with allied health assistants, which examines allied health workforce shortages as a feature of Australian and international health care, and the need to prioritise workforce innovation to meet increasing clinical need while maintaining clinical outcomes.

9.2.4 Full citation

Abstract

Allied health workforce shortages are a feature of Australian and international health care, which prioritises workforce innovation to meet increasing clinical need while maintaining clinical outcomes. Working with assistants has the potential to be an economically viable and professionally sustainable solution. This exploratory study is aimed at understanding perceptions of speech-language pathologists working within an established clinical model to a workforce redesign involving assistants. Our findings provide insight into professional acceptance of this vocationally trained group and highlight discrepancies between perceptions and actualities which may influence the way assistants are utilised within the profession. While assistants were seen as augmenting existing capacity, findings also demonstrated ambivalence towards their utilisation. The introduction of assistants was perceived (Bach et al., 2007) as both empowering and degrading; it presented both potential relief alongside dilution of the professional role. Thorough understanding of these consequences is required to influence the success of these new roles.
**Introduction**

Roles are changing in health services in response to increased awareness for the need for efficiency and sustainability secondary to changing environmental circumstances (Segal & Bolton, 2009). The role of allied and related health professionals is becoming busier and in greater demand, resulting in difficulties in providing timely and appropriate services (National Health and Hospitals Reform Commission, 2009). Speech-language pathologists are a relatively recent but well-established group that has worked to establish and maintain a professional identity separate from other allied health and related disciplines, such as dietetics, nursing and teaching (Godsey, 2011). However, with the change in approach to traditional service delivery models, roles and role boundaries are being challenged in order to make way for a more sustainable and efficient health system with a greater focus on the service user (Bach et al., 2007).

The emerging roles of support staff is an international trend in health services (O’Brien et al., 2013). Utilising unqualified but suitably skilled staff to provide clinical services to consumers is an example of a workforce redesign which may improve health outcomes as well as improve recruitment and retention of clinicians by decreasing waiting lists and promoting reasonable workloads. The literature recognises that the introduction of assistants often happens in situations including workforce shortages or crises within health services. The aim of this workforce redesign is to employ vocationally trained staff to provide clinical support under the supervision of allied health professionals (Lizarondo et al., 2010).

Acceptance of this workforce reform of delegating tasks to allied health assistants (AHAs) has been slow in Australia compared to other places such as the UK. It is unclear whether clinicians have a good understanding of the motives behind this workforce reform (O’Brien et al., 2013). It is necessary to clarify this understanding in order to work with professions, as working with AHAs will change both the way that health professionals are trained and the way they work. Despite health service policy and evidence that suggests positive outcomes from working with an assistant workforce, there is still ambivalence amongst professionals regarding the purpose and outcomes of redesigning the workforce via
increased utilisation of AHAs (O’Brien et al., 2013). Some challenges which have been identified include fears of potential job losses, role replacement or significant role change in allied health professions (Lizarondo et al., 2010). Fear of unknown factors about an assistant workforce may lead to negative rather than positive perceptions (O’Brien et al., 2013). This research aims to explore the perceptions of allied health professionals towards work with AHAs and consider the implications of these perceptions on successful implementation and uptake of this workforce redesign.

Demand for speech-language pathology services is increasing internationally and workforce redesign is required in order to respond equitably to this need (Wylie et al., 2013). Workforce redesign of existing roles and the development of new ones aim to ensure the most appropriate skill mix to meet consumer need. The effect of this for SLPs is discussed in terms of the role of the SLP and the introduction of an increased utilisation of the AHA. This paper presents semi-structured interviews conducted with SLPs, part of a larger mixed methods study of the perceptions of professionals to working with allied health assistants. It utilises the speech-language pathology profession in NSW, Australia as a case study in order to consider factors that will impact upon the introduction and utilisation of an assistant workforce into established allied health professions. A case study approach will allow exploration of SLPs’ perceptions of their skills and knowledge, and the impact that workforce redesign may present to traditional roles and professional identity.

The current research examines the perceptions of members of one professional group in one organisation. This group was selected as at the time of conducting the research, there were no policies guiding SLPs in utilising AHAs in the organisation. As such, the research aimed to explore the various factors which may have some impact on perceptions. For example, variations in clinical experience or background, previous exposure to working with AHAs, number of years working as a speech-language pathologist and other professional and personal factors were expected to impact upon perceptions. Moreover, given the lack of AHAs working with SLP in the organisation, perceptions were expected to be largely based on stereotypical features of an AHA given the lack of available opportunities to work with AHAs in the organisation.
The perceptions of speech-language pathologists to this workforce change have not been researched extensively in Australia or internationally. This research presents these perceptions in terms of barriers and enablers in order to plan for and implement real and sustained change within and across this and other allied health disciplines. This change will include enabling collaboration with an assistant workforce to be successfully adopted by allied health professions. The presence of a positive perception of a workforce change is vital in ensuring its sustainability (Kotter & Schlesinger, 2008). This research presents a necessary first step in enabling a positive, rather than enforced, workforce change which aims to mitigate the shortage of speech-language pathologists in Australia and internationally.

**Method**

This research was conducted in two phases in 2008 and 2012. In total 20 SLPs participated in this study. Twelve of these participants were recruited to the study in 2012, and eight participated in the pilot study of rural speech-language pathologists’ perceptions of working with allied health assistants (O’Brien et al., 2013). The participants represented a range of clinical contexts, years of experience and age. Clinicians working with adult or paediatric caseloads were equally represented (approx 50% of participants working with each caseload). Years of clinical experience ranged from less than one year to over twenty years, with nine of the participants having over twenty years clinical experience. Thirteen participants reported experience or exposure to working with allied health assistants in some capacity.

Individual semi-structured interviews were conducted with the participants to ascertain their previous experience and perceptions of working with AHAs (Smith, Flowers, & Larkin, 2009b). The interview schedule allowed participants to provide their perspectives in their own terms, and not according to pre-determined categories (Smith et al., 2009). Participants were interviewed individually by the first named researcher and were asked to describe their experience and perceptions of working with AHAs and how these perceptions were formed.
Analysis:

The analysis was informed by Interpretative Phenomenological Analysis (IPA), an iterative and inductive cycle where emergent patterns from the data illustrate how people make sense of their experience (Smith et al., 2009). Sections of the data were then assigned themes, with similarities and differences being noted within and across transcripts. The themes were revisited many times as the researcher moved between transcripts, and the data set was finally coded using ‘NVivo 10’ qualitative data analysis software enabling the management and manipulation of the large amount of data (QSR International Pty Ltd, 2012).

The interviews were intended to explore the speech-language pathologists’ experience of working with allied health assistants (if any) and the perceptions of such a workforce change. Ethical clearance was granted by Hunter New England Local Health District and the University of Newcastle Human Research Ethics committees, reference # 08/12/17/4.03 and # H-2009-0225 respectively.

Findings and discussion

The following discussion presents the findings to date and is organised around the main themes that evolved from participant accounts. Bach and colleagues’ (2007) empowerment and degradation consequences of the introduction of the AHA role were used as a means of further exploring the results of the current study, and in particular, of making practical and theoretical links between the current study and relevant literature. Using these extant categories enabled evaluation of those other issues which did not easily fit into the categories of empowerment or degradation.

Strong association with the professional identity as a speech-language pathologist was evident in most participant accounts. Participants identified the influence of professional values and standards of behaviour as factors which helped them define themselves as members of the profession, as well as to differentiate themselves from other groups within the organisation. This definition related to the speech-language pathology qualification expected skill sets including technical skills and knowledge, commitment to evidence,
quality and clinical outcomes, and standards of professional behaviour. As one participant described:

“Your typical speech pathologist... Wow, you’ve really got a package there of somebody that’s got all the range of characteristics from somebody that can be anal and systematic, and statistical and, to somebody that’s innovative and interpersonal, and a great communicator, and sensitive. It’s quite a package” (participant # 3).

Some participants felt that AHAs could present an opportunity to enhance or empower the professional role. That is, there is potential to increase the SLPs’ available time for caseload management and intervention with a higher level of clinical complexity, thereby creating a higher status role for the SLP. However, some participants did not feel that SLPs’ roles and boundaries were defined enough for the organisation, colleagues or consumers; as such the introduction of AHAs could result in a poorer status and role for SLPs through lack of prior knowledge of the role. The findings indicate that the traditional wholistic nature of SLPs’ work may be threatened by the increased fragmentation necessary in delegating tasks and activities traditionally conducted by the professional. One of the results of the workforce redesign of working with AHAs is that boundaries between allied health professionals and assistants are blurred, resulting in some measure of role ambiguity. It was raised by participants that the development of the AHA role would result in decreased recognition and understanding of the SLP role and profession. The findings demonstrated ambivalence towards the introduction of an assistant workforce and indicate the potential for threat to social identity that they pose for SLPs.

Suggestions of strategies to strengthen professional identity included incorporating working with AHAs into professional training to ensure that this becomes an accepted part of the professional role. Rather than being perceived as a workforce redesign enforced by employing organisations, it was felt that this would be perceived as being driven from within the profession. All participants discussed the need to have appropriate skills, experience and techniques for working with AHAs, as well as the support of the profession and personal confidence to practice in a more collaborative manner. As such, this may serve to strengthen professional identity by protecting professional boundaries and
increasing new clinicians’ sense of role ownership, both important factors in the empowerment/degradation paradox.

While there was an acknowledgement of the potential for the AHA role in speech-language pathology, the majority of participants felt that they were being utilised as a cheaper workforce option at the expense of the professional role. This, in turn, led to concerns being expressed regarding organisational intentions, organisational valuing of the professional role, and subsequently, job security;

“I think it’d be nice for them not to push this on us, to give us the option... I think if we lost, if people lost a speech pathology position in favour of an assistant that would gain a lot of ill will. So in terms of how it’s rolled out by (the employing organisation), it would need to be very much, you know, we’re going to give you this little bit of extra, or something like that” (Participant # 14).

The perception of the SLP role being misunderstood by employing organisations led to the concern that the increasing presence of AHAs has the potential to compromise the value of the speech-language pathology role;

“I can see a government department saying well if they can do the simple ones (clients) then obviously they can train up enough and they can have enough skill to do complex ones” (Participant # 8).

Participants in the current study were not opposed to changing work practices and agreed that SLPs required ongoing training to maintain evidence-based practice and to ensure they maintained up-to-date skills and knowledge. However, SLPs’ concerns regarding implications of working with assistants reflect the level of ambivalence within the profession surrounding future roles and skills of a speech-language pathologist.

Although not all participants shared identical viewpoints regarding working with AHAs, there was a common understanding on practical matters including the need for role boundaries and guidelines for utilising AHAs, recognition of the need for supervision and further training and support for SLPs, and that the profession would need to advocate for
the interests of new graduates. There was agreement that if the role of the AHA continued to expand, that any delegated tasks would need to remain within the control and under the responsibility of the qualified allied health professional. There was also agreement that the AHA role should supplement but not replace the AHP role, and that clarity surrounding tasks and role boundaries should be a high priority when planning this workforce redesign. The SLPs, therefore, shared similar views on some aspects particularly related to profession-specific issues and the employing organisation overall. There were differences however regarding working with AHAs. Participants varied in their attitudes and reactions to potentially working with AHAs, as well as the tasks they felt to be appropriate or otherwise for delegating. All participants wanted to have input into how the system would be shaped and were generally resistive to the workforce redesign unless their input was sought and acted upon by management and workforce planners.

From the interviews, there appeared to be an understanding among the participants of the SLP group’s existence, where they recognised the boundaries of the group and had a measure of group coherence despite not having identical viewpoints. As SLPs shared the group belonging and perspectives, they formed an opinion about AHAs and clients or patients. Coherence in the perceptions of the SLPs could have been contributed to by common professional socialisation, similar social backgrounds, or common professional perspectives. It is evident that while SLPs viewed themselves as different to the AHAs and clients/patients, they may have perceived AHAs and clients/patients as being more similar to each other. Boundaries between professionals and allied health assistants are changing and moving towards new clinical service delivery models driven by the need to ensure sustainable workforce supply and meeting increasing clinical need. While this may be of overall benefit to the health service, consumers and health workers, it also has the potential to threaten professional identities and result in pressure and disquiet in the workplace if measures are not taken to address the importance of strengthening professional identities prior to workforce redesign and implementation.
Conclusion

This study demonstrates the tension between empowering and degrading factors for a profession related to the introduction of an assistant workforce. With need increasing in the early intervention, disability and aged care sectors, need for speech-language pathology services also increases. To increase input using only SLPs is not economically viable or possible. Rather, the health service model needs to change to be more appropriate and responsive to the needs of the population. Changed work practices are required to accommodate increasing consumer need. Participants perceived that while this need is being acknowledged from within the profession, the pressure for role redesign is being driven by employing organisations, from an economic rather than clinical perspective. Participants perceived that they needed to continue to have excellent clinical skills, but also to increase their professional distinctiveness in order to maintain or increase the understanding of the role from outside of the profession and have meaningful input into the discourse surrounding AHAs.

SLPs’ concerns regarding implications of working with assistants reflect the level of ambivalence within the profession surrounding future roles and skills of a speech-language pathologist. The consequence of introducing an AHA workforce has implications for status and professional identities, as well as having implications for organisations and consumers (Bach et al 2008). It is important to acknowledge the anxiety of existing staff regarding role change as this will have a direct impact on the successful implementation of the workforce redesign. Before it is able to be claimed that working with AHAs is a solution to workforce supply shortages and increased clinical demand, professions and employing organisations need a clear understanding of the perceptions of workers to this workforce change, as this will have a direct impact upon successful uptake of the workforce redesign. Perceptions of working with AHAs require further research in order to fully evaluate professional practices and services, and the possibility of expanding these services to meet demonstrated need.
References


9.3 Paper 3: Resistance to a workforce redesign and perceived professional identity threat

9.3.1 Statement of contribution of others

Statement of contribution of co-authors

We, Rebecca Mitchell, Nicole Byrne and Rachael O’Brien attest that PhD candidate Rachael O’Brien had the primary and lead role in the study concept, design, data collection and analysis, preparation and final revision of the publication entitled;


Rebecca Mitchell (Co-author)
Date: 4th July 2017

Nicole Byrne (Co-author)
Date: 4th July 2017

Rachael O’Brien (PhD Candidate)
Date: 4th July 2017

Suzanne Ryan (Assistant Dean Research – Faculty of Business and Law)
Date: 17 July 2017
9.3.2 Introduction

This paper focuses on the resistance noted in participant accounts. Kotter and Schlesinger (2008) discussed the human components of resistance to change being (1) desire not to lose something of value, (2) a misunderstanding of the change and implications, (3) belief that change does not make sense and (4) low tolerance for change (Kotter & Schlesinger, 2008). While resistance is often presented as a purely negative response to workforce change (Turner & Knight, 2015), this paper argues that participant resistance was complex and considered, and links this with participants’ professional identity construction and threat. In this paper the process of the speech-language pathology professional identity construction is discussed, and how assistants may be perceived as a real or potential threat to this identity, leading to resistance.

This paper contributes to the speech-language pathology discourse surrounding professional identity. While considering changes to the profession, it is important to have a clear understanding the importance of identity factors and the impact these factors have on other facets of the role. Having a clearly articulated professional identity will also allow the profession to have a clear message for ourselves, employers and consumers regarding the SLP profession, including the ethical standards and evidence base to which the profession is committed, as well as beliefs and rationales of the profession. This clarity of identity and role contribute to more effective workforce planning, by understanding that changes in speech-language pathology have an impact on other professional and vocational groups (Duckett & Willcox, 2015).

9.3.3 Criteria for conference selection

The Organization Studies Summer workshops are connected to the Organization Studies journal (which has an impact factor of 3.107) and have been run annually since 2005 in order to facilitate high-quality research in the area of organization studies. Participation in the workshops is competitively selected by peer review and aims to allow international scholars to interact and advance current research. The workshops are linked with a special edition of Organization Studies – the 9th annual Organization Studies summer workshop.
was focused on Resistance, resistors and resisting in and around organizations. It was therefore chosen as a logical outlet for *Paper 3: Resistance to a workforce redesign and perceived professional identity threat*. Given the lack of research based on professionals, the oral presentation and paper focused on the possibility that resistance may be impacted upon by construction of and perceived a threat to the professional identity.

### 9.3.4 Full citation

9.3.5 Publication

Resistance to a workforce redesign and perceived professional identity threat

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Abstract

This article explores resistance to a workforce redesign based on the introduction of vocationally trained assistants into the speech-language pathology profession. In particular, we discuss underlying concerns which may motivate resistance and posit that resistance may be impacted upon by construction of, and perceived threat to professional identity. Findings indicate a strong shared professional identity amongst participants in terms of role and values. Participants perceived that management values reflected budgetary, economic and resource-based concerns and that these were opposed to their professional values of client care and clinical outcomes. The introduction of assistants, when perceived as resultant of economic pressures to increase efficiencies, was interpreted as detrimental to the professional role, particularly in terms of devaluing the consumer and deskilling of the professional workforce. Participants described the introduction of assistants as a way of cheapening the labour process and this reinforced fear of substitution, replacement and threat to job security. Findings indicate that workforce redesign can threaten professional identities and can cause tension within organizations. Working with assistants was acknowledged by participants as having the potential to extend professional roles, increase complexity and potential for specialised practice. Conversely, it is also perceived as potentially contributing to the loss of some traditional and desirable aspects of the role including the ability to provide services in a wholistic manner. It is therefore proposed that professional identity threat accounts for the perception of professional degradation, resulting in resistance to change.
**Introduction**

Traditionally, employee resistance to workforce redesign has been viewed from within a negative paradigm, proposing that employee resistance to workforce redesign presents as short-sighted or oppositional behaviour (Piderit, 2000). However, more recent research challenges this view by presenting resistance as a non-linear construct, with greater complexity than that found within the traditional hierarchical studies of workers resisting the imposition of management (Thomas & Davies, 2005). Within this new construct, resistance may be viewed as the presentation of valid concerns, as well as illustrating the more subtle contributing factors to resistance, such as social and professional identity.

We address two gaps in the resistance literature. Firstly, Thomas and Davies (2005) note that there has been a relatively small amount of research attention paid to the role of identity in resistance. The tendency to frame resistance as negative may account for this lack of research and the existing studies of resistance focus largely on behaviours deemed to be resistant. Secondly, we note that few studies of resistance focus on professional or knowledge workers, such as teachers, engineers or healthcare professionals (Drucker, 1999; Thomas & Davies, 2005). As such, the identified factors that contribute to resistance in these populations are not well understood. Thus, we examine participant accounts in order to understand the real or perceived threat to professional identity presented by a proposed workforce redesign involving the introduction of vocationally trained assistants.

These accounts allow us to explore responses to a workforce redesign and in particular, focus on the professional resistance encountered in response to the introduction of assistants. This facilitates further examination of the professional identity of a group and how this may impact on resistance to organizational change. Prior research has identified consequences of resistance but has not explored in great detail the antecedents of this resistance. Contested professional boundaries have been addressed in research on professions (Nancarrow & Borthwick, 2005); however, the majority of past studies have ignored the challenges associated with introducing new occupational groups which may be perceived as being of lower professional status, or of adding a new layer to the occupational group hierarchy. While our results relate to the SLP professional group, we contend that
there is wider applicability of the current findings to other professional groups within organizations who may experience a professional identity threat from another occupational group.

The research contribution of our paper is to empirically examine how resistance to workforce redesign is influenced by social and professional identity. The study draws upon and contributes to the literature on social and professional identity, resistance to change and workforce redesign. The research utilises the speech-language pathology profession in the state of New South Wales, Australia as a case study of workforce redesign in health care. This population was chosen to provide an understanding of perceptions of workforce redesign from a relatively new but well-established discipline. It was also designed to understand perceptions of a professional group with limited previous exposure to an assistant workforce (hereafter referred to as assistants), making the findings applicable across a wide range of health and related disciplines. We explore the possibility that perceptions of working with assistants may be based on the professional identity and professional group membership of the tertiary qualified speech-language pathologists (SLPs), and what this workforce redesign may represent in terms of changing or threatening this professional identity. SLPs’ accounts of their perceptions of working with vocationally trained assistants are examined in order to explore how their professional identity and existing role contribute to their assessment of the redesign and their subsequent ambivalence or resistance. Through analysing the impact of SLPs’ perceptions of belonging to a professional group, we have been able to explore how this commitment and identity impacts upon resistance to a workforce redesign. This paper offers insight into the ways professions and professionals may respond to a perceived threat posed through the introduction of a vocationally trained occupational group. Theoretically, this paper offers a contribution on the micro level of resistance (Thomas & Davies, 2005), where empowerment accounts for positive perceptions of change, and perceptions of degradation may lead to negative perceptions. However, it is also possible that feelings of ambivalence may equally lead to resistance to a workforce redesign. Based on an in-depth exploration of professional perceptions of workforce change and in a context of relatively experienced and knowledgeable clinicians, we posit that resistance may be less in direct response to fear of
unknown factors, and more indicative of a considered assessment of the impact that this workforce redesign would have on the profession, organization and consumers. This research provides important new perspectives across health professions, and may also contribute to a wider professional literature on organizational change.

The next section will present the workforce context for the current research, and how this led to the exploration of issues of social and professional identity. We will discuss the use of the Social Identity Perspective (Hornsey, 2008) as an analytical lens for the research. Following this, we will present our methodology for the overall research, and the methods adopted for this case study and analysis. The findings will then be presented to illustrate the participant perceptions specifically related to professional identity, how they perceive their employing organization views their role, and how this contributes to overall perceptions of a workforce redesign involving the possible introduction of assistants. Finally, we discuss the theoretical and practical implications of professional identity in conjunction with resistance to workforce change.

**Research context**

This paper is located in the context of challenges in international health services with respect to workforce supply, decreasing resources and concurrent changing consumer need and increasing consumer demand. These challenges have necessitated the creation of new roles such as assistants in allied health in an attempt to provide the right skill mix and sensitivity to consumer need (Bach, 2007). Common themes underpin the change towards increased utilisation of assistants in health services, including the positive aspects of increased access to services and better service satisfaction for consumers, increased service provision for organizations, and improved manageable workloads for clinicians. However, the negative themes include the introduction of job insecurity for traditional tertiary qualified roles and the concern that resourcing is being prioritised over the utilisation of best practice to ensure optimal client care through maximised clinical outcomes. Working with assistants has the potential to be an economically viable solution to workforce shortages and is argued as a more cost-effective way of providing clinical services (Lizarondo, Kumar, Hyde, & Skidmore, 2010). However, there is some resistance to the
implementation of an assistant workforce, and the factors that determine whether and how assistants are utilised beneficially are not well understood. Past research suggests that redrawing boundaries between professions and introducing new roles has presented major organizational challenges (Nancarrow & Borthwick, 2005), with the majority of stakeholders remaining unconvinced about the potential benefits of change (Kotter & Schlesinger, 2008). Redefinition of existing workforce roles is fundamental to the introduction of new roles and ways of working in health services. This is particularly pertinent for workers whose profession provides a strong sense of identity. While this paper focuses on SLPs, it could be equally applied to other allied and related professions with similar professional backgrounds, including the process of professional preparation, training and workplace conditions.

The literature regarding the sociology of professions and change management highlight that the perceptions of potential loss and risk need to be considered in order to understand and respond to the professionals’ needs. An understanding and appropriate response to perceptions regarding potential loss are important in minimising resistance to change (Kotter & Schlesinger, 2008). It has also been demonstrated that the successful implementation of workforce redesign does not necessarily occur without consultation regarding design and implementation of the proposed new system (Hudson, 2002; Kotter & Schlesinger, 2008; O’Brien, Byrne, Mitchell, & Ferguson, 2013). In times of significant organizational change and workforce uncertainty, it is important to be aware of the likely reactions of employees, including anticipating potential resistance to change and the antecedents and consequences of such resistance (Kotter & Schlesinger, 2008).

**Social Identity Theory, Self Categorisation Theory and the Social Identity Perspective**

This paper takes the social identity perspective to explore the meanings that clinicians assign to their social identity and perceived threats to these boundaries. Thomas and Davies (2005) have discussed that resistance is conceptualised at this level. The social identity perspective is the dominant theory comprised of social identity theory and self-categorisation theory, which seeks to explain intergroup relations and group processes (Hornsey, 2008). Social identity theory is concerned with intergroup relations, and how
people make comparisons between groups to ascertain the social status of their own in-group as compared with an out-group (i.e. ‘us’ versus ‘them’). Tajfel (1979) discusses that individuals divide the world into categories, and social identification is the way in which an individual determines their own and others’ place. It assumes that group membership entails value or emotional significance which contributes to an individual’s positive social identity (Tajfel & Turner, 1979). Self-categorisation theory is concerned with intragroup processes, and the conditions under which an individual will perceive themselves as a member of a group (Turner, Hogg, Oakes, Reicher, & Wetherall, 1987). It also explores the consequences of such belonging and is concerned with the shift from behaving and defining oneself as an individual to behaving and defining oneself in terms of a shared social identity (i.e. ‘I’ and ‘me’ versus ‘we’ and ‘us’) (Haslam, 2004). The social identity perspective assumes that within an organizational context, individual perceptions and behaviour are strongly influenced by group membership (Haslam, 2004). As such, the social identity, including the thoughts, feelings and resultant behaviour of individuals will be influenced by social structures such as professional background, status and socialisation.

With reference to the current research, it is important to explore the perceptions of SLPs to a proposed workforce redesign in order to illustrate the processes enabling the professional group to act collectively (Haslam, 2004). The exploration of these perceptions provides a contribution to the understanding of behaviour in an organizational context.

It is possible for self-identity to be entirely made up of the values derived from group membership and it is likely that intergroup conflict in a workplace can occur when group values are or are perceived to be different or misaligned (Turner et al., 1987). The current study is part of a larger research project looking at how SLPs perceive working with assistants prior to the proposed workforce change. The existing research provides evidence that SLPs without previous exposure to working with assistants have generally more negative perceptions than those who have had previous exposure, and also have limited awareness of the value an assistant can add to the profession and service provision (O’Brien et al., 2013). Against this theoretical background and given the lack of research currently available in the area, the study reported in this paper explores the role professional identity
has in SLPs’ perceptions of and resistance to working with assistants in order to decrease potential barriers if such a workforce redesign is implemented.

_Protessional identity_

The formation of a professional identity includes relating oneself with a specific body of knowledge, attitudes, values and belief systems which can form an important part of an individual’s personal identity (Hudson, 2002); that is, defining yourself based on your professional group. When a social identity becomes salient, it is the dominant social identity and determines an individual’s perspective, attitude and behaviour relevant to the context. Different circumstances influence which social identity is the most prominent at any one time. It has been suggested that professional identity is one form of social identity which directly relates to the categories in which individuals place themselves and others (Turner et al., 1987). This process contributes to the development of professional identity, in that it assists in categorising the people who are part of the work environment, and contributes to impressions formed regarding their role, skills and culture (Lingard, Reznick, DeVito, & Espin, 2002). The process of perceiving and categorising people into socially constructed groups usually results in the understanding that those who are outside of the in-group become to a certain extent, strange and different from oneself. The sense of belonging to a particular group results in the formation of a boundary where those in the in-group are viewed differently from those in the out-group. It also allows an understanding of whether out groups are of a higher or lower perceived status than ourselves. Hudson (2002) and Randel (2002) discuss that professional identity salience increases with the perceived threat. That is, a threat to the collective group identity can result in people identifying more strongly with that group, or behaving in a manner more stereotypic of that in the group (Haslam, Oakes, Reynolds, & Turner, 1999). Nancarrow and Borthwick (2005) propose that professions may act in ways to ensure the maintenance of their group status in society by controlling professional behaviour and tasks, as well as limiting entry to the profession (Payne & Keep, 2003), while Zurn and colleagues (2004) discuss the actions of professional associations who, through their positive representation of a profession, attempt to increase the standing of the profession in society and increase influence and income.
The allied and related health discipline literature has devoted much attention to health professionals’ clinical application of professional skills (e.g. therapy techniques, assessment, therapy planning and administration) (Bach, 2007; Lizarondo et al., 2010; Lowe, Grimmer-Somers, Kumar, & Young, 2008). However, there is little research related to workforce or service redesign. Health professionals hold the view that they have considerable expertise in their chosen profession, and that their distinct role is in planning and overseeing successful health intervention. Our interest is in how SLPs presented this idea of professional identity as well as the idea of how a threat to distinctiveness or value could constitute a threat to their professional identity (Branscombe, Ellemers, Spears, & Doosje, 1999). A key argument that we present is that SLPs’ identities are shaped by their expectations and experience of their professional group (Mackey, 2007). This experience includes professional training, qualifications and socialisation. It also includes agreed standards of practice and behaviour which are strongly encouraged by employing organizations (McNeil, Mitchell, & Parker, 2013). It is felt that the current research has implications beyond speech-language pathology, and that results are equally applicable to other allied and related health contexts. It may also be that there are implications beyond health services; there are clear examples of technically versus professionally qualified roles where there is the potential for one part of the workforce to constitute a cheaper option. Examples in the health sector include technical roles being implemented in professions such as medicine, nursing and dentistry, but there are also examples in other sectors such as education, design and manufacturing. By analysing SLPs’ perceptions of the expected standards of practice and behaviour, we seek to understand how the introduction of a vocationally trained occupational group may present a threat to this sense of identity, and in turn, the impact it has on resistance.

**Method**

The current article draws from a larger project examining the perceptions of speech-language pathologists (SLPs) to working with assistants in an environment with limited previous exposure to this vocational workforce. We use Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) as the overall methodology and a qualitative case study design in this specific component. We use the social identity perspective as an
analytical lens in order to explore the issues of resistance to organizational change and professional identity within the speech-language pathology profession in one health organization in Australia.

Allied health directors and senior SLPs in each Local Health District (LHD) in one state of Australia were contacted to discuss requirements for participation in the study. Five LHDs elected to be involved, and ethical approval was sought and granted by Hunter New England LHD Lead Ethics committee (reference # 08/12/17/4.03) and the University of Newcastle Human Research Ethics committee (reference # H-2009-0225). Following approval, senior SLPs in the five LHDs were provided with an electronic copy of the participant information sheet, which they disseminated to the SLPs in their area via email. Speech-language pathologists were invited to contact the researcher directly by email or phone to indicate their interest in participating. Twenty SLPs volunteered to be interviewed, and their demographic data are presented in Table 1.

<table>
<thead>
<tr>
<th>Participant N=20</th>
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</thead>
<tbody>
<tr>
<td>Clinical setting</td>
</tr>
<tr>
<td>7/20 (35%) Generalist clinicians with majority paediatric component</td>
</tr>
<tr>
<td>4/20 (20%) Acute adult inpatient</td>
</tr>
<tr>
<td>3/20 (15%) Brain injury rehabilitation</td>
</tr>
<tr>
<td>3/20 (15%) Paediatric service</td>
</tr>
<tr>
<td>3/20 (15%) Inpatient and / or outpatient rehabilitation</td>
</tr>
<tr>
<td>Caseloads</td>
</tr>
<tr>
<td>10/20 (50%) Adult caseload</td>
</tr>
<tr>
<td>10/20 (50%) Paediatric caseload</td>
</tr>
<tr>
<td>Working hours</td>
</tr>
<tr>
<td>15/20 (75%) Full time</td>
</tr>
<tr>
<td>5/20 (25 %) Part time</td>
</tr>
<tr>
<td>Employment status</td>
</tr>
<tr>
<td>17/20 (85%) Permanent</td>
</tr>
<tr>
<td>3/20 (15%) Temporary</td>
</tr>
<tr>
<td>Years of clinical experience</td>
</tr>
<tr>
<td>7/20 (35%) Less than 10 years</td>
</tr>
<tr>
<td>4/20 (20%) 10 – 20 years</td>
</tr>
<tr>
<td>9/20 (45%) Greater than 20 years</td>
</tr>
</tbody>
</table>

**Table 1**: Participant Demographics

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Interviews were conducted in two phases. The pilot phase was conducted in 2008 with nine rural or remote SLPs volunteering to participate. One participant withdrew due to ill health. Interviews were conducted in the participant’s or the researcher’s workplace – either a hospital or community health interview room, and one interview was conducted in a participant’s home. All interviews were conducted by a SLP researcher (RO). Phase two was conducted in 2012 with twelve rural and metropolitan SLPs. Interviews for phase two were conducted in the participant’s workplace (N=7) if within a reasonable distance to the researcher, or via teleconference (N=5) where the participants worked a significant distance away from the researcher. Semi-structured interviews were between 45 and 90 minutes duration depending on detail and extent of responses. Interviews were audio recorded with the participants’ permission, and field notes were taken. All interviews were transcribed verbatim by the researcher (pilot phase), or by an external transcription service (second phase). All participants were offered the opportunity to review and provide feedback on their transcript, however, none accepted this offer. The focus of the interviews was to explore perceptions of a workforce change involving the introduction of assistants, and participants were asked about their role, perception of boundaries, job security and satisfaction. Despite varying overall perceptions of the actual workforce change, it became apparent from interviews and later in the analysis that issues of identity relating to resistance were a strong feature of participant reports.

In order to explore the perceptions of professional identity threat and resistance to a workforce redesign, we utilised qualitative principles of Interpretative Phenomenological Analysis (IPA) in order to examine how participants made sense of their experiences. This was an iterative and inductive process whereby participant accounts are presented in a double hermeneutic interpretative process (Smith et al., 2009). This means that the information presented in this paper is the authors’ interpretation of the participants’ interpretation of their experience and subsequent perception (Smith et al., 2009). As such, we recognise the interpretative nature of the analysis as both a strength and inherent limitation of the IPA methodology. Given that two of the authors (RO and NB) are SLPs, we acknowledge that we bring a pre-existing perspective to the research. Within the interview context, it was clear that there was also a large degree of ‘insider knowledge’
resulting from the interviewer being a member of the ‘in-group’ under consideration. It was found that this was influential on the interview process – there was a degree of shared assumption, and the technical language and vocabulary of the profession was understood by the researcher and participants, which rarely required clarification. This in turn impacted upon the style of interview, the questions asked, and information sought. It was felt that greater empathy and understanding was achieved given the shared assumptions and similar experiences in terms of work practices, professional preparation, socialisation and identity. This also led to gaining greater depth in the data.

The preliminary analysis involved each transcript being read several times by a researcher who was concurrently listening to audio recordings in order to note any nuances present in the verbal account which were not fully ascertained from the written transcript alone. This process allowed a good overall understanding of the ideas being expressed. Preliminary points of interest were noted on the transcripts, sections of the data were assigned themes, and similarities and differences were noted within and across transcripts. We searched for internal consistency and specificity of each theme (Smith et al., 2009). Themes were revisited many times, as analysis moved from concrete description to conceptual interpretation prior to coding of the dataset. Use of ‘NVivo 10’ qualitative data analysis software enabled efficient management and manipulation of the large amount of data (QSR International Pty. Ltd., 2012). A coding sample was presented to co-authors, and we discussed the representative nature of the coding of the dataset and resultant themes. The data were constantly reviewed, recoded and reorganised.

The data analysis revealed a number of recurrent themes. For the purpose of this paper, two superordinate themes will be explored and discussed. The first theme relates to professional identity; it is concerned with how participants constructed and portrayed their identity in terms of their traditional role and the values they were professionally committed to. The second theme relates directly to real or perceived professional identity threat posed by the proposed workforce redesign of introducing assistants into the profession, and subsequent resistance to change. It is important to note that the research was conducted with a cohort of experienced clinicians.
Findings and Discussion

The study focuses on the perception of SLPs to the introduction of assistants in an area with limited previous exposure to such a workforce and examines the salience and role of professional identity as an explanation for such perceptions. The ambiguity and tensions between positive and negative perceptions provided the stimulus to further explore the professional identity which appears to be relatively consistent across the cohort. Many of the concepts raised in the participant accounts relate to a strong professional identity as a SLP, and it is discussed by Ibarra & Barbulescu (2010) that it is during periods of role transition where identity work is utilised to maintain a sense of professional identity and value. The following results will be organised around two major concepts; professional identity function and professional identity threat. Professional identity function explores the construction of professional identity and the functions it serves in the work context, as well as the perception of how the role is viewed by others outside the profession (i.e. the organization). The professional identity threat section will address the factors which may constitute professional identity threat, and how they contribute to resistance to a workforce redesign.

Professional identity function

How SLPs construct and present their professional identity

The participants are a group of healthcare professionals who are demographically and clinically diverse (see table 1), but who identify and present as a homogenous group in terms of professional values and behaviour. This is evidenced by the interpretation of participant accounts indicating that they tended to differentiate themselves from other groups within the organization. The professional identity of the participants was found to be salient within the work context and had a strong impact on perceptions of the proposed workforce change. This identity emerged from accounts as individuals reflected on their professional and personal values and how these values emerge at work. The identity being portrayed for the SLPs is of an organised, strategic and ethical professional, with high standards of behaviour and practice;
...your typical speech pathologist... Somebody that’s got all the range of characteristics from somebody that can be...systematic, and statistical, to somebody that’s innovative and interpersonal, and a great communicator, and sensitive (Participant #3).

Clinicians discussed the consistently busy workloads and the pressure created by the tensions between large caseloads, more intensive clinical need and service access issues such as long waiting times. The level of clinical control and decision making experienced by most of the participants contributes to the construction of the professional identity as an effective and independent clinician. Some participants explained their effectiveness in their role as being indicative of a thorough understanding of complexity and quality of care. All participants regarded clinical outcomes as a fundamental principle of being a SLP, claiming it to be their ethical, legal and professional responsibility to ensure maintenance of a high standard quality of care. Clinicians saw themselves as effective in their roles, and emphasised that achieving clinical outcomes efficiently is one measure they use to ascertain their level of effectiveness;

A good speech pathologist can be very effective very quickly, and is the best person, well the person who is going to get through the waiting list and deal most effectively with it (Participant #20).

In the process of illustrating their professional identity, it was clear that organizational, personal and social factors contributed to identity construction, and also contributed to the positioning of the professional identity in comparison with other identities in the work context;

We work with people from catering and people from, you know, other parts of the hospital...and there’s probably social differences there and I think that works fine, so. I think if you had that kind of personality where you think I’m better than you ’cause I’ve got a degree, well then you’re a dickhead, but also...I think everyone’s here making a difference for patients regardless of what job you’ve got (Participant # 14)
Participants’ construction of their professional identity was also bound in the perceived feminine nature of the role (Litosseliti & Leadbeater, 2013). For example, being empathetic and caring is perceived to be required in order to listen to and understand disempowered or vulnerable clients. The way that participants perceived this was in direct contrast to how they perceived assistants. The assistant demographic is largely female, generally older than the SLP workforce and shown to have carer responsibilities such as being a parent or caring for elderly relatives (Chief Health Professions Office, 2008; Lizarondo et al., 2010). However, the identity of assistants was not constructed in participant accounts as having these same feminine gendered attributes of a SLP – rather they were portrayed at times as more likely to disregard professional and occupational boundaries, and wanting to invade and undermine the SLP role;

*Your stock-standard speech path is going to be a young female and your stock-standard therapy assistant in some of these places is going to be a motherly type, maybe an older woman – they might say ‘I know better than you do, you haven’t got kids yet’ (Participant #15)*

Participants emphasised their advocacy role in relation to the often vulnerable clients in their service. They discussed how they attempt to increase self-efficacy of clients and increase access to the community through their care. They also discussed their perceived responsibility for advocating for appropriate access to other services within the organization, in addition to the assessment, therapy plan, clinical management and outcomes. Participants consistently responded as highly valuing and being protective of their clinical discretion and critical thinking skills. They reported a level of professional and clinical autonomy in their current service delivery models, despite some reports of organizational control. For example, some participants reported having time limits to their sessions, and some services required that clients received a limited number of service sessions prior to discharge.

The participant accounts illustrate the motivation to portray themselves and other members of the profession as having high standards and a particular set of client centred values distinctive from other professional and vocational groups. Our findings indicate a shared
emphasis on professional identity, both in terms of role and values which is consistent with previous research conducted with other allied health professions (Mackey, 2007; Nancarrow & Mackey, 2005). The participants’ construction of their professional identity is positive, with a measure of responsibility without absolute control. This identity provides empathy and advocacy while ensuring high levels of professional quality and achievement of clinical outcomes. However, there are also references to disempowering aspects of the professional role. These are generally framed as being out of the individual clinician’s control, and more in the realm of the employing organization’s policies and ways of working. For example, high workloads and increasing administrative demands were considered to decrease the amount of clinical time available. At the same time, other competing priorities such as statistics, meetings and other administrative tasks are increasingly prevalent and perceived as being valued more highly by the employing organization than clinical input or outcomes.

**Perceived Organizational View of the SLP role**

Participants tended to express their professional values as being opposed to what they perceived to be the values of organizational management. That is, the management values were perceived as reflecting budgetary, economic and resource-based concerns. Participants’ professional values were framed in terms of patients, clients and high-quality clinical outcomes. Participants perceived that management decisions regarding resourcing devalue both the client and the clinical evidence base to which clinicians are professionally committed. The interview data suggests that this devaluing leads to a perception of professional degradation, which is consistent with the findings of Bach (2007). In the context of this study, degradation relates to the perception that delegating clinical tasks to assistants may lead to a fragmentation of clinical service provision and have a negative impact on clinical outcomes for clients. Additionally, the introduction of assistants, perceived as being pursuant to economic efficiencies, was also interpreted as degradation of the professional role by way of deskilling the professional workforce and devaluing established roles;
De-skilling... And, not just de-skilling but losing, what’s the word? Losing recognition for the role, the speech pathology role (Participant #16).

Participants described the introduction of assistants as a way of cheapening the labour process and introducing fears of substitution, replacement and threat to job security;

*I think that’s where you’re going to have job security fears... the threats are that they might give the money to assistants because they’re cheaper* (Participant #4).

The introduction of assistants was presented by some participants as being a method of organizational rationalism, where they provide a cheaper, less effective method of service provision. This service delivery model was seen as decreasing the individualised treatment that the majority of clinicians in the cohort were currently working in. This at once devalues the clinical role of the SLP, where participants perceived they would be unable to personally achieve the clinical outcomes for the client. At the same time, it was perceived by some participants that delegating clinical tasks to assistants may undermine the importance of the traditional advocacy role, where the SLP may have less contact with the client, possibly resulting in a poorer clinical relationship.

Resisting the workforce redesign in this context can be seen as challenging the larger organizational values which in turn are perceived by participants to be in opposition to the values of the profession. Therefore, the workforce redesign that the organization constructs as an evidence-based intervention to increase access to service provision for consumers and improve the clinical utilisation of clinicians, was perceived by some participants as a non-clinical, resources based method of forcing role boundary changes and increasing the number of clinical interventions at the expense of quality. The idea of redesigning the workforce to include assistants introduced a level of uncertainty regarding the control that clinicians would have in future over their own work. Similarly, a lack of consultation regarding the workforce redesign was perceived as degrading;

*I’m just concerned we’re going to get it enforced on us without, without choice. And if this is a mechanism to increase workforce capacity over time,*
fantastic. If it’s a way to save money without the right consultation, then, no, it’s not good (Participant #14).

Participants identified a number of mechanisms which would assist in the successful professional uptake of the redesign, including role definition, outcome measures, quality controls and training needs. However, they reported that these mechanisms would need to be in place prior to the workforce redesign being implemented, and they felt that they had no input or control over such factors. The participant accounts show that the resistance displayed is multidirectional, being used to oppose the workforce redesign, but also to suggest and shape what a similar workforce redesign may look like.

*Professional identity threat*

The introduction of assistants was perceived as a potential threat, in theory, or in practice, to the professional identity of the SLPs. This threat, in turn, appeared to increase the importance of the professional identity among members of the workgroup. The consistent professional identity aided collective perception, which leads to a consistent stereotypic presentation of both SLPs and assistants in the current study (Haslam et al., 1999). Randel (2002) discusses that exposure to other groups who may be considered as rivals increases the salience of professional identity. Being (or not being) a SLP was used consistently as a defining category to describe individuals and others. This definition referred largely to qualifications and expected skill sets, quality management and outcomes, and professional behaviour. A representative comment from a participant was;

*Because they’re not a speech pathologist, they don’t have a degree*  
(Participant # 14)

As a consequence of the perceived threat to professional identity, it may be argued that greater homogeneity was perceived among the participants of their in-group. Following on from this, there may then be the expectation that others within the in-group would agree on, or consider the same issues with regard to the proposed workforce redesign in a similar manner, as found by Haslam and colleagues (1999). Although not all participants shared identical viewpoints regarding working with assistants, there was a common understanding
of professional matters such as the need for strict role boundaries and guidelines for utilising assistants. Similarly, participants recognised the need for supervision, further training and support for SLPs, and the need for professional advocacy for new graduates. Professionalism and maintenance of professional standards were viewed by participants as being an integral part of their role and to a certain extent, contributed to their job satisfaction (i.e. a job well done led to being more satisfied). As the SLPs emphasised their professionalism, it is possible that they viewed assistants as not necessarily professional, and that they, therefore, constituted a different group from themselves. The professional nature of the SLP role has had the effect of highlighting the differences between SLPs and assistants. Some participants saw merit in the idea of assistants working with clients where intervention requires no significant modification;

I think that it could be really, really good to have somebody who might actually carry on with some of the stuff that we as Speech Paths would come up with... It would have to be something within some fairly limited constraints about what somebody who doesn’t have the benefit of a four-year speech path degree could handle... Stuff that a patient could do with practice in, that doesn’t really require novel thought, doesn’t really require a whole lot of active modification (participant #9)

Other participants held reservations regarding assistants’ ability to provide an appropriate level of clinical care required to maintain the outcomes for the client. This belief is generally attributed to the perception that assistants lack the appropriate knowledge and training to undertake such tasks, which highlights the strength of the resistance;

They don’t have that training. They’re not a speech pathologist; they’re not the person who’s actually qualified... (participant #20)

SLPs perceived that although assistants presented a potential threat to their professional identity, it was management and the employing organization which were introducing the threat. It is possible in this situation that the organization and assistants are both perceived as being a source of professional identity threat, providing an explanation for them both receiving some measure of outgroup derogation from the SLPs;
Not that managers are evil people or anything, but that’s their job. To watch the bottom line and to make sure you’re doing a good job, but basically, they still need to come in on budget. And if they can see that the allied health assistant is trained to do a similar role to ours, I think they’re going to question the role of the more expensive version (Participant # 8)

Such perception of threat contributes to the increased salience of professional identity evident in the participant accounts.

The psychological basis for the behaviour of individuals and groups is an important area for research within organizations, and one which may provide insight into how perceptions are formed and may be positively influenced (Haslam, 2004). Participant accounts consistently highlighted the perception that those outside the profession have a poor understanding of the speech-language pathology role. Participants drew on their perceptions of themselves as members of a professional group to highlight the disempowering aspects of this workforce redesign. It is important to consider the meanings they ascribe to the perspective of the employing organization, their clients and their profession. While participants had a strong sense of their own professional distinctiveness, they were not confident that those outside the profession (including organizational management, other health and education workers, and consumers) understood their unique contribution, given the close boundaries and task sharing with other related professions such as nursing, teaching, occupational therapy and dietetics. Research has shown a consistent poor understanding and knowledge of the profession by the general public as well as from people with close collegial relationships with speech-language pathology (Byrne, 2007). The blurring of boundaries and poorly defined professional identity has been identified as a source of professional rivalries with tension and hostility within the clinical practice (Hudson, 2002).

All participants in the study had a strong professional identity as a SLP in the work context, regardless of whether or not they were prototypical members of the profession. All participants appeared to have internalised the values of the profession, indicating a high commitment to the professional group (Ellemers, Spears, & Doosje, 2002). This indicates that the real or perceived threat posed by the introduction of assistants may be in the form
of a threat to the distinctiveness of the SLP group and their professional identity (Ellemers et al., 2002). Jetten and colleagues (2004) discuss distinctiveness as the differences perceived between the in-group and a relevant out-group, and it is this distinctiveness which justifies the existence of the group. It also determines interactions with other groups.

The current results are consistent with the findings of Ellemers and colleagues (2002) who discuss that highly committed groups respond to threat to their distinctiveness or value by increasing the differentiation between the ingroup and outgroup, with the purpose of improving the status of the ingroup. The motivation to maintain the distinctiveness of the profession was evident in the participant accounts, which is consistent with the social identity perspective (Tajfel & Turner, 1979). This is indicative of the placement of individuals into social groups, and the importance of professional identity in an organizational context (Haslam, 2004). In the current context then, it is possible that participants did not perceive a conflict between their membership of the profession and their membership of the larger organization because the professional affiliation was ascribed a more significant meaning for them. The emphasis placed on achieving clinical outcomes and providing client advocacy speaks to the empowerment of clinicians within the traditional professional role and the unique input that they are able to provide (Bach, 2007). In this case, resistance to the proposed workforce redesign should not be seen as a negative response. Rather, it contributes to the argument that resistance is a complex phenomenon impacted upon by group commitment and features of the social context (Ellemers et al., 2002).

Professional socialisation of new members of a profession leads to similar values and belief systems being shared amongst novice and experienced members, reinforcing the professional identity and maintaining the status of the discipline (Hudson, 2002). Hudson (2002) discusses that a strong and well defined professional identity assists groups to resist enforced change as well as maintain professional autonomy, whereas poor definition has the potential to result in encroached boundaries and enforced loss of independence. Lizarondo, Kumar, Hyde and Skidmore (2010) discuss issues such as professional status, security and professional identity being challenged by role boundaries which are not well defined (Ibarra & Barbulescu, 2010; Walshe & Shortell, 2004). It is understandable then,
that a professional group perceiving a threat to their professional identity would respond with protective behaviours and poor perceptions of proposed workplace changes. The resistance displayed by the participants, therefore, cannot be simply viewed as oppositional. There is an apparent irony, however, that participants perceive professional erosion by an increasing non-clinical workload, yet also view delegating some of these tasks to an assistant workforce as a form of professional identity threat. Having a very experienced cohort means that the identities illustrated have been processed and constructed over some time, with a significant amount of clinical and organizational expertise.

In the current context of a high level of political awareness and a measure of suspicion over managerial intent, the meanings assigned to a workforce redesign that involves assistants may vary substantially between and within groups (e.g. within a profession, or between a profession and an organization). The changing of roles that are associated with a professional identity has the potential to change the way people view themselves, in both a work and social context (Haslam, 2004; Mackey, 2007). In cases where workforce redesign is likely, perceived threats to employee social identity and the impact this has on their perceived status within the organization will be important barriers to overcome. There is evidence that in times of job and employment insecurity, the importance of understanding professional and social identity in order to maintain a positive employment relationship is greater (Alvesson & Willmott, 2002). Considering the tensions and efforts to maintain or increase control during a process of workforce redesign based at the level of everyday practice, there is potential for resistance to start with low-level discontent but escalate to potential destabilisation and creation of weakness in a work context (Thomas & Davies, 2005).

This paper contributes to the study of identity and resistance to workforce redesign in two important ways. Firstly, it illustrates the process of identity construction and how the threat to this identity may be a precursor to resisting a proposed workforce redesign. Secondly, it provides empirical data regarding the experience of professional identity threat through the actual perceptions of relatively experienced individuals currently working in an established service delivery model. This paper has built on recent studies in which the conceptualisation of resistance focuses on ascribed meaning and dynamic of identity.
A possible limitation of our study is that participants were interviewed in a work context and asked their perceptions as a SLP. It is possible that this questioning and their understanding of the study purpose may have contributed to heightened professional identity, and resulted in stronger in-group identification and out-group stereotyping (Haslam et al., 1999). However, all interviews were conducted individually and not in a group setting to reduce the risk of manipulation of this professional identification. Additionally, this contributes to our argument against resistance being seen as a negative response related to fear or lack of information. The findings have highlighted the impact of professional identity on group identification, and subsequent expectations of self and other members of the in-group (Haslam et al., 1999). Further research would be beneficial to explore how changes in consensus regarding out-group stereotypes may be made.

The insights from the current study have theoretical implications for understanding how professional groups perceive their shared identity and practical implications relating to the perceived threat of introducing a new vocationally trained group. Future research could explore the importance the role of gender in strongly masculine versus feminine dominated professions, and whether the shared identity yields similar or different responses. It would also be beneficial to explore in greater detail who professionals perceive to be the source of the professional identity threat in the context of workforce redesign (e.g. organizational management or the new occupational group themselves). Another important area for further exploration would be whether recent graduates and experienced clinicians differ in their perceptions.

In conclusion, our study provides evidence of a previously underexplored antecedent to resistance, professional identity threat (Hornsey & Hogg, 2000). Our novel context allows a detailed exploration of professional identity, its construction and role in understanding oppositional reactions to a significant workplace redesign. We found that the introduction of assistants prompted threat to the distinctiveness of the SLP professional role (Branscombe et al., 1999). This occurred when SLPs were faced with the possibility that they belonged to a group whose expertise may soon overlap with the assistant role (Jetten et al., 2004). Lessening the sharpness of professional boundaries distinguishing SLPs was
interpreted as a threat to the uniqueness of SLPs role in terms of knowledge, values and professional contribution, and prompted efforts towards maintaining the positive distinctiveness of the SLP role through active opposition. Preserving professional boundaries has been linked to an underlying "need for distinctiveness" (Brewer & Pickett, 1999) that accounts for a complex array of behaviours and attitudes including motivation, perseverance in the face of barriers and commitment (Sheldon & Bettencourt, 2002). As such it provides a powerful basis for resistance.

References


9.4 Paper 4 - Paradoxical perceptions towards the introduction of assistants in speech-language pathology and potential impact on consumers

9.4.1 Statement of contribution of others

Statement of contribution of co-authors

We, Rebecca Mitchell, Nicole Byrne and Rachael O'Brien attest that PhD candidate Rachael O'Brien had the primary and lead role in the study concept, design, data collection and analysis, preparation and final revision of the publication entitled;


Rebecca Mitchell (Co-author)
Date: 4th July 2017

Nicole Byrne (Co-author)
Date: 4th July 2017

Rachael O’Brien (PhD Candidate)
Date: 4th July 2017

Suzanne Ryan (Assistant Dean Research Training – Faculty of Business and Law)
Date: 17 July 2017
9.4.2 Introduction

Professional perceptions of working with assistants are complex and multifactorial. These perceptions have the potential to influence professional uptake and sustainability of a workforce redesign, and as such, it is important to understand the underlying principles. It is argued that perceptions can be influenced either positively or negatively depending on conditions, and pivotal points are identified in the following paper, including consumer focus and professional identity threat which need to be understood and addressed in order to overcome resistance.

This paper critically examined a major finding of the research – the existence and strength of paradox in participant accounts. Throughout the interviews, contrasting perspectives were found in relation to nearly every aspect of the speech-language pathologists’ role, task and relationships subsequent to the introduction of assistants. This paper highlights the sometimes-contradictory nature of the perceptions within the findings. The strength of the polarised perceptions among members of the same profession illustrates the complexity of the overall perceptions. The success of health professions and organisations relies on a diverse and dynamic workforce capable of meeting the needs of health consumers. This paper contributes to the understanding of polarisation of health professionals’ responses to the implementation of assistants and identifies factors accounting for such reactions. This is beneficial to policy and practice, in that it may contribute to the positive implementation and management of an assistant workforce, potentially increasing the demographic diversity of the health workforce. It also contributes to the research on workforce redesign and the studies of professional identities and subgroups in an organisational context.

9.4.3 Criteria for journal selection

Scandinavian Journal of Caring Sciences (SJCS) explores scientific knowledge on caring and has an emphasis on patient, family and community. It is a high-quality international journal which is published quarterly, has an impact factor of 1.438 (2016), and is ranked 30/114 (nursing) (Wiley online library, 2017). Manuscripts submitted to SJCS are subject to editorial screening prior to a rigorous double-blind peer review process.
SJCS has a strong focus and considerable publishing record regarding interprofessionality. It was therefore considered as a relevant publishing outlet for Paper 4: *Paradoxical perceptions towards the introduction of assistants in speech-language pathology and potential impact on consumers*. In order to further contribute to the literature surrounding identity and subgroups in a healthcare team environment, this paper identifies the impact of a consumer focus on overall perceptions of working with assistants. It is an important and novel contribution to the existing literature.

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### 9.4.4 Full citation

Paradoxical perceptions towards the introduction of assistants in speech-language pathology and potential impact on consumers

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Introduction

Healthcare reform typically focuses on creating a health system which is responsive to changing consumer health needs in an equitable and sustainable way (1, 2). To provide the right skill mix in order to increase sensitivity to consumer needs and involvement in health service delivery, new roles and working practices have been introduced internationally (1, 3). Such changes have led to considerable emphasis on workforce role redesign. Role redesign is concerned with reorganising the design or configuration of healthcare roles within the overall healthcare system (4). The availability of an appropriately skilled workforce is vital for the ongoing effective delivery of quality healthcare services. While there is evidence to support the success of some redesign initiatives (5), many efforts to tackle workforce reorganisation and job redesign have been unsuccessful (6) with the majority of stakeholders remaining unconvinced about the potential benefits of the change (7).

Research is being conducted in health organisations internationally exploring how the workforce redesign of utilising assistants may be of benefit to consumers,
professionals and organisations (8). An allied health assistant is a worker whose role it is to complement and provide support to qualified allied health professionals, allowing them to work on more complex or specialised tasks (9). For consumers, there is evidence that assistants may be able to increase sensitivity to consumer need given their close demographic proximity to the local community (1, 2). For organisations, potential benefits associated with this workforce redesign include alleviating workforce shortages and increasing service capacity while being a more financially viable resource than a qualified allied health professional (1, 10).

Despite the potential benefits, resistance to such a workforce redesign, and in particular, the introduction of assistant roles, continues to be documented. For example, qualified professionals raise concerns that assistants may represent a challenge to job security (5). Other studies have reported poor role clarity (11) and unrealistic expectations for the role of assistants (12) leading to perceptions of threat to professional identity (1, 11). This in turn has been shown to be a precursor to interprofessional conflict and potential failure of interprofessional practice (13). It appears, therefore, that while there is evidence of beneficial outcomes, such as increased access to and efficiency of health services (9), there is also evidence of substantial resistance to such workforce redesign (14). This has the potential to negatively impact on successful uptake (15) and professional acceptance of assistants as a useful workforce redesign initiative (16). Our understanding of the factors that engender such resistance is relatively limited (17). This represents a significant research gap as a clearer understanding of the perceptions that trigger resistance is likely to better inform strategies that aim to minimise resistance and facilitate the integration of assistant roles into the complex hierarchy of healthcare occupations (18, 19).

In an effort to address this research gap, our study investigates how a group of healthcare professionals, speech-language pathologists (SLPs), interpret the consequences of assistants for their profession. In addition to building a better understanding of the perceptions that may contribute to resistance against the introduction of an assistant workforce, we also aim to identify possible levers available to lessen resistance or, at least, safeguard against misinterpretation that may exacerbate opposition. In doing so, we respond to a need in the broader literature by moving beyond describing perceptions of a workforce redesign and attempting to understand how the perceptions of a group are formed and the ways in which these perceptions may be influenced (20). This contributes to both the workforce redesign literature and the study of professional identities and subgroups in an organisational context. The aims were therefore both clinically and theoretically relevant to the changing shape of the health workforce.

We pursue these aims through study of the introduction of allied health assistant roles (hereafter referred to as assistants) into the speech-language pathology profession. The introduction of an additional workforce tier, vocationally trained and with lower income, is a workforce redesign that has become increasingly utilised across health professions (9). There has been a significant increase in the utilisation of an assistant workforce in speech-language pathology in US, UK and the Canada, extending the existing services provided by qualified SLPs (11). The introduction of assistants into speech-language pathology has the potential to maximise consumer access to services while maintaining positive clinical outcomes in a professionally sustainable and economically viable manner.

The growing focus on assistants in speech-language pathology internationally provides the opportunity to consider this workforce change in a profession with limited previous exposure to such a workforce configuration. As such, the introduction of assistants provides a useful example of workforce redesign that has potential to provide enhanced outcomes for clients and their families, but has also been shown to prompt significant professional resistance. The current research involved discussion with SLPs to identify their perceptions of the impact that utilisation of assistants has on the following:

1. The workforce as a whole
2. On individual professionals and
3. The clients accessing services.

The next section presents the method pertaining to the research setting, with the findings and interpretation to follow. In particular, we explore the polarisation of responses, factors contributing to these perceptions and the applicability of current findings to practitioners and organisations.

Method

Study design

Given the exploratory nature of this study, a qualitative approach was taken in order to explore the experiences of the participants. More specifically, we employed the principles of Interpretative Phenomenological Analysis (IPA) (21) to analyse participant accounts.

Participants

The criteria for inclusion were being a speech-language pathologist in any one of six local health districts in NSW, Australia, and a willingness to participate in an interview. The researchers provided the details of the project to Local Health District service managers. A SLP independent of the project disseminated the email invitation and information statement about project participation to senior SLPs, who in turn distributed to their SLP
staff. SLPs were invited to contact the first named researcher directly, so recruitment was conducted remotely. Participation in the project was voluntary, and SLPs who expressed interest in participating were offered an interview. All participants accepted an interview except one who withdrew due to ill health.

A total of 20 SLPs from New South Wales, Australia, participated in this study and represented a range of clinical contexts, years of experience and age (see Table 1). Seventeen women and three men participated in the study, indicating that male participation rates in the current study were slightly higher than would usually be expected (22). Participants working with adult or paediatric caseloads were equally represented (approximately 50% of participants working with each caseload). Thirteen participants reported experience or exposure to working with assistants in some capacity. This experience included working with speech-language pathology-specific assistants while working in another organisation, interstate or overseas, working with living skills assistants in brain injury settings, working with multidisciplinary assistants or providing training to government-funded carers.

**Interviews**

Individual semi-structured interviews included open-ended, non-directive questions which allowed participants to provide their perspectives in their own terms (21). The interviews were based on an interview schedule covering several key areas relevant to working with assistants including role, supervision, budget and resource management, professional accountability, workload and productivity, skills and training. The interview schedule was continually refined with reference to emerging themes. The aim of developing the schedule was to be cognisant of issues of importance to the participants, which in turn allowed the author to be more attentive and flexible within the interview (21). Not all questions were asked of each participant, and participants themselves were invited to lead the discussion (21). Participants were interviewed individually by the first author and were asked about their perceptions of working with assistants and what factors they felt influenced these perceptions. They were also asked about their own needs in terms of training and supervision if they were to work with assistants. Examples of questions are provided in Appendix A. Each interview was recorded using a digital voice recorder and lasted between 45- and 90-minute duration. All interviews were transcribed verbatim. Participants were provided with the option of reviewing their own transcripts for accuracy; however, none accepted this offer.

**Analysis**

The data were analysed using Interpretative Phenomenological Analysis (IPA), which implies an iterative and inductive cycle to encourage the author to determine emergent patterns from the data to illustrate how people make sense of their experience (21). All transcripts were coded in NVivo qualitative data analysis software analysis (23), allowing efficient management and manipulation of the large amount of data. Each individual transcript was analysed as described by Smith et al. (21) before moving to group-level analysis.

Text was analysed line by line according to the content of what was said, the language and manner used by the participant and the author’s interpretation of participant perceptions. Text from all transcripts was organised into meaningful categories, allowing observation of patterns and emerging themes reflecting both the direct participant account and author interpretation (21). An example of coding is included in Table 2. Creating word files of each category allowed the authors to look at the internal consistency and specificity of each category (21). A list of emergent themes and their definitions from each transcript were created for each participant account, with similarities and differences being noted within and across transcripts. All authors were given a copy of transcripts and the category codes considered as representative of themes evident in the data. A sample of transcripts was then coded independently by two authors with 90% inter-rater reliability in regard to category codes assigned to statements. This enabled combination of categories under themes. Themes were defined for scope and purpose, with definitions finalised by consensus. The text and subsequent analysis was subject to connection with the extant literature after identification of the themes.

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Table 2: Example of Coding

<table>
<thead>
<tr>
<th>Raw text from the transcription</th>
<th>Exploratory comments</th>
<th>Assigned code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, so I guess it works very well because our assistants are very good and very experienced, just in terms of language, general interactions. Within the Brain Injury caseload, engagement’s a real issue. So they’re very good at helping, that first line of engagement I feel, and they’re both very down to earth. ‘Cause they’ve been working here for 20 years, they’re in their 40s and 50s, so that’s good for a lot of our clients to have a bit of peer support if you want to say that. And even with the young guys, because they’re so relaxed, they still get along quite well with them. So I find that very useful and the engagement’s the main thing. So if I’m doing something else with a client, I can focus on the speech stuff, but they can just help me get that client there in the first place and keep them engaged for the hour while I want them to do certain things.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of experience working with caseload</td>
<td>First line of engagement ‘helping’</td>
<td>On-the-job experience</td>
</tr>
<tr>
<td>Engagement between assistants and clients, difficulty for professionals engaging patients in the caseload</td>
<td>Personality and demographic traits of the assistants leading to positive engagement</td>
<td>Demographics and personality</td>
</tr>
<tr>
<td>Discusses presence of assistants as ‘peer support’ for clients closer to the demographic of the client than the clinicians are</td>
<td>Repeated use of ‘EngageEngagement’</td>
<td>Client focus</td>
</tr>
<tr>
<td>When assistants are present, allow SLP to focus on speech path goals, while assistant gets the patient to the session to start with and keeps them engaged for the hour</td>
<td>Complementarity</td>
<td></td>
</tr>
</tbody>
</table>

Ethical considerations

Prior to the study taking place, ethical approval was granted from relevant University and Local Health District Research Ethics Committees (# 08/12/17/4.03 and # H-2009-0225). All participants gave their written informed consent to participate in the study. It was acknowledged that talking about working conditions may cause some anxiety about other work issues (e.g. long waiting lists, large caseloads, professional burnout), in which case arrangements would be made to refer participants on to an employee assistance programme to discuss concerns and seek assistance for same.

Results

The data provide a rich account of the perspectives of participants in regard to the implementation of an assistive workforce. Analysis of the transcripts provided strong evidence of polarised perspectives in relation to the introduction of assistants across the key themes of assistants’ influence on the professional role, tasks undertaken by the SLP and the relationship between the SLP and client.

Polarised perspectives on SLP assistants

Professional role. In relation to the issue of professional role, there was evidence of a dichotomy – many participants noted the potential for increased time for complex work core to the professional role, while others were concerned about fragmentation and decreased holism of SLP services. Participants identified that increasing demand for services and increasing workloads negatively impacted on their ability to provide appropriate and equitable services to clients. Many felt that by delegating routine tasks to an assistant, they could gain more time to devote to complex caseload management. This was identified as providing a higher level of complexity, and some participants identified this as empowering. Conversely, participants identified that working with assistants has the potential to fragment intervention by delegating parts of a client’s management and could prevent SLPs from providing the individualised care that consumers require. Participants perceived this as a move away from the consumer-centred ethos that is highly valued by their profession. It was felt that this would have a negative impact upon both the professional role and clinical outcomes and was perceived as potentially undermining the professional role:

"Where does it end if something were to happen...and the child didn’t get better? Can the parent come back and say, ‘well, you’re a hopeless speech pathologist... you don’t even do your job’ (Participant # 6)

Participants discussed the issue of clinical complexity and workload variety and noted that delegation of routine clinical tasks could lead to a more clinically complex caseload. However, there were conflicting views on this increased complexity. Some participants saw this as a positive for the profession:

"...it would mean you know that I would be a lot more time efficient... (Participant # 7)

While others perceived it as having potential to decrease clinical variety and increase in pressure on SLPs with an already busy and stressful workload:

"I’d just be assessing people all the time... I’d have no variety whatsoever (Participant #19)"

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It was discussed by some participants that lower complexity clinical tasks allowed them to be afforded some ‘down time’ while still providing clinical intervention. This allowed them to work more efficiently across a busy and varied caseload.

Tasks. A similar polarising of views was evidenced in relation to the tasks and activities that were likely to be performed subsequent to the introduction of assistants. Participants discussed the potential for a reduction in mundane tasks required of them, vs. delegation of such tasks resulting in skill loss. They discussed the relief that could be gained from delegating lower-level tasks to assistants:

...making up therapy packs... doing communication stuff... which was great because we don’t always have the time... (Participant # 17)
...all that administrative stuff which is really the time saver for us (Participant # 13)

It was perceived that there was potential for SLPs to provide more or varied services if sharing their workload with an assistant, and there was discussion about the potential for increased clinical input that could be provided when delegating tasks to an assistant:

...you could essentially have one therapist rotating between the three (assistants)... and just “Oh that’s really good, you’ve improved on that, let’s move onto that next” and then you move to the next room and push something else along. That could be your clinic, where your turnover is just extraordinary (Participant #15)

However, participants perceived that the introduction of assistants raises concerns regarding their own competence in traditional professional skills and the potential to deskill in the key areas, for example, basic clinical skills such as conducting therapy. This suggested a perception of dilution of the professional role.

Relationships. Concerns were raised regarding the relationships between SLPs and clients, and compromising clinical outcomes with the introduction of assistant roles. It was discussed that working with assistants has the potential to erode the relationship between the SLP and clients, resulting in poorer control that professionals have over clinical intervention. Participants discussed the importance of trust in the professional knowledge of SLPs in their relationships with clients;

It (working with an assistant) kind of breaks that link between me and the parent, and that’s the relationship I’m trying to develop, the relationship so that they trust me as a professional person, and go with my recommendations (Participant # 20)

Assistants were recognised as being members of the local community and having a similar demographic background to the people accessing speech-language pathology services. This was recognised as being different to the demographic of SLPs:

The most useful people have been the staff members who will just have a very casual conversation with the parents, and join me in on that conversation... they do the cleaning up and they get morning teas for people, and put the toys out and clean the toys at the end... But the beauty of them is the ease at which these families are coming in and talking to those workers on a very, they’re members of the community. They trust them (Participant #13).

A lot of life experience... she was a mother, so you know, she already had a bit of a... good interaction with the children (Participant #7)

There was recognition that having assistants who were closer to the demographic of the client group could be advantageous to clinical progress, by complementing the professional role of the SLP:

They bring with them a wealth common sense as well... and having an assistant there that’s saying ‘mate, you could just do it like this’, and they go ‘oh yeah I didn’t think of it like that’ (Participant #1)

Participants discussed the perception that the workforce redesign was being driven by economic factors rather than consumer need, impacting on the relationship between professionals and the employing organisation. This was evidenced by the perception that the assistants, consumers and the profession were devalued by employing organisations:

...and the threat that management will see it as a cost cutting measure and then cut actual Speechies (Participant # 12)

It was also discussed that substitution and replacement could be an issue in terms of the working relationships between assistants and SLPs:

Especially in a small team, let’s say a small rural team where there’s been a big struggle to, such as maybe... competition for money, went to the (assistant) and they have to work on the (allied health) team. This challenges the professionalism of everyone concerned (Participant #4)

Factors contributing to SLP perceptions

There was recognition from participants that utilising assistants could be an efficient and cost-effective way of providing services; however, if this and other economic factors were perceived as the primary drivers for workforce change, then this had a negative effect on overall perceptions of the initiative. If the redesign was perceived as being driven from a consumer perspective, it is possible that overall perceptions would be more positive:

...and if this is a mechanism to increase workforce capacity over time, fantastic. If it’s a way to save
money without the right consultation, then, no, it’s not good (Participant # 14)

Participants discussed the need for including SLPs and the overall profession in decisions related to the introduction of assistants. The idea that the profession would have input into the shaping of the workforce redesign was empowering for participants and resulted in more positive overall perceptions:

So I think there’s potential but it’s got to be rolled out sensitively…Collaboration, lots of support and education, and giving people options to opt in. (Participant # 14)

Some participants noted the need for the profession to have input into this workforce redesign; however, in contrast, participants raised the issue of lack of consultation, communication, and transparency in the workforce redesign from an organisational perspective:

Where’s the liaison? Where’s the clear link, the clear communication? (Participant # 16)

Participants explicitly suggested that speech-language pathology professional input was necessary in defining roles and boundaries, ensuring the security of the professional role, inclusion of the necessary skills and knowledge to work with assistants into professional preparation. The majority of participants identified that assistants had the potential to augment the professional role and that the profession and professional associations (e.g. Speech Pathology Australia) should be active in advocating for clarity regarding roles and boundaries:

I would see that that would be something that Speech Pathology Australia would have to make quite clear (Participant # 18)

There was consensus among participants that if working with assistants, the boundary between SLPs and assistants needed to be clear for professionals, assistants and employing organisations in order to maintain the two distinctive roles.

Effective forward planning was identified as an important factor contributing to overall perceptions. Participants discussed the need to ensure emerging SLP roles were planned for and managed effectively. In contrast, poor planning was identified as an issue which would result in negative perceptions:

…if you have them (assistants) tomorrow you’re going to run into some problems because you’d want to have something clear about what they’re going to do. I think it’s a recipe for disaster (Participant # 9)

Discussion

The purpose of this study was to investigate the perceptions of professionals to a workforce redesign involving an additional workforce tier with vocational training and lower income. Specificaly, we sought to understand what perceptions engendered professional resistance to the workforce redesign and what factors influenced these perceptions in the first instance. Our data provide support for the influential role of polarised perceptions on overall resistance. Understanding such resistance may lead to framing the workforce change effectively through an alternative perspective, such as a consumer benefit perspective.

Our study makes three major contributions to the existing literature. Firstly, our findings align with or confirm previous findings related to polarisation of responses to workforce redesign, particularly regarding the introduction of assistants (1, 11). Secondly, we identify a number of factors that account for these different types of reactions, and finally, we discuss implications for what our findings mean for practitioners and leaders.

Polarisation of perceptions

Our study is amongst the first to explore the role of SLPs’ perceptions of working with assistants and one of the only studies to bring together research in the areas of professional resistance with past research in the area of polarisation of factors leading to this resistance. As such, we are able to make several significant contributions to the understanding of workforce redesign within the allied and related health professions. This will be beneficial to the understanding of responses to working with assistants and contribute to the positive introduction and management of this new workforce.

Throughout our interviews, contrasting perspectives emerged in relation to nearly every aspect of SLP role, task and relationships subsequent to the introduction of assistants. It is important to highlight the sometimes contradictory nature of the perceptions within the cohort. That the same issue can be perceived in such opposing ways by members of the same profession shows the complexity of the perceptions. It remains then that perceptions of a workforce redesign will increase in complexity again when consulting members of both relevant vocational groups.

Relationships and the rapport between professionals and their clients have been discussed as being important to the therapy process (24) particularly in client-centred approaches, such as speech-language pathology (25). Ferguson & Armstrong (26) indicated unequal power relationships between clients and SLPs. They discussed that the aim of collaborative intervention was to value the client perspective in order to achieve therapeutic outcomes, in which case such an imbalance can result in poor engagement with the therapeutic process (26). Fottie (27) discussed that how SLPs constructed their relationships with clients with acquired communication or swallowing disorders was meaningful to clients and that such relational factors could contribute to the efficacy of treatment. Fottie et al. (25) discussed that therapy is comprised of goals or outcomes, bonds or interpersonal
relationships and tasks or specific therapy activities. In their study of the relationships between paediatric clients and SLPs, they discussed that children's perceptions of an unequal power relationship with their SLP were lessened with perceptions of the SLP providing a measure of choice within the therapy process, as well as the SLP being seen as a friend (25). Such findings point to the importance of good therapeutic relationships and that failure to achieve such bonds with clients has the potential to be detrimental to the therapeutic process (25). However, research has also shown that relationships between assistants and clients may differ to the relationship between clients and allied health professionals. Nancarrow and Mackey (5) discussed the ability of assistants to better identify with clients than their professional counterparts, given their similar demographic backgrounds, use of accessible language and increased time spent in interactions. There is a documented lack of diversity in the speech-language pathology profession, resulting in a lack of engagement with therapeutic services by under-represented groups, such as people from culturally and linguistically diverse backgrounds and Indigenous Australians (28). Working with assistants has the potential to widen the demographic of the speech-language pathology workforce and, in turn, increase the profession’s ability to access these under-represented groups (29).

This polarisation of perspectives aligns with previous investigations into the introduction of assistants and has been discussed as contrasting, but co-occurring perspectives concerning assistants being introduced into professions (1). For example, Bach et al. (1) identified that the perception of empowerment as a consequence of the introduction of assistants has been related to the benefits employees may expect, such as establishment of new expectations for qualified professionals, improved professional autonomy and increased clinical variety (1). Conversely, the losses associated with the introduction of assistants have been linked to deskilling the professional workforce and cheapening the labour process, thereby degrading traditional professions and established workplace roles (1). O’Brien, Byrne, Mitchell and Ferguson (2013) examined the perceptions of rural SLPs to working with assistants and found that perceptions existed across three inter-related domains: professional, organisational and economic (11). Ambivalence was identified in the majority of participants’ perceptions across these three domains, and it may be surmised that perceptions of empowerment and degradation may underlie such perceptions. This research has extended upon the findings of Bach et al. (2007) and O’Brien et al. (2013) by proposing that consumers must be an important consideration in the strategy formation of introducing a workforce redesign. We argue that there is a need to emphasise relationships between workforce strategies and what drives consumers to successfully participate in clinical services in order to positively influence professional perceptions.

Factors accounting for perceptions

Throughout the interviews, a number of factors were identified as potentially influencing the perceptions of SLPs to assistants. These factors appeared to moderate perceptions such that, under some conditions, a more positive outcome was posited, while under the converse condition, a negative outcome was touted as more likely. These factors included perceived drivers for change, the inclusion of SLPs in decisions relating to the introduction of an assistant workforce, effective forward planning and role clarity for both professionals and assistants (Table 3).

Consumer focus. The overall focus of the participants’ perceptions was the importance of consumers, and the need for increased, or at least maintained, consumer focus. The participants perceived themselves to be responsible for providing the treatment plan as well as for achieving clinical outcomes, which is in line with professional ethical guidelines. The Speech Pathology Australia Code of Ethics (30) states the principles which bind SLPs’ practice include beneficence and nonmaleficence, that is, for SLPs to act in a manner which will ensure clinical benefit to consumers, but also to ensure that no harm is being done. SLPs maintaining clinical, legal and ethical responsibility for consumers ensure that their clients are not only receiving beneficial treatment, but also ensuring that they are not receiving treatment which is ineffective (31). Consumer focus is seen as a core value for SLPs and was reflected in discussion of the importance of

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Factors associated with positive or negative perceptions</th>
</tr>
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<tbody>
<tr>
<td><strong>Positive focus</strong></td>
<td><strong>Negative focus</strong></td>
</tr>
<tr>
<td>Consumer focus and clinical need as drivers for workforce redesign</td>
<td>Economic focus as a driver for workforce redesign</td>
</tr>
<tr>
<td>Inclusion of SLPs and speech-language pathology profession in shaping the workforce redesign</td>
<td>Organisational level shaping the workforce redesign, with a lack of professional consultation</td>
</tr>
<tr>
<td>Effective forward planning</td>
<td>Impulsive implementation</td>
</tr>
<tr>
<td>Role clarity for SLPs and assistants</td>
<td>Devaluing the professional SLP role</td>
</tr>
</tbody>
</table>

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maintaining clinical outcomes, standards of care and client/family satisfaction with services received (32).

Professional inclusion in shaping future workforce. The results of the present study are important in terms of the cultural evolution of allied health professions. The nursing and medical workforce has received the largest amount of attention regarding changing roles and boundaries with health service reforms (33); however, little is known about the particular issues which are faced by allied health professions with regard to workforce redesign and organisational change. Indeed, allied health professions have been described as ‘invisible’ in the health workforce literature (34). There has been a cultural shift in the allied health professions since the 1970s, where allied health has acquired a more autonomous practice role from the medical dominance which directed practice previously (34). However, Boyce (34) discussed the perception of allied health professions that while they make an important contribution, they also feel marginalised within the larger organisation. Such perceptions contribute to the understanding of the negotiation of occupational boundaries and the endeavours taken by specific professions in order to protect and maintain their professional boundaries (33). Examples of instances where this has occurred include the dentistry profession and implementation of dental assistants, and orthopaedic surgeons and other health providers such as podiatrists, emergency medicine physicians and physiotherapists (33). There is evidence of similar endeavours in other allied health professions, where a medically dominated paradigm has been the prevailing position (30). The present data can be argued as being representative of the perceptions of professionals who maintain a level of ownership of their professional skills and knowledge in the context of this evolution of their workforce hierarchies and role. It is of social and cultural importance to explore these perceptions and provides an historical perspective, as documentation of professional boundaries prior to workforce change being implemented (35).

Effective forward planning. Our study provides a unique contribution to the extant research – in addition to emphasising the ambivalence that can characterise responses to workforce redesign, our research also highlights several factors that potentially increase the likelihood of success in such redesign efforts. This is important for organisations wishing to implement assistants, as it will enable more efficient use of resources by directing planning to positive rather than enforced change. For example, the principles of consumer-centred care include engaging consumers in the healthcare process, from encouraging consumers to participate in their own healthcare decision-making to fostering collaboration with the planning design and delivery of health services (3). These principles carry roles and responsibilities for all partners; for clinicians, to participate in organisational processes and provide appropriate supervision and education of other members of the workforce; for consumers, to contribute to decisions regarding service planning as well as developing and measuring models of care; for managers, to implement systems which ensure clinicians are able to deliver safe and effective healthcare services; and for senior executives to provide support for the principles of consumer-centred care and clearly express genuine commitment for organisational safety and quality (3).

Role clarity for professionals and assistants. The manner in which professionally and vocationally trained staff work together can present challenges in healthcare teams. Diversity in such teams has the potential to enhance outcomes for consumers, but also has the potential to be the cause of interprofessional conflict (36). The clear delineation of roles is important to ensure that services are provided safely with appropriate supports in place, ensuring that consumers remain the focus of health service provision. If role boundaries are not clearly defined, safety and quality issues may arise in health service provision where, for example, it may be unclear to an allied health professional which tasks may be delegated to an assistant (37). Additionally, clear delineation will serve to protect against feelings of threatened professional identity and avoid misunderstandings and overall role within an organisation. Difficulties have been reported with regard to delineating roles between members of interprofessional groups leading to role ambiguity which has implications for the perception of professional identity (37). In turn, threatened professional identity has the potential to impact upon perceived status within an organisation (38). It will be important for allied health professions to have a clear understanding of their professional identity and core roles, including ethical standards and evidence base to which the individual professions are committed, as well as professional beliefs and rationales (38).

Implications for practitioners and leaders. There is little existing research to frame the hypotheses about the way in which polarised perspectives to a workforce redesign will interact. Our findings integrate an increased understanding of factors that engender resistance to workforce change, such as the potential impact assistants may have on the relationship between the allied health professionals and their clients, and identification of factors that may lessen such resistance. However, this research has extended upon the existing literature by theorising that the way a workforce redesign is framed will impact either positively or negatively upon professional perceptions. The main theoretical contribution is to introduce the importance of the notion of framing the redesign from the perspective of the consumer. Ensuring that consumer
focus is at the core of the workforce redesign may be a means by which the profession, consumers and employing organisations may be able to move forward and reach mutually satisfactory outcomes with regard to working with assistants. Consumer care is central to the speech-language pathology professional code of conduct and ethical values, and as such, having clear systems in place for protecting consumers is important for the success of such a workforce redesign. For example, ensuring that professionals retain clinical responsibility by maintaining decision-making capacity and monitoring clinical outcomes is a key protection for consumers. It will also be important to ensure that the profession and employing organisations achieve agreement regarding the role and purpose of assistants, to ensure that consumers receive a consistent message through their clinical service experience, reducing the potential for misunderstanding.

Perceptions of a professional or consumer benefit resulting from workforce redesign can have powerful positive outcomes for employers. For example, research has indicated that empowered employees have greater organisational commitment and lower perceptions of uncertainty related to job security (39). Conversely, perceptions of redesign may undermine or degrade position status may impact upon uptake of new innovations (15). Previous research by McLaughlin, Lincoln & Adamson (40) identified that organisational stressors and professional rewards may be related to SLPS’ attrition or retention in the profession.

Limitations and future directions

Given that the introduction of assistants is a controversial topic, it is acknowledged that possible selection bias may have occurred, where participants with stronger opinions may have elected to participate as a means of channeling their thoughts and perceptions. A limitation of the current study was the geographic location being limited to one state in Australia, and therefore, further research is needed to investigate transferability to SLPS in other geographic locations. Further research is warranted to ascertain the transferability of the current results to other allied health and related professions. Future research may particularly address whether the ambivalence in responses to workforce redesign is applicable in other forms of healthcare or professional workforce redesign, with particular focus on the paradoxical nature of such perceptions. It will also be important to explore the extent to which additional empirical support can be found for our recommendations.

Conclusion

Despite evidence that suggests working with assistants has positive outcomes for consumers, professionals and organisations, this workforce redesign continues to be the subject of debate. This study has highlighted the importance of understanding the ambivalent nature of professionals’ responses to such redesign and the factors that may influence. Thorough understanding of these opposing factors increases the possibility of positively influencing participants in the workforce redesign, while acknowledging that professions may perceive a risk to their professional status and consumer service. This has implications for the introduction and uptake of working with assistants and provides valuable insights for employing organisations, professions and workforce planners. The information identified in this paper leads to two important recommendations that align well with our understanding of effective change management and principles of healthcare organisation; the need for professional inclusion in decisions and role clarity for both professionals and assistants. The implementation of these recommendations has potential to increase positive perceptions, relating to the beneficial role for assistants, and decreases perception of risks related to undermining professional role and consumer service. Managing these contrasting perceptions is necessary to minimise resistance to the introduction of an assistant workforce.

Acknowledgements

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Author contributions

All authors were involved in the study conception, design, analysis and interpretation of the data. Data collection and drafting of the manuscript were undertaken by Rachael O’Brien, Rebecca Mitchell and Nicole Byrne undertook critical revisions for important intellectual content.

Ethical approval

The research was approved by Hunter New England Local Health District (#08/12/17/4.03) and the University of Newcastle Human Research Ethics committees (#H-2009-0225).

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APPENDIX A: SAMPLE INTERVIEW QUESTIONS

1. What do you think about assistants in speech-language pathology?
2. What makes you feel this way?
3. What have you heard about working with assistants from other allied health professionals (e.g. physio or OT) or have you read anything about assistants?
4. What do you think you or your service could gain from working with an assistant?
5. What types of tasks do you think an assistant could conduct in your work context?

6. Do you think there are differences between contexts – for example, would it be easier for an assistant to work in a paediatric or an adult setting, or in rural vs. metropolitan setting?
7. What do you know about workforce issues in speech-language pathology?
8. What circumstances or supports do you think could make working with an assistant easier or more difficult?
9. What would you or your service need to monitor if employing an assistant?

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9.5 Paper 5 – The role of the speech-language pathology professional identity as a response to workforce redesign

9.5.1 Statement of contribution of others

Statement of contribution of co-authors

We, Rebecca Mitchell, Nicole Byrne and Rachael O’Brien attest that PhD candidate Rachael O’Brien had the primary and lead role in the study concept, design, data collection and analysis, preparation and final revision of the publication entitled,


Rebecca Mitchell (Co-author)
Date: 19th February, 2018

Nicole Byrne (Co-author)
Date: 19th February, 2018

Rachael O’Brien (PhD Candidate)
Date: 19th February, 2018

Sue Wright
Assistant Dean Research Training – Faculty of Business and Law
Date:
9.5.2 **Introduction**

The allied and related health discipline literature has devoted much attention to health professionals’ clinical application of professional skills (e.g. therapy techniques, assessment, therapy planning and administration) (Bach et al., 2007; Lizarondo et al., 2010). However, in this literature, there is much less research related to workforce or service redesign. Health professionals hold the view that they have considerable expertise in their chosen profession, and that their distinct role is in planning and overseeing successful health intervention.

Speech-language pathology has close boundaries and shares tasks with other related professions such as nursing, teaching, occupational therapy and dietetics. Research has shown a consistent poor understanding and knowledge of the profession by the general public as well as from people with close collegial relationships with speech-language pathology (Byrne, 2007; Karasinski & Schmedding-Bartley, 2018). The blurring of boundaries and poorly defined professional identity has been identified as a source of professional rivalries with tension and hostility within the clinical practice (Hudson, 2002). Godsey (2011) discusses that speech-language pathology does not have a well-defined professional core of practice, and subsequently, there is scant written evidence regarding the speech-language pathology professional identity. In health workforce literature, there is a tendency to assume that single discipline-specific training and practice is an outdated concept, which is being superseded by interprofessionality (McNeil, 2014). However, the maintenance of professional identity as it currently exists appears to continue to be a goal for professionals. Our interest is in how SLPs presented this idea of professional identity as well as the idea of how a threat to distinctiveness or value could constitute a threat to their professional identity (Branscombe, Ellemers, Spears, & Doosje, 1999).

9.5.3 **Criteria for journal selection**

The Journal of Clinical Practice in Speech-Language Pathology (JCPSLP) is the major clinical publication of the Speech Pathology Association of Australia (SPA), the peak professional body for SLPs. JCPSLP publishes 3 issues per year and is distributed to over 8000 members of SPA. It provides a clinical and professional forum for SLPs and ensures
access to professional and clinical research. All research papers submitted to JCPSLP are subject to double-blind peer review.

The JCPSLP was chosen as the publishing outlet for Paper 5: The role of the speech-language pathology professional identity as a response to a workforce redesign, as the intended readership is practising SLPs. This paper aims to contribute to a discourse regarding the SLP professional identity, and more specifically the role of professional identity threat introduced by a workforce redesign involving changes to the traditional SLP role. Lack of clarity of the professional identity of SLPs has the potential for SLPs to underestimate their status within an organisation and to have blurred role boundaries because of workforce change (Turner & Knight, 2015). Having a clearly articulated professional identity will allow the profession to respond strategically to the workforce redesign of the introduction of assistants.

9.5.4 Full citation

9.5.5  *Publication*

The role of the speech-language pathology professional identity as a response to a workforce redesign

*Running head: Professional identity and workforce redesign*

Key words: Professional identity, assistants, workforce redesign, speech-language pathology, perceptions

Rachael O’Brien, Rebecca Mitchell and Nicole Byrne

**Declaration of interest:** The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

**Abstract**

The introduction of assistants in speech-language pathology is a workforce change including modification to the roles and responsibilities of speech-language pathologists (SLPs). However, resistance to working with assistants continues, and there has been little research into the impact of SLPs’ professional identity on perceptions of assistants. This paper explores SLPs’ perceptions of their professional identity in response to working with assistants. Semi-structured interviews were conducted with 20 SLPs in NSW, Australia. Working with assistants may be perceived as a potential threat to the SLP professional identity via challenge to the values and distinctiveness of the professional group. Participants’ professional identity was impacted by the real or perceived threat presented by the introduction of assistants. Consideration of professional identity construction and its role in perceptions of a significant workforce redesign will contribute to understanding the future speech-language pathology profession.
Introduction

Changes in healthcare workforce encompass modifications to the roles and responsibilities of healthcare professionals (Bach, Kessler, & Heron, 2007). This includes, for example, the introduction of assistant roles which is designed to enhance efficiency within finite health resources. An assistant in allied health (hereafter ‘assistant’) is a vocationally trained person whose role is to support the work of tertiary trained allied health professionals (AHPs), with either a single- or multi-disciplinary focus. The work undertaken by assistants in speech-language pathology can be clinical or non-clinical (Lizarondo, Kumar, Hyde, & Skidmore, 2010), they may be employed in all settings in which SLPs work, including both adult and paediatric settings, across the full range of acuity. Speech Pathology Australia recognises the value of the profession working with assistants (Speech Pathology Australia, 2016b), however clearly state that assistants are to be considered as a supplementary role, and never as a replacement for a fully qualified SLP. Speech Pathology Australia further specify tasks which are the responsibility of SLPs only and are unsuitable for delegation, including assessment, differential diagnosis, clinical problem solving and therapy planning (Speech Pathology Australia, 2014, 2016a).

However, current literature suggests that reforms involving assistants may also drive a perception that professional roles are at risk and professional expertise is not valued (Nancarrow & Borthwick, 2005; O’Brien, Byrne, Mitchell, & Fergusson, 2013) reflecting a challenge to professional identity. Professional identity is defined as “the relatively stable and enduring constellation of attitudes, beliefs, motives, and experiences in terms of which people define themselves in a professional role” (Ibarra & Barbulescu, 2010, p764). Threats to professional identity have been linked to behaviour that aims to defend the professional role, and professionals’ exit from organisations. This is particularly likely when the new identity required as a result of the change is inconsistent with the pre-existing professional identity (Schilling, Werr, Gand, & Sardas, 2012). O’Brien and colleagues (2013) discussed the perception of professional identity threat being linked to SLP willingness or otherwise to work with assistants. This paper extends on this critical issue in relation to professional identity and workforce change in speech-language pathology.
Professional identity formation

The formation of a professional identity occurs when a person relates to and identifies with a specific professional group including distinct knowledge, attitudes, values and belief systems (Hudson, 2002). Professional identity can determine an individual’s perspective, attitude and behaviour relevant to the work context (Adams, Hean, Sturgis, & Macleod Clark, 2006). Professional identity helps individuals compare and differentiate themselves from others in the workplace (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) contributing to perceptions of relative status of groups and professions (Turner et al., 1987), and impacts on interprofessional interactions. SLPs’ professional identities are shaped by their expectations and experience of the professional group (Mackey, 2007) including training, qualifications and socialisation. It also includes agreed standards of practice and behaviour which are encouraged by universities, professional associations (Speech Pathology Australia, 2007, 2011, 2015) and employers e.g. employer’s code of conduct.

Speech-language pathology can be considered a community of practice (Ferguson & Armstrong, 2004; Wenger, 1998), by way of its shared practices, goals and language. Wenger (1998) suggests that dynamic change in a community of practice occurs at the boundaries of the community (in this instance, the profession), and so it is suggested that by examining the activity occurring at these boundaries, the potential future scope of professional practice for speech-language pathology may be found. For example, considering advanced scope of practice at the upper end of the professional boundary (e.g. Fibreoptic Endoscopic Evaluation of Swallow). While reforms involving contested professional boundaries have been addressed in research on different professions (Nancarrow & Borthwick, 2005), past studies have been scant in relation to the role of professional identity consequent to introducing new occupational groups which may be perceived as being on the lower end of the professional boundary. The contribution of this paper is towards understanding that perceptions of workforce redesign are not only informed by the sense of self as an individual, but also by the sense of belonging to a distinct professional group (Haslam, 2014). It is acknowledged that unclear definition of the assistant role, and subsequent uncertain delineation between that and the SLP role may contribute to threatened professional identity.
Speech-language pathologists’ perceptions of assistants

Assistants have been utilised by SLPs internationally, with aspects of their role including being delegated lower complexity direct patient care as well as provision of administrative support, thus allowing professionals to concentrate on more complex clinical needs (Lizarondo et al., 2010). It has been shown that ambivalence is consistent in perceptions of working with assistants in allied health research. Specific to speech-language pathology, McCartney and colleagues (2005) conducted a case study of speech-language therapists working with assistants in the UK and found both benefits and ‘disbenefits’ to working with assistants. For example, participants identified that working with an assistant contributed to ensure the SLPs’ clinical reasoning and rationale, but also resulted in less time for planning the SLPs’ own caseload. They noted that perceptions established in their 2005 study were similar to those found in an important study by Van der Gaag and Davies (1993) more than ten years previously, where SLPs reported conservative views in their willingness to share tasks with assistants. At this time, it was suggested that this conservatism related to working with assistants was attributable to having less experience and exposure to working with assistants (Davies & Van der Gaag, 1992). O’Brien and colleagues (2013) explored the perceptions of SLPs in one local health district in Australia and found that SLPs with previous exposure to working with assistants were generally more positive towards working with assistants than those with no previous exposure (O’Brien et al., 2013). They suggested the need for positive perceptions to ensure the sustainability of such a workforce redesign and suggested a potential role for professional identity in understanding such perceptions. McCartney and colleagues (2005) discussed the need to consider whether working with assistants provided satisfaction for the SLPs in order to maintain the workforce redesign. More recently, O’Brien and colleagues (2017) further explored the paradoxical nature of SLPs perceptions of working with assistants and found the importance of consumer focus in the formation of professional perceptions. These findings are consistent with the consumer focus within the professional code of ethics, which state the fundamental values of the profession include integrity, professionalism, respect and care, quality standards and continuing competence (The Speech Pathology Association of Australia Limited, 2010).
**Aims**

This paper aims to explore the role of professional identity in SLPs’ perceptions of working with assistants. SLPs’ accounts of their perceptions of working with assistants are examined to explore how professional identity contributes to their assessment of the redesign. Thus, this paper aims to address the following:

- How do SLPs perceive their professional identities?
- How are SLP values described? and
- What factors in the introduction of assistants potentially impacted upon this identity?

**Methods**

*Research design*

The current study is part of a larger research project looking at how SLPs perceive working with assistants prior to assistants being introduced by the health organisation. Given the exploratory nature of this research, an inductive qualitative methodology was used. Interviews were conducted with SLPs in remote, rural and metropolitan areas to ascertain their perceptions of a workforce redesign involving assistants. Ethical approval was sought and granted by a Health based Lead Ethics committee as well as the University Human Research Ethics committee.

*Participants*

Given the researcher (Author A) is a practising SLP, recruitment was conducted independently to ensure perceived coercion was avoided. Details of the study were provided to a SLP independent of the research, who disseminated the information to senior SLPs across a public health organisation in NSW, Australia. Senior SLPs then distributed this information to their staff, who were invited to contact the researcher directly if interested in participating. Twenty SLPs volunteered to be interviewed, and their demographic data are presented in Table 1. Seventeen of the sample were women; three
were men, and participants were from community, hospital, or mixed settings. The majority worked full time and had more than 10 years’ clinical experience. Both adult and paediatric caseloads were represented. Fourteen of the twenty participants reported some experience of working with assistants in their careers, however this was not a selection nor exclusion criteria for participation in this research.

<table>
<thead>
<tr>
<th><strong>Characteristic</strong></th>
<th>% (Number)</th>
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<tbody>
<tr>
<td><strong>Clinical setting</strong></td>
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<tr>
<td>Generalist clinicians with majority paediatric component</td>
<td>50% (10)</td>
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<tr>
<td>Acute adult inpatient</td>
<td>20% (4)</td>
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<tr>
<td>Brain injury rehabilitation</td>
<td>15% (3)</td>
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<tr>
<td>Inpatient and/or outpatient rehabilitation</td>
<td>15% (3)</td>
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<tr>
<td><strong>Caseloads</strong></td>
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<tr>
<td>Adult caseload</td>
<td>50% (10)</td>
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<tr>
<td>Paediatric caseload</td>
<td>50% (10)</td>
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<tr>
<td><strong>Working hours</strong></td>
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<tr>
<td>Full time</td>
<td>75% (15)</td>
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<tr>
<td>Part time</td>
<td>25% (5)</td>
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<td><strong>Years of clinical experience</strong></td>
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<tr>
<td>Less than 10 years</td>
<td>35% (7)</td>
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<tr>
<td>10 – 20 years</td>
<td>20% (4)</td>
</tr>
<tr>
<td>Greater than 20 years</td>
<td>45% (9)</td>
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**Table 1:** Participant demographics (n=20)

**Data collection**

Semi-structured interviews were conducted by a SLP researcher (Author A) to explore perceptions of the introduction of assistants, and participants’ understanding of their role, boundaries, job security and satisfaction. Participants were encouraged to lead and direct the discussion about issues they perceived as most important (Smith, Flowers, & Larkin, 2009). A comprehensive list of questions was written based on a literature review of perceptions of working with assistants, but as the participants themselves were invited to lead the discussion on areas which were important to them, not all questions were asked in each interview. The question set evolved as knowledge grew throughout data collection (Smith et al., 2009). A sample of interview questions is provided in Appendix A.
Analysis

The qualitative principles of interpretative phenomenological analysis (IPA) were followed to examine how participants made sense of their experiences. Transcripts were examined, data assigned themes, and similarities and differences noted within and across transcripts (Smith et al., 2009). Themes were revisited many times, as analysis moved from concrete to conceptual interpretation. Given that two of the authors (Authors A and C) are SLPs, it is acknowledged that a pre-existing professional perspective is brought to the research. In the interview context there was also a large degree of ‘insider knowledge’ resulting from the interviewer being a SLP; there were shared assumptions and technical vocabulary of the profession rarely required clarification.

Use of ‘NVivo 10’ qualitative data analysis software enabled efficient management and manipulation of the large amount of data (QSR International, 2012).

Rigour

All participants were invited to view their own transcripts however none accepted this. All authors were given copies of transcripts and discussed the representative nature of the dataset coding. A sample of transcripts was coded independently by two authors with 90% inter-rater reliability regarding category codes. Definitions of themes were finalised by consensus.

Results

Despite varying overall perceptions of the workforce change, it was apparent that issues of professional identity were consistent in participant reports. The analysis identified two over-arching themes; the presence of attitudes, beliefs and behaviours that characterised the SLP professional identity, and reports of real or perceived threat to that identity.

<table>
<thead>
<tr>
<th>Professional Identity</th>
<th>Professional Identity threat</th>
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<tbody>
<tr>
<td>Professionalism</td>
<td>Threat to professionalism</td>
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<tr>
<td>Clinical autonomy and critical thinking</td>
<td>Threat to clinical autonomy</td>
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<tr>
<td>Client focus and advocacy</td>
<td>Threat to client focus and advocacy</td>
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Table 2: Themes and subthemes
Professional identity

The identity that emerged was of an organised, strategic and ethical professional, with high standards of behaviour and practice. Participants focused on the sub-themes of SLP professionalism, clinical autonomy and client focus as key pillars of their professional identity.

“...your typical speech pathologist... Somebody that’s got all the range of characteristics from somebody that can be...systematic, and statistical, to somebody that’s innovative and interpersonal, and a great communicator, and sensitive” (Participant #3).

Professionalism

Professionalism and maintenance of professional standards was viewed by participants as being integral to their role and contributed to job satisfaction (i.e. a job well done led to being more satisfied). Participants valued and were protective of their clinical discretion and critical thinking skills, illustrated in the following quote:

“... it is my call as to whether I feel based on that screening, whether their language skills are normal or not...that’s still a clinical judgement I think as to whether that’s normal or not...” (Participant #20)

Clinical autonomy and critical thinking

All participants regarded clinical outcomes as a fundamental principle of being a SLP, claiming it to be their ethical, legal and professional responsibility to ensure high standard care. Participants emphasised that achieving clinical outcomes efficiently is one measure they used to ascertain their level of effectiveness, as in this example:

“A good speech pathologist can be very effective very quickly and is the best person... who is going to get through the waiting list and deal most effectively with it” (Participant #20).
The level of clinical control and decision making experienced by most participants contributed to the construction of the professional identity as an effective and independent clinician. Some participants explained effectiveness as being indicative of a thorough understanding of complexity and quality of care:

“a lot of knowledge across a really broad caseload with little time to bring that... develop that knowledge in a way... its crossing multiple sites, its working with all the disciplines, its working independently...” (Participant #6)

Participants discussed tensions between large caseloads, intensive clinical need and service access issues including long waiting times. Participants reported professional and clinical autonomy in their current service delivery models, despite some organisational control. Participants described their frustration with being unable to implement professionally identified best practice due to service limitations (e.g. session limits or discharge policies):

“You can’t follow... guidelines of dosage for your clients and intervention and stuff like that, you just can’t. You’re basically not following the evidence base just due to the restrictions that you’ve got in the workforce” (Participant #11)

Participant accounts indicated that their sense of professional identity came from being able to implement best practice and achieving clinical outcomes for clients. These reports contributed to the SLP identity of an organised and strategic professional, skilled in clinical prioritisation and time management.

Client focus and advocacy

Participants discussed client focus and advocacy as key components of the SLP professional identity, particularly in relation to vulnerable clients. They discussed attempts to increase self-efficacy and service access for clients, as well as their responsibility for advocating for appropriate access to other services, in addition to assessment, therapy, clinical management and outcomes.

“We really try and focus on that collaboration... It’s like, ‘what do you want to work on? I’ll support you to do it’” (Participant #11)
**Professional identity threat**

The analysis suggested that the introduction of assistants was perceived as a potential threat, in theory, or practice, to the professional identity of SLPs, and was particularly focused on clinical autonomy, client focus and advocacy.

**Threat to professionalism**

The introduction of assistants, perceived as being pursuant to economic efficiencies, was interpreted as degradation of the professional role by deskilling the professional workforce and devaluing established roles:

“De-skilling... And, not just de-skilling but losing... recognition for the role, the speech pathology role” (Participant #16)

Some participants held reservations regarding assistants’ ability to provide an appropriate level of clinical care required to maintain outcomes for clients. This was based on the belief that assistants lack appropriate knowledge and training to undertake such tasks:

“They don’t have that training. They’re not a speech pathologist; they’re not the person who’s actually qualified...” (Participant #20)

Some participants saw merit in the idea of assistants working with clients where intervention requires no significant modification, again highlighting the perception of the difference between the skills and knowledge of the SLP and assistant:

“It would have to be something within some fairly limited constraints about what somebody who doesn’t have the benefit of a four-year speech path degree could handle... that doesn’t really require novel thought, doesn’t really require a whole lot of active modification” (Participant #9)

Being a SLP was used as a defining category referring largely to qualifications and expected skill sets, quality management and outcomes, and professional behaviour. A representative comment from a participant was:
“Because they’re not a speech pathologist, they don’t have a degree”

(Participant # 14)

“we’ve fought for so long to be recognised as equals of physios and things like that
and then to say well, someone else could do my job, that sort of could be a little bit
demeaning for them” (Participant #10)

The introduction of assistants was presented by some participants as providing a cheaper,
less effective and less professional method of service provision.

Threat to clinical autonomy and critical thinking

Participants perceived management decisions regarding resourcing devalued both clients
and the evidence base to which clinicians are committed. Professional values were framed
in terms of consumer focus and clinical outcomes:

“Are we getting good outcomes for the patient? You know you’d have to really look
at that” (Participant #5)

“You’d just want to make sure that you maintain the standards of care”

(Participant #6)

The participants portrayed the profession as having high standards and client centred values
distinctive from other professional and vocational groups.

Threat to client focus and advocacy

Delegating clinical tasks to assistants was seen by some participants as decreasing
individualised treatment that most participants valued. i.e. delegating clinical tasks to
assistants may cause the SLP to have less contact with clients, resulting in poor clinical
relationships, as follows:

“will it increase the efficacy of what’s going on or will it just mean that people that
wouldn’t have received a service then get a service because they’ve only got mild
problems - rather than a home program they get to see an aide” (Participant #1)
“I guess Speech Paths will be able to sit in a room and do a whole lot of stats now, when I think what it should be doing is allowing us to do more specialised intervention, assessment” (Participant #9)

Perceptions that poorer clinical relationships with clients led to perceptions of decreased consumer focus. Consumer focus was perceived by participants as being pivotal in ensuring maintenance of standards of care and client satisfaction with speech-language pathology services.

Discussion

This paper demonstrates the presence of a strong professional identity for the SLPs involved in the study. Findings demonstrate the potential impact of the redesign on identity and the emergence of professional identity threat. This paper highlights the importance of professional identity in the success or otherwise of a planned workforce redesign (Haslam, 2014).

Professional identity

Our data suggest that SLP professional identity reflects professionalism, client focus and clinical autonomy. Client focus is consistent with findings of O’Brien, Mitchell & Byrne (2017) who found that consumer focus was a core value for SLPs, and a moderating factor influencing perceptions of the introduction of assistants. This finding was reflected in the discussion of standards of care, outcomes, advocacy, and the profession’s ethical values. Participants identified the importance of positive professional relationships with clients in achieving clinical outcomes, given the client-centred nature of the profession. The emphasis on achieving clinical outcomes and client advocacy speaks to the unique input that SLPs provide.

Participants identified more strongly as SLPs than as employees of the organisation which highlights the significance they ascribed to being a SLP and fits with research suggesting that clinicians identify with their profession to a greater extent than their organisation or unit (Ashforth & Mael, 1989). Our findings related to professional identity are particularly
important given past research suggesting that there is a misunderstanding of the role of SLPs (Byrne, 2008) and that SLPs perceive their role is misunderstood by employers, consumers (O’Brien et al., 2013), and other health professions (Byrne, 2010). Perceptions that employing organisations do not recognise core professional values of consumer focus (O’Brien et al., 2017) may result in a heightened sense of professional identity and threat regarding decisions relating to workforce and role (McNeil, Mitchell, & Parker, 2013).

Participants had a strong sense of their professional distinctiveness but were not confident that organisational management, other health and education workers, and consumers understood their unique contribution. The blurring of boundaries and poorly defined professional identity has been identified as a source of professional rivalries with tension and hostility within clinical practice (Hudson, 2002). Poor understanding of the SLP role combined with perceptions of decreased valuation of the profession’s expertise may lead to an indistinct professional identity. Turner and Knight (2015) discussed the consequences of an indistinct professional identity included an inability to strategically react to change. This is an important consideration for the profession to be prepared to respond to future needs of the community.

*Professional identity threat*

Participants reported that assistants threatened the three core components of their identity, professionalism, consumer focus and clinical autonomy. Participants indicated that the introduction of assistants may negatively impact their level of involvement with the client and their intervention, resulting in poorer clinical outcomes. This was seen as a threat to professional identity in terms of limiting SLPs’ ability to maintain their holistic focus of the client’s intervention and impacting upon the provision of high levels of professional care and ethical practice (i.e. ensuring that intervention is both beneficial and also not causing harm). This research provides one of the first explorations of professional identity threats in speech-language pathology.

It will be important for organisations to communicate the positive impact assistants may bring to the profession with a focus on the benefits to consumers, which was found to encourage positive perceptions (O’Brien et al., 2017). Increasing overall understanding of
the intent of the workforce redesign and having better knowledge of the existing professional identity and influencing factors, organisations may attempt to bring about positive, rather than enforced change. Similarly, by encouraging interaction between professional bodies (i.e. Speech Pathology Australia) and employing organisations, strategies for change may be identified to create the diverse and dynamic future speech-language pathology workforce (Speech Pathology Australia, 2016b).

The changing of roles that are associated with a professional identity has the potential to change the way people view themselves, in both a work and social context (Haslam, 2004). In cases where workforce redesign is likely, perceived threats to professional identity and the impact this has on their perceived status within the organisation will be important barriers to overcome. There is evidence that in times of job and employment insecurity, the importance of understanding professional identity to maintain a positive employment relationship is greater (Alvesson & Willmott, 2002). Considering the tensions and efforts to maintain or increase control during a process of workforce redesign based at the level of everyday practice, there is potential for resistance to start with low-level discontent but escalate to potential destabilisation and creation of weakness in a work context (Thomas & Davies, 2005). It will be important for the speech-language pathology profession to have a clear message for ourselves, employers and consumers regarding the SLP professional identity. This will include the ethical standards and evidence base to which the profession is committed, as well as beliefs and rationales of the profession. Having this clearly articulated will allow the profession to respond in an organisational sense if challenges to the professional values are experienced (Turner & Knight, 2015).

**Limitations and future directions**

Participants were interviewed in a work context and asked their perceptions as a SLP. It is possible that this questioning and their understanding of the study purpose may have contributed to heightened professional identity.

Given the paucity of information or a specific description of the professional identity of SLPs, further study is needed to determine what factors influence existing professional identity and how this identity might impact or be impacted upon, by workforce redesign. It
would also be beneficial to explore in greater detail who professionals perceive to be the source of professional identity threat in the context of workforce redesign (e.g. organisational management or the new occupational group). Another important area for further exploration would be the development of professional identity throughout SLP training and early graduate experiences.

**Conclusion**

The contribution of this paper is towards understanding that perceptions of workforce redesign are not only informed by the sense of self as an individual, but also by the sense of belonging to a distinct professional group (Haslam, 2014). This study has provided an exploration of the speech-language pathology professional identity construction and role in understanding reactions to a workforce redesign. It offers insight into the ways professions and professionals may respond to the introduction of a vocationally trained group. Lessening the sharpness of professional boundaries distinguishing SLPs was interpreted as a threat to the uniqueness of SLPs role in terms of knowledge, values and professional contribution, and prompted efforts towards maintaining the positive distinctiveness of the SLP role through opposition. Preserving professional boundaries has been linked to an underlying need for distinctiveness that accounts for a complex array of behaviours and attitudes including motivation, perseverance in the face of barriers and commitment (Sheldon & Bettencourt, 2002). As such it provides a powerful basis for resistance.

**References**


Appendix A: Sample interview questions

- What do you think about assistants in speech-language pathology?
- What makes you feel this way?
- Do you have any prior experience working with assistants?
- Do you have any concerns about working with assistants? If yes, what are they?
- What are some roles you think an assistant might perform in speech-language pathology? In your specific work setting?
- How do you think your role would change if you were to work with an assistant?
- What do you think your service would gain if working with assistants?
- What sort of circumstances or supports do you think the profession would need to make the transition to working with assistants easier for clinicians?
- Do you think there is a difference between contexts when working with assistants? E.g. would it be easier / harder in a paediatric vs adult setting? Rural vs metropolitan setting? Large department vs small department/ sole clinician?
9.6 Paper 6 - What value can assistants bring to speech-language pathology practice?

9.6.1 Statement of contribution of others

Statement of contribution of co-authors

We, Rebecca Mitchell, Nicole Byrne and Rachael O’Brien attest that PhD candidate Rachael O’Brien had the primary and lead role in the study concept, design, data collection and analysis, preparation and final revision of the publication entitled:


________________________________________
Rebecca Mitchell (Co-author)
Date: 12th January, 2018

________________________________________
Nicole Byrne (Co-author)
Date: 12th January, 2018

________________________________________
Rachael O’Brien (PhD Candidate)
Date: 12th January, 2018

________________________________________
Suzanne Byrne (Assistant Dean Research Training – Faculty of Business and Law)
Date: 15th January 2018
9.6.2 *Introduction*

Some allied health disciplines have a long history of working with assistants and as such have a more established professional culture of delegation and supervision. Professions such as occupational therapy have an understanding in their undergraduate training that they will be working with assistants and have some knowledge of what tasks can and can’t be delegated (Salvatori, 2001). However, unclear expectations of the role of assistants and what they are able to contribute to clinical practice may be an ongoing issue with regard to negative perceptions of this workforce redesign (O’Brien et al 2013). Similarly, poor ongoing exposure to assistants as a workforce has been shown to have negative implications on speech-language pathologists’ perceptions (O’Brien et al 2013).

The aim of *Paper 6* – ‘*What value can assistants bring to speech-language pathology practice?*’ is to provide information to the speech-language pathology profession in Australia about who the assistant workforce is, what their training entails and to assist SLPs to understand the positive impact that assistants can bring to the profession. Having this information may allow SLPs to utilise an assistant more effectively, having the greatest benefit to consumers.

9.6.3 *Criteria for journal selection*

International Journal of Speech-Language Pathology was chosen as the most appropriate publishing outlet for *Paper 1* and *Paper 6*. Please see point 9.1.3 for a more in-depth discussion of the journal’s status.

While conducting the research, it became apparent that SLPs had little knowledge regarding who assistants were and what they could bring to the profession, which led to *Paper 6* being written. Being able to disseminate the research to all members of SPA was an effective way of ensuring the research was available to as many clinicians possible in order to engage them in the topic. Given the lack of literature available regarding assistants in speech-language pathology, papers one and six are important and innovative additions to the professional discourse.
9.6.4 Full citation

What value can assistants bring to speech-language pathology practice?

Running head: Assistants and speech-language pathology

Key words: Assistants, workforce redesign, speech-language pathology

Rachael O’Brien, Rebecca Mitchell and Nicole Byrne

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Abstract

Providing appropriate and effective services to a broad range of clients is a core value of the speech-language pathology profession. The changing needs and increasing complexity of clinical caseloads is an issue for the profession, while resourcing is limited. Working with assistants is a potential workforce strategy which may assist the profession to provide a broader range of services to those who need it while allowing qualified speech-language pathologists (SLPs) to provide services to meet the needs of those with more complex clinical presentations. However, relatively little is known about allied health assistants in Australian speech-language pathology, and how much value assistants can bring to speech-language pathology practice. This discussion paper considers the role of assistants in speech-language pathology, what they can contribute to the profession, and benefits to consumers in working with assistants.

What is known about the topic? Greater understanding of the assistant workforce including training, skills and tasks they can undertake, is required to ensure the speech-language pathology profession is utilising their services effectively.
What does this paper add? There is a gap in the literature about the speech-language pathology profession’s understanding and effective utilisation of assistants. This paper provides strategies for practitioners and the profession, including a call to embrace assistants via associate membership of the professional body.

What are the implications for practitioners? There are clear benefits to utilising assistants to consumers, organisations and professionals. This paper provides information regarding the training, role and value that assistants may bring to the profession.

Introduction

There is an increasing need for speech-language pathology services in both early intervention and services to adults. More effective diagnosis of conditions requiring early intervention such as autism spectrum disorders, and more effective understanding of the SLP’s role with (for example) clients with complex needs including neurodegenerative conditions and stroke, means that speech-language pathology services are in increasing demand. There is an increasing prevalence of chronic conditions requiring speech-language pathology input, and it has been identified that in order to meet this increased demand, profound changes to the profession must be considered (Wylie et al., 2013), including the employment and utilisation of assistants (O’Brien, Mitchell, & Byrne, 2018). Working with assistants is one workforce strategy the speech-language pathology profession uses to enhance efficiency to meet community need in an equitable and sustainable manner. However, ongoing resistance to working with assistants continues to be documented which presents barriers to the success of such collaboration (O’Brien et al., 2018).

The health workforce is required to be adequately skilled to match community need (Sibbald et al., 2004). Any mismatch will result in a lack of adequate care for the community, particularly those in vulnerable populations including the elderly, those with chronic conditions or mental illness, and Aboriginal and Torres Strait Islander people (Health Workforce Australia, 2012). Role restrictions and regulation for health professions are in place with the intention of protecting the safety of consumers accessing health services (Australian Health Practitioner Regulation Agency, 2014), and ensures that health professionals are appropriately skilled and qualified to undertake specific tasks. However,
role restriction and regulation may also be viewed as overly cautious in terms of patient safety. The community may be denied access to services due to workforce shortages, particularly in rural areas, when tasks may be safely provided by a health worker other than the professionals who traditionally perform them.

This need for clarity is reflected in the work of the Speech Pathology Association of Australia (SPA), which recognises the possibility of unsafe and ineffective service delivery if a clinical governance framework for assistants is lacking (Speech Pathology Australia, 2016b). The provision of appropriate care to all consumers requiring SLP services is a priority for the profession, as well as providing services in a way which is consumer focused as well as culturally and demographically appropriate (O’Brien et al., 2018). It is recognised that the speech-language pathology profession lacks diversity (Byrne, 2015), and as such, it is important to look at how the profession plans to provide culturally competent services given the current demographic makeup of the profession.

In this paper, we argue that allied health assistants (hereafter, assistants), have a valuable role to play in speech-language pathology service delivery in Australia, and can value-add in numerous ways. As such, we will describe what is known about assistant training and demographics, and outline the role of assistants working with SLPs including the tasks which remain the sole responsibility of SLPs which are not to be delegated. We will describe what is known about assistants in speech-language pathology and the preparedness of the profession to the more widespread utilisation of assistants. Finally, we highlight the need for more information about the introduction of assistants into speech-language pathology, and for the profession to consider greater inclusivity of this workforce into our professional association to maximise the effectiveness of speech-language pathology services Australia wide.

**Assistant training and demographics**

An assistant in allied health is someone whose role it is to support the work of allied health professionals (AHPs). People in these roles are generally vocationally trained with a Certificate III or IV in allied health assistance. Assistants are required to have supervision provided by an AHP and are encouraged to access continuing vocational development by
way of appropriate training and in-services. There are people in the workforce undertaking assistant roles who have not undertaken vocational training, and in these instances, some Australian health services are conducting recognition of prior learning in order for them to gain vocational recognition for the skills and experience gained through their employment (NSW Health, 2012; Queensland Health, 2016). There is currently a movement in health services to employ assistants with Certificate IV qualifications, however, variation remains in assistant training given the different available training organisations and courses.

Allied Health Assistance training is a nationally recognised qualification (specifically Certificate IV) which allows the assistant to work either with their chosen allied health field or as a generalist assistant across two or more allied health areas (including, for example, physiotherapy, occupational therapy or podiatry). General electives in the allied health assistance course include modules such as ‘Work with diverse people’, ‘Interpret and apply medical terminology appropriately’, and ‘Manage legal and ethical compliance’ (TAFE NSW, 2017). Assistants training to work with speech-language pathology can choose to undertake specific electives, including for example, ‘Provide support in dysphagia management’ and ‘Supporting the development of speech and communication skills’ (TAFE NSW, 2017). Student assistants are required to pass assessments using case studies, presentations, and undertake clinical placements totalling at least 120 hours under the supervision of a qualified AHP (TAFE NSW, 2017). Assistants’ level of supervision in these placements is dependent on their level of experience and skill, as judged by their supervising AHP. The AHP delegates tasks to the student assistant as guided by their professional association, employing organisation, and their own confidence in delegation (Queensland Health, 2016). Prior to completing these placements, assistant students are required to meet the specific requirements of the health service including criminal records checks, relevant codes of conduct, and working with children checks.

In a systematic review of the literature, Lizarondo and colleagues (Lizarondo et al., 2010) explored the roles and responsibilities of people in roles whose aim was to assist AHPs, including but not limited to, therapy assistants, rehabilitation assistants and Indigenous support workers. In this work, they discuss that the roles of assistants fall into two key categories; clinical duties requiring client contact, and non-clinical duties requiring no
client contact. Lizarondo and colleagues discuss the diverse ways in which the tasks of assistants and professionals are described; the professionals’ tasks were described as “evaluating, assessing, diagnosing, planning, and implementing” (p151), while assistants’ tasks were described as “assisting, supporting, administrating, monitoring, and maintaining” (p151). The difference between the description of tasks was discussed as accurately representing the scopes of practice of the professional and vocational groups, and reflecting the tasks which remain the sole responsibility of AHPs (Lizarondo et al., 2010).

In a 2012 survey of assistants employed by NSW Health (NSW Health, 2012), it was found that the assistant workforce was largely female (78.9%). 48.9% of assistants worked part-time, with 38.9% working in metropolitan areas, 38.9% in regional areas, and 21.7% working in rural areas (NSW Health, 2012). 30% of assistants worked in acute or community settings respectively, 40% in a subacute setting, with the average length of employment being 6.6 years. It was noted that there were inconsistencies with the qualifications gained, with only 33.7% of participants holding a Certificate IV at the time of the survey (NSW Health, 2012). As shown in Table 1, male participation and rural working are very different between assistants and speech-language pathologists.

<table>
<thead>
<tr>
<th></th>
<th>Assistants</th>
<th>SLPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>% males</td>
<td>21.1% (NSW Health, 2012)</td>
<td>2.5% (Health Workforce Australia, 2014)</td>
</tr>
<tr>
<td>Part time work</td>
<td>48.9% (NSW Health, 2012)</td>
<td>38.9% (Lambier &amp; Atherton, 2003)</td>
</tr>
<tr>
<td>Rural</td>
<td>21.7% (NSW Health, 2012)</td>
<td>23.7 SLPs/100000 population (Health Workforce Australia, 2014)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approx. 4.5% (O’Callaghan, McAllister, &amp; Wilson, 2005)</td>
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Table 1: Workforce and demographic characteristics of assistants and speech-language pathologists

The role of assistants in speech-language pathology

 Assistants have been utilised in speech-language pathology in the US, UK, Canada and in some states of Australia. However, working with assistants remains poorly documented in
the speech-language pathology literature (O’Brien et al., 2013). Assistants in speech-language pathology are employed across a range of settings including both paediatric and adult caseloads, disability and brain injury services. They have been utilised across levels of acuity from inpatient to community and telepractice settings. Some professional associations such as the American Speech Hearing Association (ASHA) and the Royal College of Speech and Language Therapists (RCSLT) have reflected the importance of assistants to the profession by creating a membership category or affiliation for assistants within the professional associations (Ostergren & Aguilar, 2015). Similarly, the RCSLT have recognised that working as a speech-language pathology assistant is a viable career pathway into the speech-language pathology profession, and are currently supporting the development of a ‘degree apprenticeship’ in order to enable such career progression (Royal College of Speech and Language Therapists, 2017).

Speech Pathology Australia has identified numerous titles for staff in support roles in the guidelines for delegation, collaboration and teamwork in speech pathology practice (Speech Pathology Australia, 2016b) and recognises the value of these roles within the management of a clinical caseload (Speech Pathology Australia, 2016c). Utilising assistants through effective delegation allows SLPs to dedicate a greater proportion of their time to tasks requiring a higher level of clinical skill and knowledge (O’Brien et al., 2018). Delegation of tasks to an assistant occurs when an AHP supervises and allows an assistant to provide treatment, in the presence of a treatment plan which has been devised by the AHP (Queensland Health, 2016). Key principles regarding utilising assistants as discussed by SPA include the importance of SLPs maintaining responsibility and accountability for care provided by an assistant under their supervision; guidelines and protocols developed by SLPs to guide the practice of assistants; and SLPs establishing competency of assistants prior to tasks being delegated (Speech Pathology Australia, 2016b). Importantly, it has been identified that it remains unclear what level of supervisory training AHPs are afforded in their undergraduate training (Schmidt, 2013).

Currently, there is a clear plan for activities assistants can perform within other allied health professions such as physiotherapy and occupational therapy, and some Australian states have speech-language pathology specific assistant job descriptions. Appropriate task lists
for assistants cover a range of clinical settings including adult rehabilitation, community paediatrics and acute settings. SPA’s guidelines for delegation, collaboration and teamwork in Speech Pathology practice outlines the appropriate delegation of tasks, taking into consideration the career stage of the assistant. For example, an established assistant with discipline-specific training may conduct specific screening tasks, and record information with no interpretation, however, it is not recommended that a newly appointed assistant complete such tasks (Speech Pathology Australia, 2016b). Arguably, the most important aim of working with assistants is to extend the breadth of speech-language pathology services. That is, increasing the intensity, frequency and availability of services. Research is clear that therapy intensity is required to achieve clinical outcomes in clinical areas such as speech sound disorders, aphasia and brain injury (Godecke et al., 2014; Meinzer, Streiftau, & Rockstroh, 2007). Similarly, working with assistants has the potential to improve access to speech-language pathology services, for example, through efficient use of telehealth; having assistants living locally and being available in rural locations while accessing supervision and being delegated to by SLPs in larger centres. They may be able to facilitate more time for the SLP to focus on tasks of a higher clinical complexity as well as being a financially viable use of human resources (O’Brien et al., 2018). SLPs are well versed in the large number of administrative tasks that accompany a clinical caseload, and there is the potential for task-sharing some of this load with an assistant, again increasing the possible time able to be spent providing direct clinical intervention (O’Brien et al., 2018).

Another valuable aspect that assistants may bring to the speech-language pathology profession is their demographic proximity to the local community, bringing much-needed diversity into the profession (Byrne, 2015). Gwynne & Lincoln (Gwynne & Lincoln, 2017) discuss the importance of culturally competent healthcare services, specifically increasing the likelihood of Aboriginal people accessing such services. It is suggested that working with assistants may improve the diversity of speech-language pathology, and in doing so, may improve the profession’s access to communities who have been traditionally more difficult to access. Importantly, recruiting and offering vocational development of assistants from Aboriginal backgrounds would be a positive step in meeting the health needs of Aboriginal people.
While it is important to consider what assistants can bring to speech-language pathology, it is equally important to consider what they cannot do. SPA states that assistants are never to be considered as a replacement to qualified SLPs and specifies roles which are the sole responsibility of the SLP and are not to be delegated. This information is also supported by the documentation of the RCSLT and is relevant to the development of local policies and procedures regarding training, employment, supervision, delegation and maintenance of quality service provision (Royal College of Speech & Language Therapists, 2008). Tasks which must remain the responsibility of the SLP include client selection or discharge from services, conducting assessment procedures, altering treatment plans or goals, and independently writing reports (Speech Pathology Australia, 2016b).

Perceptions of speech-language pathologists to working with assistants

Despite potential benefits of working with assistants, ongoing resistance to working with assistants continues to be documented. In a 2018 study, O’Brien and colleagues found SLPs had paradoxical perceptions in relation to the introduction of assistants across the spheres of role, tasks and relationships. They explored the perceptions of SLPs to working with assistants and found a paradoxical relationship between positive and negative perceptions. While it was found that positive perceptions included sharing workload and decreasing administrative tasks, this was moderated by the perception that working with assistants had the potential to decrease the focus on consumers which is a strongly held value for SLPs. However, there is evidence to suggest that assistants are able to develop good relationships with clients given their demographic similarity to the general population, use of accessible language, and ability to spend more time with clients than AHPs (O’Brien et al., 2018). Research by O’Brien, Byrne, Mitchell and Ferguson suggested that professionals with previous exposure to working with assistants had generally more positive perceptions than those without prior experience (O’Brien et al., 2013). From the findings of both studies, the role of the client needs to be a central consideration in the move towards SLPs working more extensively with assistants.
The preparedness of speech pathologists to working with assistants

The literature highlights the importance of the speech-language pathology role across the lifespan, and it is also becoming apparent that working in the traditional 1:1 service delivery model is not a financially viable option if services are going to be equitably provided in future (O’Brien et al., 2013). Consideration is needed about how prepared (both in perceptions and formal training) SLPs are to work with assistants. Without SLPs being educated in what an assistant can do and what value they can add to practice, it is unlikely that the profession will be able to get the most value out of working with assistants.

Speech-language pathology recorded a high percentage of time which could be appropriately delegated to an assistant (Somerville et al., 2015), indicating the potential for improved efficacy of services through the effective utilisation of such a workforce.

Clinical outcomes and consumer focus are priority considerations for SLPs, but there remains a perception that the workforce redesign of introducing assistants is being driven by economics and service issues rather than specific evidence or consumer need (O’Brien et al., 2018). This indicates that further information regarding assistants, what they can contribute to the profession and to client care needs to be more widely available to SLPs.

Introduction of supervision and delegation topics in SLP undergraduate training may go some way to preparing entry-level practitioners for working in such a model. Further research is required to develop a strategy for the education of clinicians regarding their role in delegating to and supervising assistants.

The literature addresses the need for SLPs to have exposure to assistants within their undergraduate clinical placements, as they are graduating with little or no experience in delegating, or effectively using the skills of an assistant (Goldberg et al., 2002). Providing practising and student SLPs with exposure to working with assistants may provide opportunities for shaping positive perceptions of such a workforce redesign (O’Brien et al., 2013). However, this presents a workforce challenge, as assistants employed to work in speech-language pathology remain relatively rare in some states of Australia (O’Brien et al., 2013). Without such exposure, existing departments may perceive employing an assistant to be a risk. The ongoing paucity of assistants in speech-language pathology has
the potential to continue the ambivalence to a new generation of graduates. This will have an impact on the training and educational preparation of SLP students in the future.

The role of the SLP and assistant are not adequately defined and delineated, which stems from a lack of discipline-specific research and literature. From this concern regarding role delineation also follows concerns regarding efficacy and supervision, as well as the potential for litigation (O’Brien et al., 2013). These are certainly issues which are addressed in the literature for other disciplines and have a strong bearing on the way that speech-language pathology may perceive an assistant program in NSW.

**Conclusion**

We suggest that SPA as the national peak body representing SLPs has a role to play in incorporating assistants in the profession nationally, in (e.g.) an associate membership capacity. This would have benefits for both SLPs and assistants. Assistants currently have relatively small numbers and no national representative body. Associate membership of the professional association would allow them to become part of a wider clinical network, acquire greater knowledge of speech-language pathology, and allow them ongoing access to training improving their vocational development. Similarly, having assistants as associate members of the association would allow them to be educated in and bound by the SPA code of ethics. We also suggest, as per the Royal College of Speech and Language Therapists, that working as SLP assistants is a viable pathway into the profession (Royal College of Speech and Language Therapists, 2017). This would be beneficial for SLPs who will have greater access and understanding of what assistants can do, and how they may value-add through their skills and demographic proximity to the local community. This could positively contribute to professional diversity by improving male, culturally and linguistically diverse and Aboriginal participation rate.

The purpose and consequences of the workforce redesign of utilising assistants remains the subject of debate from individuals, professions and organisations (Lizarondo et al., 2010). Understanding how SLPs perceive working with assistants and the impact on their current role in the context of this workforce redesign may impact overall perceptions of working with assistants, allowing more effective utilisation and resulting in a greater benefit to
consumers. Having clearly articulated professional boundaries for both the SLP and assistant roles is an important step in increasing the profession’s preparedness for practising in such a workforce model. Similarly, an understanding of the speech-language pathology values and identity will be a critical point of clarification for SLPs and will allow the profession to strategically respond to workforce changes. It is suggested that a thorough understanding of what an assistant can and cannot be delegated can be of assistance in preparing clinicians and individual services to work with assistants. Assistants have the potential to make a valuable contribution to the profession and to the communities we serve. It will be increasingly important for SLPs to be prepared to work with assistants and to be competent and confident in their roles and responsibilities in relation to delegation and supervision.

References


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10 Contributions and implications

This discussion summarises the original contribution made to the existing literature by the six core papers included in this thesis, and the importance of these contributions. The purpose of the research presented in this thesis was to explore and generate a deep understanding of SLPs’ perceptions of working with vocationally trained assistants and to examine the factors contributing to the formation of such perceptions. Further questions emerged from findings of the preliminary stages of qualitative analysis, including developing a deeper understanding of the speech-language pathology professional identity, how such an identity was formed and presented by the participants, and how this identity impacted upon SLPs’ perceptions of working with assistants. Further, the lack of professional knowledge about assistants as a workforce was an important finding of this research. This discussion will illustrate how these questions were explored and answered. The strengths and limitations of the research will be discussed, as well as future directions arising from the study.

10.1 Summary

The introduction to the thesis outlined the dynamics of the Australian health system, including the ways the health system is funded and the changing focus being reflective of community need. This provided the context and impetus for exploring in detail the introduction of an assistant workforce in an allied health profession such as speech-language pathology. The importance of using speech-language pathology as a location for the study of perceptions of such a workforce redesign was highlighted, given the profession’s history in Australia, and its work across multiple sectors including health and education. Employment and training parallels with other allied health professions allow this research to be relevant across disciplines.

At the commencement of this research, it was found that resistance to working with assistants was apparent in allied health professions (other than speech-language pathology) with longer and more established histories of working with assistants. There was also continued uncertainty in the wider allied health literature regarding how assistants were
utilised and how professionals perceived working with assistants. There was very limited profession-specific research available to guide the implementation of assistants in the speech-language pathology profession. The absence of such research meant that there was limited knowledge about what assistants could bring to the existing profession, what their roles and boundaries would be, and how this would impact on the speech-language pathology profession and professionals. This gap in knowledge meant that implementation of assistants was done in conjunction with literature from other professions, or in a locally based service-specific manner.

Although working with assistants has been shown to have good clinical and resource management outcomes (Dickson et al., 2009; McCartney, Boyle, Ellis, Bannatyne, & Turnbull, 2011), the implementation from a workforce perspective remains problematic. In identifying this problem, this research has examined various, often conflicting factors that contribute to the formation of perceptions of working with assistants. Following completion of the research that is the basis of this thesis, a number of important contributions have been made to the speech-language pathology profession, as well as wider allied and related health professions. The research makes contributions to the literature surrounding workforce redesign and organisational change, professional resistance, paradox, and professional identity and subgroups in an organisational context.

This thesis argues that there are several critical factors which impact on professional perceptions of a workforce redesign. It particularly examines how the issues of resistance, paradox and professional identity contribute to the formation of perceptions of working with assistants. Additionally, this research identified that professionals’ knowledge of assistants as a workforce was lacking, which was another pivotal factor in the formation of perceptions. The following section will discuss the contributions made by the research and the significance of these contributions.

10.1.1 The impact of professional identity in workforce change

The papers included in this thesis contribute to the understanding that perceptions of a workforce redesign are informed by the sense of self as an individual, as well as by the sense of belonging to a defined professional group. A central argument of this thesis,
discussed in *Paper 5* is how SLPs perceive and portray their existing professional identity, and how they perceive assistants may impact on this identity.

As discussed in *Paper 1*, participants perceived that the purpose of SLPs’ work was different to the purpose of assistants’ work. There was also consistent discussion that organisational management had limited understanding of SLPs’ role in the organisation, leading to concerns over replacement and substitution of qualified SLPs with assistants. This is further discussed in *Paper 5*, where the perceived lack of management understanding of the speech-language pathology role may have contributed to more negative perceptions of working with assistants. As discussed in the literature review, previous research has identified that professions sharing a working relationship with speech-language pathology have limited understanding and knowledge of the SLP role (Lesser & Hassip, 1986), along with poor public awareness (Byrne, 2010; Parsons et al., 1983). This poor understanding contributed to perceptions that the speech-language pathology role may be threatened by the introduction of assistants, where boundaries are already perceived as being unclear. Similarly, the perception that the SLPs’ unique contribution to clients and the health team was devalued also contributed to negative perceptions of working with assistants. *Paper 3* introduced the concept of professional identity in SLPs’ perceptions of working with assistants and *Paper 5* critiqued the identity factors evident in participant accounts, with the aim of distinguishing the speech-language pathology professional identity allowing it greater transparency in consideration of the implementation of assistants.

The limited literature on professional identity in speech-language pathology suggests that the speech-language pathology profession’s identity hasn’t yet been defined in a meaningful way. It is necessary for the profession to have a clear understanding of its own professional identity, which is then able to be communicated to and understood by those outside of the profession. This clarity of professional identity is vital in strategic workforce planning (Duckett & Willcox, 2015; Hudson, 2002). The consistent reports of concern about professional identity threat in the participant accounts give cause to consider how this professional identity is presented by individuals, and how speech-language pathology is perceived by the wider community.
Speech-language pathology has struggled with a lack of public awareness of the profession (Byrne, 2010; Greenwood et al., 2006; Lesser & Hassip, 1986; Parsons et al., 1983), and therefore also of the value of the role. Acknowledging this is important in the context of a workforce redesign involving a change in the boundaries of the profession (Wenger, 1998). This research is the first to consider how the social identity perspective may be used to explain how the perception of belonging to the speech-language pathology professional group may lead to perceptions of difference between this group and assistants in an organisational context.

The papers included in this thesis represent significant contributions to knowledge in the speech-language pathology profession. They are the first to consider the impact of professional identity threat in SLPs’ perceptions of working with assistants and contribute to the definition of a speech-language pathology professional identity. The published papers also contribute to the wider allied and related health professional literature regarding real or perceived identity threat in relation to workforce redesign impacting on professional boundaries. A significant argument of this thesis is that perceptions of a workforce change involving assistants are strongly influenced by the real or potential threat to professional identity.

Overall, this thesis and the papers therein suggest that SLPs have similar perceptions of their professional identity despite variations in their overall perception of working with assistants. Having a professional identity clearly articulated will allow the profession to respond in an organisational sense if challenges to the professional values are experienced (Turner & Knight, 2015). A contribution of this research is to provide a platform for future research relating to further defining the speech-language pathology professional identity. Similarly, it is suggested that the meanings ascribed to a workforce redesign involving assistants may vary substantially between and within groups. Therefore, future work may also focus on a comparison of perceptions across stakeholder groups; that is between SLPs, assistants, and consumers.
10.1.2 Paradox and profession-related resistance to workforce change

The research that forms the basis of this thesis is able to make a unique contribution to knowledge surrounding professional level resistance, which is under-explored in the literature (Thomas & Davies, 2005). Understanding the perceptions of professionals relating to workforce redesign is important in determining the level and type of resistance which may be encountered.

The findings show that most clinicians were willing to work with assistants and were readily able to think of ways in which assistants could benefit health consumers, health services, and clinicians themselves. However, all clinicians discussed issues impinging on the successful uptake of such a workforce change. These issues included the need for protection of professional boundaries, which was largely presented as being for the protection of consumers and their clinical outcomes (Paper 4), as well as organisational and economic issues, such as the concern that assistants had the potential to be perceived by organisations as a less expensive alternative to tertiary qualified professionals (Paper 1).

A major contribution of this research relates to the understanding of polarisation of responses to the implementation of an assistant workforce. Paper 4 is the first paper to explore this paradox in speech-language pathology and to identify factors accounting for these reactions. This research highlights the paradoxical nature of overall perceptions and the complexity of factors contributing to such perceptions.

The importance of professional, organisational and economic issues was highlighted in Paper 1 and indicated the need for further research in order to define the scope of practice of the assistant role policies guiding their implementation. The presence and strength of paradox evident in participant accounts led to further investigation of the tension evident between positive and negative perceptions, and conditions which led to one or the other.

The paradox is evident in organisations. For example, flexibility in health organisations is required to allow them to adapt to changing health needs of consumers. However, there are also individual and organisational forces seeking work stability (Leana & Barry, 2000). Consideration of paradox encourages the abandonment of traditional theoretical approaches.
to workforce planning, which encourages a rational, linear approach to change. Research into a paradox in organisations has increasingly focused on how these tensions and opposing demands may be supported (Lewis & Smith, 2014). Such tensions are believed to challenge and contribute to better long-term solutions to organisational problems, by engaging a holistic mindset leading to dynamic decision making. That is, rather than seeking to resolve the tension between positive and negative perceptions of working with assistants, *Paper 4* investigated the paradoxical nature of SLPs’ perceptions, allowing consideration of the existence and inter-relationship of identified issues. Having this new knowledge aims to contribute to well-planned and better functioning long-term workforce change.

Utilising Ford and Backoff’s (1988) definition of paradox; “some ‘thing’ that is constructed by individuals when oppositional tendencies are brought into recognizable proximity through reflection or interaction” (Ford & Backoff, 1988, p89), this research examined participants’ perspectives through a paradoxical lens. *Paper 4* considered participants’ perceptions, feelings and identity, their perspectives as being constructed as they attempt to make sense of a complex phenomenon, through their interaction and discussion of working with assistants (Lewis, 2000). Eisenhardt (2000) discussed the need to explore both extremes in a paradoxical relationship, supported by Lewis and Smith (2014) who discuss the importance of understanding tensions and their influences. The discussion of paradox in this research makes a unique contribution to knowledge by increasing the understanding of the factors contributing to a significant workforce change for speech-language pathologists. The in-depth exploration of participants’ paradoxical perceptions in *Paper 4* led to greater understanding of this paradoxical relationship and identified as well as clarified previously ambiguous factors contributing to perceptions such as professional identity (*Paper 5*). The analysis of paradox in *Paper 4* allows understanding of the factors involved in professional perceptions and reinforces the view that the existence of paradox need not mean that either one or the other side of the paradoxical relationship be sought, but to increase awareness and engage both perspectives (Lewis & Smith, 2014).
10.1.3 The relationship between identity and resistance, and identity, resistance and paradox

The analysis that forms the basis of this thesis has important implications for research on professional identity in workforce redesign. It suggests that in order to understand the resistance to a workforce redesign involving a change to professional roles and boundaries, attention must be paid to the construction and subsequent meaning assigned to membership of a professional group. Further, findings suggest that it is important to understand the importance of this identity in the larger organisational context. This is a valuable contribution when considering the significant workforce redesign required in healthcare organisations to address the changing needs of the population, as well as changing health workforce demographics.

These identity findings may also be linked to Paper 6. With consideration of greater inclusivity in the profession, as per the US and UK speech-language pathology professional associations, assistants would be bound by the speech-language pathology code of ethics (Royal College of Speech and Language Therapists, 2017). Findings in Paper 4 indicate SLPs’ concerns over maintaining consumer focus, which is central to the profession’s ethics and values. Including assistants in the association provides the potential of a superordinate goal of consumer focus, while being cognisant of the inherent professional values. As discussed in the literature review, speech-language pathology is not a registered profession in Australia, which Cimoli (2011) discussed as being consequent to having inadequate evidence of public safety concerns resulting from speech-language pathology intervention. The original application for the profession to be a registered profession discussed the potential risk to consumer safety if intervention was carried out by inappropriately skilled / qualified individuals. The lack of recognition of the importance of such matters may contribute to SLPs’ negative perceptions working with assistants. That is, while speech-language pathology remains unregulated, the public cannot be guaranteed safe and competent services from suitably qualified clinicians, and there is limited guidance in order to define boundaries between assistants and SLPs.
Dynamic change in a community of practice occurs at the boundaries of the community (in this instance, the profession) (Wenger, 1998), and so it is suggested that by examining the activity occurring at these boundaries, the potential future scope of professional practice for speech-language pathology may be found. SLPs’ perceptions of working with assistants provide insight into professional identity construction and factors which may impact upon and threaten this identity. As a study of identity and resistance, this research has practical implications – for example, it may be that organisational commitment and loyalty are directly impacted when professional identity is considered, and health organisations engage at high levels with professions.

10.1.4 Practical implications and clinical application

At the commencement of this research, there was very limited research available in speech-language pathology to guide the implementation of assistants in the profession. The absence of such research meant that there was limited knowledge about what assistants could bring to the profession, what their roles and boundaries would be, and how this would impact on the speech-language pathology profession. This gap in knowledge meant that implementation of assistants was done in conjunction with literature from other professions, or in a locally based service-specific manner. This research makes a significant contribution to the professional knowledge of working with assistants. Paper 6 discussed the training and preparation of assistants to work with SLPs, the demographic differences in between the two groups, and what value assistants can bring to speech-language pathology practice.

In conjunction with this increased understanding, improved education for professionals is required regarding the role of assistants, and the workforce benefits they can offer. The absence of profession-specific guidelines was compounded by the general paucity of information about assistants and the value they can add to speech-language pathology practice. This significant gap in the literature existed around assistants and the potential for improving and expanding upon access to, and breadth of clinical services. It seems that the lack of literature was due in part to limited reporting of workforce research in profession-specific publications. It is also possible that where assistants are utilised, their
implementation is localised and service-specific, and therefore difficult to extrapolate to the profession as a whole.

The research was conducted to address this gap, and to examine factors that contribute to perceptions of working with assistants. In order to facilitate positive and effective workforce reform, there is a need for an improved profession-specific understanding of why assistants are being implemented, what their contributions can be to speech-language pathologists, and how best clinicians can engage and utilise their services to the benefit of consumers. In addition to this improved understanding, communication between employing organisations and the profession/ professional body would be beneficial to practising clinicians, in ensuring their concerns are voiced and understood, as well as adequately addressed in the workforce planning process.

The concerns of clinicians regarding delegating clinical tasks as reported in this research are consistent with findings of studies in other allied health professions (e.g. Saunders, 1999). This finding illustrates that despite different clinical focus and profession-specific differences, the implementation of assistants and the pre-implementation concerns may be addressed at a whole allied health service level. This brings the possibility that peak professional bodies for a number of allied health professions may collectively negotiate for the planned implementation of assistants across multiple allied health disciplines. This finding also illustrates the importance of understanding and acknowledgement of concerns, to facilitate better outcomes for stakeholders, rather than long term organisational unrest (Thomas & Davies, 2005). From the perspective of health workforce planning, it is important to acknowledge the concerns of professionals and professions and appropriately address such factors.

Speech Pathology Australia may also consider how to improve training opportunities and a sense of belonging for assistants themselves. In the UK and US for example, the professional associations have an associate membership category for SLP assistants, enabling better contact between SLPs and assistants, better and more effectively shared understanding of the profession’s values and beliefs, and allowing assistants to be bound to the professional standards of ethics. Having an associate membership for assistants would
be an effective method by which the professional body could positively influence practising clinicians’ perceptions of working with assistants.

10.1.5 *Speech-language pathology workforce literature in Australia and internationally*

This research represents a significant contribution to the workforce literature for speech-language pathology in Australia and internationally. Speech Pathology Australia has identified that the profession requires a more diverse and dynamic workforce who can meet the needs of consumers (Speech Pathology Australia, 2016c). *Paper 1* acknowledged a call from Wylie and colleagues (Wylie et al., 2013) who stated that speech-language pathology required a profound professional change in order to equitably meet the needs of the community. However, literature detailing how the profession aims to achieve such changes remains limited.

Following completion of the research that is the basis of this thesis, a number of important contributions to the workforce literature can be made. These are both specific to the speech-language pathology profession, as well as to the wider allied and related health professions. Although working with assistants has been shown to have good clinical and resource management outcomes (Dickson et al., 2009; McCartney, Boyle, Ellis, Bannatyne, & Turnbull, 2011), the implementation from a workforce perspective remains problematic. In identifying this problem, this research has examined various, often conflicting factors that contribute to the formation of perceptions of working with assistants.

*Paper 1* was a first, exploratory study for the speech-language pathology profession in Australia. It was important to know what the perceived barriers and enablers were to working with assistants, and this paper provided insight into the most critical issues for SLPs. This early study provided direction for the remainder of the research. Analysis of the data gathered for the research was used to begin a profession-specific discussion about the inclusion of assistants in the speech-language pathology workforce and to determine the factors which led to SLPs having either positive or negative perceptions of the workforce redesign. This research demonstrated that while SLPs were amenable to working with assistants, there were some reported factors which contributed to more negative overall perceptions.
The importance of professional, organisational and economic issues was highlighted in Paper 1 and indicated the need for further research in order to define the scope of practice of the assistant role policies guiding their implementation. The presence and strength of paradox evident in participant accounts led to further investigation of the tension evident between positive and negative perceptions, and conditions which led to one or the other, as discussed in Paper 4.

This research identified the ambivalence in the perceptions of the majority of participants. This ambivalence is important in understanding the overall perceptions in the context of workforce redesign. Papers 1 and 2 highlighted that the goals and purpose of SLPs’ work were perceived as different to that of assistants and proposed that this may contribute to SLPs’ overall perceptions of working with assistants. The analysis in Paper 2 concluded that identification of differences between SLPs and assistants may assist in clarifying roles and practices and argued that employing organisations need to acknowledge and work with professions in light of such concerns. Research has indicated that empowered employees have greater organisational commitment and lower perceptions of uncertainty related to job security (Mishra & Spreitzer, 1998). Conversely, perceptions of degradation as a result of workforce redesign may impact upon uptake of new innovations (Kotter & Schlesinger, 2008). Therefore, an important contribution of the research was to identify fear of unknown factors and concern over potential loss of professional interests and autonomy in terms of workforce management.

Paper 5 makes an important contribution to the workforce literature by providing some definition relating to the speech-language pathology professional identity and highlighting the importance of this identity being understood and considered when planning workforce redesign for the profession. It is important to consider the role of professional identity and real or perceived threat to this identity in workforce redesign. There is well-documented evidence of identity conflicts stemming from workplace disputes (for example, job security), and how simplified stereotypes of identities lead to invalidation by outgroup members (Fiol, Pratt, & O’Connor, 2009). Additionally, Paper 3 illustrated that identification with the speech-language pathology profession is much stronger than identification as a member of the employing organisation. This makes an important
contribution to planning workforce redesign, in terms of uptake of innovation (Kotter & Schlesinger, 2008).
11 Additional contributions

11.1 Additional contribution 1 – Assistant literature review

11.1.1 Full citation

11.1.2 Contribution

Rural speech pathologists’ perceptions of working with allied health assistants:

A pilot study

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- The author would like to thank the participants who volunteered their time and valuable insights to contribute to this study
**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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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.
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 \cite{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 \cite{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 is 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 the 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 coordinators.

**Recommendation Three:**

Participants reported a 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 is 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 is
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.

**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\textsuperscript{[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\textsuperscript{[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\textsuperscript{[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\textsuperscript{[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.

**Background and literature review**

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 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
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**

**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. 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.

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. Speech Pathology Australia recommends a clinical governance framework include a definition of the AHA scope of practice, clear position descriptions and risk management plans. To date, there is no such framework for SP.

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. It seems that varied terminology has led to role confusion and a lack of role clarity between AHAs and allied health professionals.

The interest in an assistant health workforce over the past decade has resulted in clinician perceptions of pressure from services to utilise AHAs. 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. These stresses are rarely addressed through a clearly delineated role for AHAs as there are rarely well-defined role descriptions. 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 the supervisor may increase this likelihood. [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 coordinated plan for the implementation of an AHA program and a clearly
delineated framework of responsibility [28].

**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 an 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 are 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 the 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 a 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.

**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\textsuperscript{[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’)\textsuperscript{[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)\textsuperscript{[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\textsuperscript{[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\textsuperscript{[3, 21, 27]}. 

![Image](image-url)
**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 the 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].

**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) state 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) cite 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 \[^{[21]}\].

**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 \[^{[3, 21, 28]}\].

**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 a 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 were analysed for the seven broad content areas covered in the interview (as above), and further analysis of 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.

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 it's 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 were 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);

“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);

“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 postgraduate 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 postgraduate 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 be 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.

**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) cite 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) discuss; 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.

**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 coordinators.

**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 is 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 is 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.

References


3. Lowe, J., Grimmer-Somers, K., Kumar, S., & Young, A. *Allied Health Scope of practice role development in the wider allied health context: The allied health assistant (AHA)*. 2008, Centre for Allied Health Evidence, University of South Australia, Government of South Australia; Department of Health: Adelaide. p. 49.


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

6) What do you think about Allied Health Assistants in speech pathology?

7) Tell me about any previous experience you have had working with Allied Health Assistants (if any)? Were there positive things about this? Negative things?

8) 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**

9) In your area of work, which tasks could be performed by an Allied Health Assistant?

10) How do you see sharing of administration tasks with an Allied Health Assistant?

11) If this happened as you describe, how do you see it changing your role?

**Skills and Training**

12) What skills would an Allied Health Assistant need to have to work successfully with speech pathology in your area of work?

13) What skills do you feel would be necessary for a speech pathologist to have in working with and supervising an Allied Health Assistant?

14) Where could these skills be taught/learned (E.g. University / clinical placements / on the job)? Which would be the most practical in your situation?

15) What support do you think you would need for supervising and working with an Allied Health Assistant?

**Main issues**

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

17) 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:*

18) What are the main issues which make you feel this way?

19) Are these issues able to be addressed? How?
Values and Beliefs

20) How do you perceive your role as a speech pathologist in your area of work?

21) How do you perceive your role as a speech pathologist in your community?

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

23) 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

24) 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?

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

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

Industrial

27) How do you perceive your current job security?

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

29) 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 on 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
11.2 Additional contribution 2 – Poster presentation for Speech Pathology Australia national conference 2017

11.2.1 Full citation


11.2.2 Contribution

**Speech pathologists’ perceptions of working with assistants and consumer focus**

Rationale:
The speech pathology profession aims to create a more diverse and dynamic workforce in order to provide the best and most appropriate services for consumers. Working with assistants is one pathway that could provide the workforce support to allow speech pathologists to provide such services. However, there is some concern about implementing a vocationally trained workforce who shares some boundaries with the profession.

Aims:
The aim of this study was to understand the perceptions of speech pathologists (SPs) towards working with assistants in order to contribute to the future direction of the profession.

Method:
Semi-structured interviews were conducted with 20 SPs across NSW.

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<thead>
<tr>
<th>Drivers for change</th>
<th>Positive Focus</th>
<th>Negative Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer focus, clinical need</td>
<td>Economic</td>
<td></td>
</tr>
<tr>
<td>Workforce organisation</td>
<td>Professional inclusion in redesign</td>
<td>Organisation only</td>
</tr>
<tr>
<td>Role</td>
<td>Clarity of changing role</td>
<td>Downsize SP role</td>
</tr>
</tbody>
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Findings:
Factors were identified as influencing perceptions either positively or negatively (Table). Managing contrasting perceptions is necessary to reverse resistance to the introduction of an assistant workforce.

Conclusions:
While assistants were seen as adding to existing capacity by contributing to community need, findings demonstrated tension between perceived benefits and risks of utilising assistants. There were concerns that introducing assistants would result in decreased consumer focus, seen as being at odds with the strongly held values of the profession.

Findings provide insight into the way SPs think about working with assistants and likely areas of concern. This may assist shaping the implementation of the workforce by highlighting potential strategies to address such issues.

References:

11.2.3 Abstract

**Speech pathologists’ perceptions of working with assistants and consumer focus**

The speech pathology profession aims to create a more diverse and dynamic workforce in order to provide the best and most appropriate services for consumers. Working with assistants is one pathway that could provide the workforce support to allow speech pathologists to provide such services. However, there is some concern about implementing
a vocationally trained workforce who shares some boundaries with the profession. The aim of this study was to understand the perceptions of speech pathologists (SPs) towards working with assistants in order to contribute to the future direction of the profession. Semi-structured interviews were conducted with 20 SPs.

While assistants were seen as adding to existing capacity by contributing to community need, findings demonstrated the tension between perceived benefits and risks of utilising assistants. Sharing workload and reducing administrative duties in favour of increasing clinical output was an important positive perception. However, there were concerns that introducing assistants would result in decreased consumer focus, seen as being at odds with the strongly held values of the profession. Findings provide insight into the way SPs think about working with assistants and likely areas of concern. This may assist shaping the implementation of this workforce by highlighting potential strategies to address such issues and impact on how SPs view their role and relationships with co-workers.

**Key words:** Assistants, workforce, speech pathology, perceptions, consumers

11.2.4 Impact and engagement
11.3 Additional contribution 3 – Oral presentation to the Allied Health national conference 2017

11.3.1 Full citation


11.3.2 Abstract

Introduction: The speech-language pathology profession aims to create a more diverse and dynamic workforce to provide the best and most appropriate services for consumers. Working with assistants is one pathway that could provide the workforce support to allow speech-language pathologists (SLPs) to provide such services. However, there is some concern about implementing a vocationally trained workforce who shares some boundaries with the profession and factors that determine how assistants are utilised are not well understood.

Research question or problem addressed: To understand the perceptions of SLPs towards working with assistants and identify factors contributing to resistance.

Sources of information: Semi-structured interviews were conducted with 20 SLPs across NSW.

Findings: While assistants were seen as adding to existing capacity by contributing to community need, findings demonstrated the tension between perceived benefits and risks of utilising assistants. Sharing workload and reducing administrative duties in favour of increasing clinical output was an important positive perception. However, concerns that introducing assistants would result in decreased consumer focus was seen as being at odds with the values of the profession.

Discussion: Findings provide insight into the way SPs think about working with assistants and highlight the paradoxical nature of perceptions across SLP role, tasks and relationships.
Factors accounting for these perceptions include drivers for change, professional inclusion in workforce planning and role clarity. It highlights the need to understand ambivalence in SLPs’ responses to such a redesign and influencing factors while acknowledging the perception of risk in terms of professional status and consumer focus.

**Innovative contribution to policy, practice and/or research**

(100 words)

The success of health professions and organisations relies on a diverse and dynamic workforce capable of meeting the needs of health consumers. This study contributes to the understanding of polarisation of health professionals’ responses to the implementation of an assistant workforce and identifies factors accounting for such reactions. This is beneficial to policy and practice, in that it may contribute to the positive implementation and management of an assistant workforce, potentially increasing the demographic diversity of the health workforce. It also contributes to the research on workforce redesign and the studies of professional identities and subgroups in an organisational context.

**How the paper addresses one of the following themes: responsive services, reliable systems, resilient workforce**

(50 words)

Having a resilient workforce as diverse as the community is an important consideration in being responsive to clinical need. Assistants potentially increase demographic diversity of allied health professions allowing increased service sensitivity, contributing to alleviating workforce shortages, increasing service capacity and being a financially viable resource.
11.3.3 Impact and engagement

Retweets extending the reach of the presentations to an audience (external to the conference attendees) of around 1000 followers.

11.4 Additional contribution 4 - Poster presentation for Speech Pathology Australia national conference 2017

11.4.1 Full citation

11.4.2 Contribution

Working with assistants has become more common in the speech pathology profession internationally and is an opportunity to increase the breadth of services provided, as well as ensuring a responsive and demographically appropriate workforce. An essential role for professionals working with assistants is providing supervision and direction, requiring some modification to the traditional role and responsibilities of SPs. Despite this increasing prevalence and impact on role, little is known about the effect that working with assistants has on the SP professional identity.

Literature from professions with a more established history working with assistants suggests that professionals can perceive their expertise as not appropriately valued when changes to their role are introduced. These perceptions reflect a threat to professional identity, which is associated with increased turnover, and behaviour which aims to defend the professional role.

11.4.3 Abstract

Speech pathologists’ professional identity in response to working with assistants

Working with assistants has become more common in the speech pathology profession internationally and is an opportunity to increase the breadth of services provided, as well as ensuring a responsive and demographically appropriate workforce. An essential role for professionals working with assistants is providing supervision and direction, requiring some modification to the traditional role and responsibilities of SPs. Despite this increasing prevalence and impact on the role, little is known about the effect that working with assistants has on the SP professional identity. Literature from professions with a more established history working with assistants suggests that professionals can perceive their expertise as not appropriately valued when changes to their role are introduced. These perceptions reflect a threat to professional identity, which is associated with increased turnover, and behaviour which aims to defend the professional role.
The aim of this study was to explore perceptions relating to SPs’ professional identity in response to working with vocationally trained assistants. Semi-structured interviews were conducted with 20 SPs.

The SP identity that emerged indicated organised, strategic and ethical professionals with high standards of behaviour and practice. Findings suggest the introduction of assistants was perceived as a threat to this professional identity via real or perceived challenges to strongly held professional values, such as the importance of consumer focus. Consideration of the professional identity of SPs may contribute to understanding potential barriers to implementation of assistants, and impact on maintaining a positive employment relationship.
12 Appendices

12.1 Appendix 1: Ethics approvals and documentation

Copies of relevant ethics approval documents appear on the following pages;
12.1.1 Approval HNEHREC: Reference # 11/03/16/5.06 (7th March 2011)

7 March 2011

Ms R O'Brien
Speech Pathology
The Maitland Hospital

Dear Ms O’Brien,

Re: Rural Speech Language Pathologists’ perceptions of working with Allied Health Assistants (11/03/16/5.06)

HNEHREC Reference No: 11/03/16/5.06
NSW HREC Reference No: HREC/11/HNE/58
NSW SSA Reference No: SSA/11/HNE/59

Thank you for submitting the above protocol for single ethical review. This project was considered to be eligible to be reviewed as Low and Negligible risk research and so was reviewed under the by the Hunter New England Human Research Ethics Committee expedited process at an executive meeting held on 7 March 2011. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (2007) (National Statement) and the CPMP/ICH Note for Guidance on Good Clinical Practice. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee’s Terms of Reference are available from the Hunter New England Area Health Service website: http://www.hnehealth.nsw.gov.au/Human_Research_Ethics.

I am pleased to advise that following acceptance under delegated authority of the requested clarifications and revised Information Statements by Dr Nicole Gerrand Manager, Research Ethics & Governance, the Hunter New England Human Research Ethics Committee has granted ethical approval of the above project.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

- The Cover Letter for Managers (Version 1 dated 15 February 2011);
- The Information Statement for the Research Project (Version 4 dated 7 March 2011); and
- The Information Statement for Speech Pathology Students (Version 4 dated 7 March 2011)

For the protocol: Rural Speech Language Pathologists’ perceptions of working with Allied Health Assistants

Hunter New England Research Ethics & Governance Unit

(Locked Bag No 1)
(Locked Bag No 1)
New Lambton NSW 2305
Telephone (02) 49214 950 Facsimile (02) 49214 818
Email: hnehrec@hnehealth.nsw.gov.au
Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of 3 years from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

The National Statement on Ethical Conduct in Human Research (2007), which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is March 2012. A proforma for the annual report will be sent two weeks prior to the due date.

- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.

- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the investigator or his deputies considers the event to be related to the trial substance or procedure. These do not need to be reported to the Hunter New England Human Research Ethics Committee.
    - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Manager, Research Ethics & Governance, of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.
    - Serious adverse events are defined as:
      - Causing death, life threatening or serious disability.
      - Cause or prolong hospitalisation.
      - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
      - Unforeseen events that might affect continued ethical acceptability of the project.
• If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, as soon as possible.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact Dr Gerrand as per the details at the bottom of the page. The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Please quote 11/03/16/5.06 in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For:  Professor M Parsons
       Chair
       Hunter New England Human Research Ethics Committee
9 December 2011

Ms R O'Brien
Speech Pathology
The Maitland Hospital

Dear Ms O'Brien,

Re: Rural Speech Language Pathologists’ perceptions of working with Allied Health Assistants (11/03/16/5.06)

HNEHREC Reference No: 11/03/16/5.06
NSW HREC Reference No: HREC/11/HNE/58
NSW SSA Reference No: SSA/11/HNE/59

Thank you for submitting a request for an amendment to the above project. This amendment was reviewed by the Hunter New England Human Research Ethics Committee. This Human Research Ethics Committee is constituted and operates in accordance with the National and Medical Research Council's National Statement on Ethical Conduct in Human Research (2007) (National Statement) and the CPMP/ICH Note for Guidance on Good Clinical Practice. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review.

I am pleased to advise that the Hunter New England Human Research Ethics Committee has granted ethical approval for the following amendment requests:

- For the addition of Dr Rebecca Mitchell as primary supervisor/co-investigator;
- For the addition of Professor Vicki Parker as co-investigator;
- For the role change of Professor Alison Ferguson from primary supervisor to co-investigator;
- To reduce sample size for speech language pathologists from 30 interviews to 8 interviews;
- For further recruitment of new participant groups seeking permission to recruit 6 Allied Health Assistants from HNELHD and 6 speech language pathologists who are currently working with Allied Health Assistants;
- For the cover letter for Managers distributing information – Speech Pathologists’ perceptions of working with Allied Health Assistants (Version 2 dated 15 October 2011);
- For the consent for Managers distributing information – Speech Pathologists’ and Allied Health Assistants’ perceptions of working together (Version 1 dated 15 October 2011);
- For the Information Statement for Speech Pathology Students – Speech Pathologists’ perceptions of working with Allied Health Assistants (Version 5 dated 15 October 2011);
- For the Consent Form for Student participants – Speech Pathologists’ perceptions of working with Allied Health Assistants (Version 4 dated 15 October 2011);
- For the Information Statement – Speech Pathologists’ perceptions of working with Allied Health Assistants (Version 2 dated 15 October 2011);
- For the Consent Form – Speech Pathologists’ perceptions of working with Allied Health Assistants (Version 4 dated 15 October 2011); and

Hunter New England Human Research Ethics Committee
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Telephone (02) 49214 909 Fax number (02) 49214 619
Email: hnehrec@hneh.health.nsw.gov.au

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- For the Information Statement and Consent Form — Speech Pathologists' and Allied Health Assistants' perceptions of working together (Version 1 dated 15 October 2011);

For the protocol: Rural Speech Language Pathologists' perceptions of working with Allied Health Assistants

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of 3 years from the date of the approval letter of your initial application, after which a renewal application will be required if the protocol has not been completed. The above protocol is approved until March 2014.

Approval has been granted for this study to take place at the following sites:

- Hunter New England Local Health District
- Far West Local Health District
- Western NSW Local Health District
- Murrumbidgee Local Health District
- Southern NSW Local Health District
- Northern NSW Local Health District
- Mid North Coast Local Health District
- Illawarra/Shoalhaven Local Health District
- South Western Sydney Local Health District
- Sydney Local Health District
- Western Sydney Local Health District
- Northern Sydney Local Health District
- Central Coast Local Health District
- Nepean/Blue Mountains Local Health District

The National Statement on Ethical Conduct in Human Research (2007) which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is March 2012. A proforma for the annual report will be sent two weeks prior to the due date.

- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.

- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure.
• Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.

• Copies of serious adverse event reports from other sites should be sent to the Hunter New England Human Research Ethics Committee for review as soon as possible after being received.

• Serious adverse events are defined as:
  - Causing death, life threatening or serious disability.
  - Cause or prolong hospitalisation.
  - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
  - Unforeseen events that might affect continued ethical acceptability of the project.

• If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible.

The Hunter New England Human Research Ethics Committee also has delegated authority to approve the commencement of this research on behalf of the Hunter New England Local Health District. This research may therefore commence.

Should you have any queries about your project please contact Dr Nicole Gerrand as per the contact details at the bottom of the page. The Hunter New England Human Research Ethics Committee Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Hunter New England Local Health District website:
Internet address: http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit

Please quote 11/03/16/5.06 in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully,

For: Associate Professor M Parsons
Chair
Hunter New England Human Research Ethics Committee
12.1.3 Renewal HNEHREC: Reference # 11/03/16/5.06 (14th March 2014)

14 March 2014

Ms R O’Brien
Speech Pathology
The Maitland Hospital

Dear Ms O’Brien,

Re: Rural Speech Language Pathologists’ perceptions of working with Allied Health Assistants
(11/03/16/5.06)

HNEHREC Reference No: 11/03/16/5.06
NSW HREC Reference No: HREC/11/HNE/58
NSW SSA Reference No: SSA/11/HNE/59

Thank you for submitting the renewal application for the above project which was considered by the Hunter New England Human Research Ethics Committee at its meeting held on 14 March 2014. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research 2007 and the CPMP/ICH Note for Guidance on Good Clinical Practice.

I am pleased to advise that the Hunter New England Human Research Ethics Committee has granted ongoing ethical approval of the protocol: Rural Speech Language Pathologists’ perceptions of working with Allied Health Assistants

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of 5 years from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

Approval has been granted for this study to continue at the following sites:

- Central Coast Local Health District
- Far West Local Health District
- Hunter New England Local Health District
- Illawarra/Shoalhaven Local Health District
- Mid North Coast Local Health District
- Murrumbidgee Local Health District
- Nepean/Blue Mountains Local Health District
- Northern Sydney Local Health District
- Northern NSW Local Health District
- South Western Sydney Local Health District
- Southern NSW Local Health District
- Sydney Local Health District

Hunter New England Human Research Ethics Committee
Locked Bag 1
New Lambton NSW 2305
Telephone: (02) 49214050 Facsimile: (02) 49214838
Email: HNELHD-HREC@hnehealth.nsw.gov.au
Should you have any queries about your project please contact Dr Nicole Gerrand as per the contact details at the bottom of the page. The Hunter New England Human Research Ethics Committee Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Hunter New England Area Health Service website.

Please quote 11/03/16/5.06 in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For:  Professor M Parsons
      Chair
      Hunter New England Human Research Ethics Committee
12.1.4 Registration of external approval University of Newcastle: Reference # H-2009-0225 (8th November 2017)

RESEARCH INTEGRITY UNIT

Registration of External HREC Approval

To Chief Investigator or Project Supervisor: Professor Allison Ferguson
Cc Co-Investigators / Research Students: Doctor Nicole Byrne

Re Protocol: Rural Speech Pathologists’ perceptions of working with allied health assistants: A pilot study

Date: 08-Nov-2017
Reference No: H-2009-0225
External HREC Reference No: 08/12/17/4.03

Thank you for your Progress Report / Renewal submission to the Research Integrity Unit (RIU) seeking to register an External HREC Approval in relation to the above protocol.

Your submission was considered under an Administrative Review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is External HREC Approval Noted effective 08-Nov-2017.

As the approval of an External HREC has been noted, this registration is valid for the approval period determined by that HREC.

Your reference number is H-2009-0225.

PLEASE NOTE:
As the RIU has “noted” the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University’s RIU, via RIMS.

Linkage of ethics approval to a new Grant

Registered External HREC approvals cannot be assigned to a new grant or award (ie those that were not identified in the initial registration submission) without confirmation from the RIU.

Best wishes for a successful project.

Mr Alan Hales
Manager, Research Compliance, Integrity and Policy

For communications and enquiries:
Human Research Ethics Administration
Research & Innovation Services
Research Integrity Unit
Appendix 2: Participant Information Statements

12.2.1 Participant Information Statement for Phase 1

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 the 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 on 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
12.2.2 Participant information statement for Phase 2

FACULTY OF BUSINESS AND LAW

Dr. Rebecca Mitchell
Newcastle Business School,
University of Newcastle,
Callaghan, NSW, 2308
Phone: +61 2 49216828
Fax: +61 2 49216911
rebecca.mitchell@newcastle.edu.au

Information Statement for the Research Project:
Speech pathologists’ perceptions of working with Allied Health Assistants
Document Version 2: dated 15/10/11

You are invited to participate in the research project identified above which is being conducted by Rachael O’Brien, Dr. Rebecca Mitchell and Professor Vicki Parker from the faculty of Business and Law, and Professor Alison Ferguson and Dr. Nicole Byrne from the School of Humanities and Social Science at the University of Newcastle. The research is part of Rachael’s Research Higher Degree studies at the University of Newcastle.

Why is the research being done?
The purpose of the research is to identify the perceptions of speech pathologists to working with Allied health Assistants (AHAs). The project is based on a pilot study conducted through the Institute of Rural Clinical Services and Teaching. The information gained from the research will increase understanding of how 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.

Who can participate in the research?
We are seeking speech pathologists from within NSW to participate in this research. Speech Pathologists working within NSW Health, the Department of Ageing, Disability and Home Care (DADHC), tertiary facilities and the private sector are invited to participate.

What choice do you have?
Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

If you do decide to participate, you may withdraw from the project at any time without giving a reason. If you withdraw you have the option to also withdraw your data.

What would you be asked to do?
If you agree to participate, you will be asked to participate in a one-on-one interview. You will be asked:

- questions about your experience working with Allied Health Assistants
- your perceptions of any training/educational requirements for working with Allied Health Assistants,
- your perceptions of your role within a team
- demographics/information (e.g., area of work, i.e., acute, rehab etc., years working as a speech pathologist, postcode, full/part time basis, permanency)

Interviews will be conducted face to face if possible, by telephone, or by videoconferencing (if facilities are available) 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. Transcripts will be numbered and you will be given access to the numerical code of your transcript. You will be given the opportunity to review, edit or erase your own audio recording and the written transcript of your interview if you wish.

**How much time will it take?**
The interview will take about 1 hour to complete.

**What are the risks and benefits of participating?**
We cannot promise you any benefit from participating in this research. There are no risks to participating in this research.

**How will your privacy be protected?**
Any information collected by the researchers which might identify you will be stored securely and only accessed by the researchers unless you consent otherwise, except as required by law. 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. Identifying information will be ensured at transcription, where identifiers will be removed and replaced with a numerical code. You will be given a copy of this code. Identifiers will be permanently removed after transcripts have been checked. The demographics data and transcripts will be stored separately. 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*.

Data will be retained for at least 5 years at the University of Newcastle.

**How will the information collected be used?**
The information collected will be presented in a thesis which will be submitted for Rachael’s research higher degree. It is also expected that the data will be reported on in papers journals and conferences, to which participants will have access.

Individual participants will not be identified in any reports arising from the project.
You are invited to review the recording and/or transcripts to edit or erase your contribution.

What do you need to do to participate?
Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, please contact the researcher.

If you would like to participate, please contact me via phone or email to arrange a convenient time for the interview.

Further information
If you would like further information please contact Rachael O’Brien on 0419 610 515, or via email on Rachael.L.Obrien@uon.edu.au. Alternatively, you are able to contact Dr. Rebecca Mitchell on the contact details above.

Thank you for considering this invitation.

Rachael O’Brien
Research Higher Degree Candidate

Rebecca Mitchell
Chief Investigator

Complaints about this research
This research has been approved by the Hunter New England Human Research Ethics Committee of Hunter New England Health, Reference 11/0316/5.06. Should you have any complaints 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, Manager Research Ethics and Governance Hunter New England Local Health Network Human Research Ethics Committee, Hunter New England Health, Locked Bag 1, New Lambton NSW 2305, telephone (02) 49214950, email Hnehrec@hnehealth.nsw.gov.au
12.3 Appendix 3: Participant consent forms

12.3.1 Consent form for phase 1

Consent Form for the Research Project:

Rural speech pathologists’ perceptions of working with Allied Health Assistants

Rachael O’Brien, Associate Professor Alison Ferguson, Dr Nicole Byrne

I agree to participate in the above research project and give my consent freely. I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained. I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing. I consent to:

- participating in a face to face or phone interview regarding my perceptions of working with Allied Health Assistants and having it recorded on digital voice recorder

I understand that my demographic information will remain confidential to the researchers. I have had the opportunity to have questions answered to my satisfaction.

Print Name: ____________________________________________________________

Signature: ____________________________________________ Date: _________

Contact Details:

Phone: ____________________ Mobile Phone: _______________________

Email: _____________________________________________________________
12.3.2 Consent form for phase 2

FACULTY OF BUSINESS AND LAW

Dr. Rebecca Mitchell
Newcastle Business School,
University of Newcastle,
Callaghan, NSW, 2308
Phone: +61 2 49216828
Fax: +61 2 49216911
rebecca.mitchell@newcastle.edu.au

Consent Form for the Research Project:
Speech pathologists' perceptions of working with Allied Health Assistants
Rachael O'Brien, Dr. Rebecca Mitchell, Professor Vicki Parker, Professor Alison Ferguson, Dr. Nicole Byrne

Document Version 4; dated 15/10/11

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to;
  • participating in a face to face or phone interview regarding my perceptions of working with Allied Health Assistants and having it recorded on digital voice recorder

I understand that my demographic information will remain confidential to the researchers.

I have had the opportunity to have questions answered to my satisfaction.

Print Name: __________________________________________

Signature: ___________________________ Date: ___________

Contact:
Phone: ___________ Mobile Phone: ___________

Email: _______________________________
12.4 Copyright permissions

12.4.1 *International Journal of Speech-Language Pathology*

------Original Message------
From: Rachael O'Brien [mailto:Rachael.OBrien@hnehealth.nsw.gov.au]
Sent: den 14 januari 2013 02:00
To: Sonnerfeld, Per
Subject: FW: Permission

Good morning Per,
Regarding below, I would like to confirm with you some copyright permissions regarding my article 'Rural speech-language pathologists' perceptions of working with allied health assistants'. Production tracking number: TSL 759623.

I have accessed Sherpa and would like to confirm that I have understood correctly that I am able to deposit a post print copy of my article onto my University repository.

I have not been able to find information specifically relating to using the article in my thesis. I intend to submit my thesis in 2017, and would like to use the article as a chapter. Am I able to gain written permission to use the article for this purpose?

If I do receive permission from you for the above, do I still complete the copyright agreement form as it is, fill in a different form, or make changes to the current form?

Thanks in advance,
Rachael O'Brien
Dear Rachael,

I have been forwarded your e-mail below, regarding copyright permissions for your article 'Rural speech-language pathologists' perceptions of working with allied health assistants', to be published in the International Journal of Speech-Language Pathology.

Permission to include the article in your theses, as per your request below, is hereby granted - for non commercial use only.

Please sign and return the copyright form the regular way, and use this granted permission to use of the article in your thesis, should you ever receive any questions about it.

When it comes to your question about self archiving of the article, please see section C, 2 on the copyright form for the policy of this journal. You are indeed allowed to self archive the article on your university repository, but only after publication and only the submitted version of the article.

Please do not hesitate to contact me should you have any further questions.

Best wishes,
Therese

Therese Franzén
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### 12.4.2 Scandinavian Journal of Caring Sciences

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12.4.3 Journal of Clinical Practice in Speech-Language Pathology

Rachael O'Brien

Mar 8, 2018 - 1:01 pm AEST

Dear Leigha,

I'm looking forward to working together on my paper "The role of the speech-language pathology professional identity as a response to a workforce redesign" for the JCPofSL.

I am preparing to submit my PhD thesis (in 21 days!), and was hoping to discuss the copyright agreement with you. I have had the draft version of the paper in my thesis (which is by publication), and I'm hoping that I might be granted permission to still use the final version as a thesis chapter?

I'm available via this email, or on my mobile 0419610515 to discuss.

Many thanks in advance,

Rachael

JCPofSL Editor

Mar 16, 2018 - 3:24 pm AEST

Dear Rachael,

Thank you for your email and congratulations on being so close to submitting your PhD. How exciting! Yes you can absolutely still use the chapter in your thesis. If you are submitting in 21 days, it won't be the desktop published version that we can provide you with, but I will format the final version of your paper as per our copy editing guidelines and you are very welcome to include that. You can then just include the full reference for the article. I will send that along with the final version which I anticipate will get to you by the end of next week.

I hope this answer your query.

Warm regards,

Leigha
13 References


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