

Private Speech and Language Therapy Practices in Aotearoa – New Zealand

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ABSTRACT

Demographic and service provision information about speech-language therapists (SLTs) working in private practice in Aotearoa – New Zealand is limited. However, anecdotal reports suggest that the number of private practitioners appears to be increasing throughout the country. Apart from publically-available information related to the marketing of their services, no additional information was found to describe the demographics of this population, the services they provide or their perceived professional needs. Speech-language therapists working in private practice in Aotearoa – New Zealand were invited to participate in this study. A survey was developed and distributed electronically to SLTs working in private practice in Aotearoa – New Zealand. An estimated 150 clinicians had access to the survey. The survey consisted of both open and closed questions related to personal and practice demographics; professional supports and needs; knowledge and experience of evidence-based practice, and an open entry response. Forty-nine SLTs responded to the survey. Data was collated and analysed according to response type. A small selection of respondents (n=4) participated in follow-up interviews designed to further explore discussion points identified through the survey. Interview data was transcribed and analysed thematically. Findings suggested that SLTs working in private practice form a notable section of the speech-language therapy workforce. A wide variety of demographic information was reported. For example, only 2% of SLTs participating in this study identified as male and only one participant stated to be Māori. In Aotearoa – New Zealand, SLTs do not have to be registered with the national professional association (New Zealand speech-language therapists' association; NZSTA). As a result, there are limited guidelines for, and oversight of the services offered by SLTs in private practice. Although respondents indicated that they understand evidence-based practice, most received minimal formal training in this area. Participants also reported a number of professional needs such as increased networking with other SLTs, including those working in the public sector.

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1. INTRODUCTION

Demographic and service provision information about speech-language therapists¹ (SLTs) working in private practice in Aotearoa – New Zealand is limited. Anecdotal reports suggest the number of practitioners working privately has been increasing over a period of years. The lack of information available is partly due to the speech-language therapy profession not being recognized under New Zealand's the Health Practitioners' Competency Assurance Act (New Zealand Legislation, 2018). This means that practitioners are not required to register with a central regulating board similar to other allied health professions such as occupational therapists and physiotherapists. Similarly, membership of the New Zealand speech-language therapist's association (NZSTA) is not mandated. This information gap makes it difficult to monitor professional trends and to record the needs of the workforce. This study aimed to gain an in-depth understanding of private practice speech-language therapy services available in Aotearoa – New Zealand². This will be achieved by identifying the private practitioner workforce, obtaining information about the demographic characteristics of practitioners, as well as the scope of therapy services available, and the perceived professional needs of the private practice workforce.

This thesis begins with a brief review of the speech-language therapy profession, its history, positioning in the broader health and education fields, and current scope of practice. This is followed by a review of workforce-based research and descriptions of the international and national contexts. Clinicians' understanding and use of evidence-based practice is also explored and compared to other related professions.

¹ The term speech-language therapist is used as this is the current term for practitioners in New Zealand, Ireland and the United Kingdom. The term speech-language pathologist (SLP) is used in Australia, USA and Canada. The terms will be used interchangeably in this thesis.

² Aotearoa is the Māori language name for New Zealand. Both terms are used interchangeably and together in this thesis.

1.1. The History of Speech-Language Therapy

Speech-language therapy is a relatively young profession when compared to other related professions such as psychology and medicine. In fact, many older more established disciplines influenced the development of speech-language therapy; aspects of biology, psychology, medicine, physics, linguistics, rhetoric, and education are reflected within speech-language therapy. Before speech-language therapy was recognised as a profession in its own right, teachers and researchers were specialising in supporting individuals who experienced speech difficulties (Robb, 2010).

The movement towards the establishment of the speech-language therapy profession started in the United States of America (USA) and Europe through the work of a number of researchers and practitioners. Robb (2010), identified several of these individuals. John Thelwall (1764 – 1834) published a number of works looking at elocution, the acquisition of language, the anatomy of the speech organs, and the link between speech and mental illness. Thelwall classified speech disorders as being either natural (organic) or habitual (functional). Alexander Melville Bell (1819 – 1905) developed a transcriptional system known as 'visible speech', drawings that showed the physical movements behind the articulation of sounds. Bell later taught this system to teachers of the Deaf. Henry Sweet (1845 – 1912) developed the broad romic symbol system that later led to the International Phonetic Alphabet. Edward Wheeler Scripture (1864 – 1945) developed skills in hearing measurement such as threshold testing and magnitude estimation. Scripture also wrote a book that compared stuttering to lisping. Carl Seashore (1866 – 1949) built the first audiometer and developed the concept of decibels. Lee Edward Travis (1896 – 1987) is recognised as the 'founding father' of the profession; he specialised in the field of stuttering. From these pioneers in the early 20th century, speech-language therapy gradually became a recognised profession in many Western countries such as the United Kingdom (UK), Australia and New Zealand. The American Speech-Language-Hearing Association (ASHA) was founded in 1925 as the

American Academy of Speech Correction (ASHA, 2018b). The association now has approximately 198,000 members (SLPs, audiologists and researchers). The repatriation of injured returning World War II and subsequent conflict veterans with trauma affecting their ability to communicate also contributed to an increased need for SLTs (Robb, 2010).

Similarly, in the UK, SLTs were largely self-taught individuals from two main groups, those interested in oratory, who worked as elocutionists with a focus on speech correction, and medical practitioners with an interest in speech disorders resulting from organic causes until formal training was introduced (Royal College of Speech and Language Therapists; RCLT, 2018). The Central School of Speech Training and Dramatic Art established a Department of Speech Therapy in 1925, hospital-based schools of speech and language therapy were established in London in 1926 and 1932, and SLT education began in Glasgow in 1928, becoming formalised as the Glasgow School of Speech Therapy in 1935. From 1945, with the establishment of the College of Speech Therapists, a UK-wide three-year qualification became established at educational institutions across the UK. Early SLTs mainly worked in voluntary or independent (private) practice. Throughout the late 20th century they gradually came to be employed by education authorities, hospitals and special education schools, as well as by the National Health System (NHS; RCSLT, 2018).

In the UK, two professional organisations were formed in the 1930s, representing the two main types of SLTs at the time (RCSLT, 2018). The Association of Speech Therapists represented the artistic, while the British Society of Speech Therapists represented the medical groups of SLTs. Although they held differing views on the role of the SLT, the pursuit of competent practice was at the core of the professional identity for both of these organisations. Following the Second World War, the organisations agreed to amalgamate, leading to the establishment of the College of Speech Therapists in 1945. It was renamed the College of Speech and Language Therapists in 1991, and in 1995 was awarded the Royal title, becoming

the Royal College of Speech and Language Therapists (RCSLT) that we know today (RCSLT, 2018). The speech-language therapy profession had an early connection with the UK's royal family. King George VI had a therapeutic relationship with Australian speech teacher, Lionel Logue, from the 1920s to the 1940s. His royal highness awarded Mr Logue the honour of Commander of the Royal Victoria Order for his services. Mr Logue was one of the founding fellows of the unified College of Speech Therapists, and asked King George VI to become its royal patron (RCSLT, 2018).

Core speech-language therapy practice has changed significantly since the early days of the 20th century, largely due to clinical innovations and the application of new evidence in disciplines that underpin speech-language therapy practice, including medicine, psychology and linguistics (RCSLT, 2018). External societal changes, such as government policy on health and education and developments in technology, have also contributed to the radical development of the profession. Early client groups for speech-language therapy in the UK included people who stammer, people with aphasia, and children with cleft lip and palate. The number of client groups and clinical areas covered by SLTs has increased over the decades and continues to expand. Clinical areas of practice now include aphasia, autism spectrum disorder, cerebral palsy, cleft lip and palate, dementia, developmental language disorder, dysarthria, dysfluency, dysphagia, head and neck cancer and voice (Robb, 2010).

The number of SLTs internationally has risen, and is projected to continue rising as global populations increase in number and age. For example, in the USA, the number of SLPs practicing in 2016 was 145,100; this is expected to rise to 171,000 by 2026 (United States Department of Labour - Bureau of Labour Statistics, 2018). In Australia, it is estimated that the SLP workforce has increased from 5,295 in 1996 to 8,500 – 9,000 in 2017 (Speech Pathology Australia, 2016). In New Zealand, the estimated number of SLTs increased from 761 to 838

between 2012 and 2014 (New Zealand Ministry of Business, Innovation and Employment, 2012).

In New Zealand, the national association of SLTs is known as the New Zealand Speech-Language Therapists' Association (NZSTA). The NZSTA was first established in the 1940s to regulate and support SLTs practicing in Aotearoa – New Zealand. The NZSTA currently represents 826 members (NZSTA, 2018a). The association accredits speech-language therapy training programmes, provides professional development opportunities for members and confirms qualifications of migrant SLTs. In New Zealand, speech-language therapy training originally involved completing a postgraduate diploma after completing a teaching degree. Interestingly, SLTs who are currently employed in schools, to this day, are employed under the same contract as teachers, the Primary Teacher's Collective Agreement, and qualify to be part of the teacher's union, the New Zealand Education Institute (NZEI) as well as the NZSTA. Additional roles of the NZSTA include the development of a Code of Ethics and Scope of Practice.

1.2. Scope of SLT Profession

The scope of practice for the SLT profession is wide (NZSTA, 2012). Speech-Language therapists are health and education professionals that specialise in human communication sciences and disorders, including swallowing and associated disorders. They work with children and adults, assessing and providing treatment for both developmental and acquired communication disorders (Robb, 2010). For example, a SLT may work with children with a language delay and / or disorder, children who stutter, or children who have communication difficulties due to intellectual and / or physical disabilities. Speech-Language therapists may also work with adults who present with communication and / or swallowing difficulties due to degenerative diseases, for example, dementia, following a traumatic brain injury, or cardiovascular accident, as well as treating voice disorders (ASHA, 2016b and 2016c).

The NZSTA specifies a Scope of Practice (The Scope) for SLTs practicing in Aotearoa – New Zealand. The scope was developed according to the guiding principles from the ASHA, the Canadian Association of Speech-Language Pathologists, the RCSLT and Speech Pathology Australia, and aligns with the NZSTA's Code of Ethics (NZSTA, 2008). Together, the Scope and the Code of Ethics detail the skill-sets, base knowledge, professional attitude and ethical behaviour expected from practising members of the NZSTA. The Scope also states that New Zealand SLTs work within the framework of the World Health Organisation's International Classification of Functioning (ICF) for Disability and Health (WHO, 2018), which guides SLTs on their practice when working with the community. The Scope also acknowledges the unique Aotearoa-context specified by the Treaty of Waitangi / Te Tiriti o Waitangi, as well as the unique cultural diversity and languages used in Aotearoa. The Scope outlines the breadth of SLT professional practice carried out in New Zealand, including the population SLTs work with, services SLTs provide, rationale for why SLTs practice, the context in which SLTs practice, and the model of service provision. The following section outlines the diverse areas of practice that SLTs work in (NZSTA, 2018b).

1.2.1. *Specific Areas of Practice*

Alternative and Augmentative Communication

An increasingly common area of practice for SLTs is the provision of support for individuals who are unable to effectively express themselves verbally and who may rely on alternative and augmentative communication (AAC). The provision of AAC systems is often an effective treatment strategy for patients with complex communication needs (both children and adults; Khan et al., 2016). These AAC systems include both low-tech options (i.e., paper-based) and high-tech, electronic options (e.g., communication apps for tablets with voice output). Sutherland, Gillon and Yoder (2005) reported that low-tech AAC strategies (e.g., sign language) were the most commonly used in the treatment of New Zealand individuals with complex communication needs. However, they also reported that SLTs did not feel confident

implementing AAC systems and perceived a need for more AAC-specific training in order to be confident that the therapy they are providing aligns with evidence-based practice (Sutherland, Gillon & Yoder, 2005). In New Zealand, specialist AAC services are provided by the TalkLink Trust via contracts with the Ministries of Health and Education, and the Accident Compensation Corporation (ACC). TalkLink employs SLTs directly to provide services for clients of all ages (TalkLink, 2018).

Dysphagia (Swallowing Disorders)

Supporting individuals who experience swallowing difficulties is a key area of practice for many SLTs. Swallowing is a complex process that can be disrupted by many developmental disorders, injuries and diseases (Huckabee & Daniels, 2013). For example, dysphagia may result from a range of acquired neurological (e.g., stroke or tumour) and congenital / developmental (e.g., cerebral palsy or cleft palate) issues. Additional causes include conditions leading to obstruction in the throat or a narrowing of the oesophagus; e.g., mouth or throat cancer and pharyngeal pouches. Dysphagia can be caused by any condition that affects the muscles used to transfer food through the oesophagus and into the stomach. For example, when the immune system attacks healthy tissue, causing stiffening of the throat and oesophageal muscles. In addition, the muscles used for swallowing can become weaker with age, potentially explaining why dysphagia is relatively common in elderly people (Huckabee & Daniels, 2013). The role of SLTs includes supporting better identification of dysphagia, documenting nutrition and hydration, implementing dysphagia management techniques and supporting individuals and families to understand the risks associated with dysphagia (Lucas & Rodgers, 1998).

Speech and Language Disorders

Perhaps the most commonly perceived role of SLTs is the support for young children who experience difficulty acquiring speech and language skills (Owens Jr, 2015). Speech is how

words and sounds are produced by people. Speech problems may eventuate by not pronouncing words and sounds clearly, through a raspy voice, the repeat of sounds or additional pauses when speaking (i.e., stuttering). Language is the use of words to share ideas and communicate with other people. People who suffer from language disorders may have difficulty reading, writing and talking with others. Both adults and children can develop speech and language disorders due to a variety of reasons such as neurological causes (stroke, brain tumours) and congenital and developmental conditions (cerebral palsy and cleft lip and palate).

1.2.2. *Allied Health Professions and Contexts*

In Aotearoa – New Zealand, three broad professional groups make up the health and disability workforce. These are the medical, nursing, and allied health professions. The allied health professions work with individuals accessing health, education and disability services. Allied health professionals predominately work for publicly-funded institutions such as District Health Boards (DHBs) and the Ministry of Education (MoE). However, an increasing number of professionals work in private practice, or in public-private partnerships. For example, most ACC services are delivered through private practices (Allied Health, 2018). Most of the professions in this group are governed by a professional body that guides their professional practice and its members must be registered with this body in order to practice. Allied health professions include occupational therapists, physiotherapists, Dietitians, audiologists, behaviour specialists, and SLTs, among others. The following sections provide a brief description that differentiates allied health professions.

Occupational Therapists

An occupational therapist (OT) uses the theory of occupation (i.e., all the things humans do; self-care, looking after others, leisure, work, etc.) to improve the well-being and quality of life of their patients (Occupational Therapy New Zealand, 2018). Occupational therapists, much like SLTs, usually work in publically-funded sectors such as early intervention contexts,

schools, rehabilitation centres, and hospitals. In Aotearoa – New Zealand it is uncommon for OTs to work in private practice, therefore, demographic information for OTs working in private practice is sparse.

Physiotherapists

Physiotherapists assist their clients with physical difficulties that impair their movement due to ageing, disability, illness or injury (Physiotherapy Board of New Zealand, 2018a). Physiotherapists can be found working in public health such as hospitals, however, the majority work in private practices (Physiotherapy New Zealand, 2018). A report by the Physiotherapy Board exploring workforce supply projections through to 2035 stated that 4,042 physiotherapists were registered in Aotearoa – New Zealand in 2014; of those 1,327 were self-employed in private practice and a further 868 were working in a private practice as an employee and 1,171 stated to be working for public hospitals and health clinics (Physiotherapy Board of New Zealand, 2018b).

Dietitians

Dietitians evaluate and translate scientific evidence on food nutrition into practical strategies that promote health and well-being (Dietitians NZ, 2018b). They can work in a range of contexts, such as directing and delivering medical nutrition therapy services, supervising food and health systems, or promoting and protecting public health. Dietitians may work in a variety of roles, including communication, education, leadership, management, the development of government policy, or research. In Aotearoa – New Zealand, there are currently 600 dietitians registered with their professional body (Dietitians NZ, 2018a). In 2010 it was reported that most dietitians (267) worked for Hospital & Health Service / DHB, compared to 50 who worked in private practice (Ministry of Health, 2018).

Audiologists

Traditionally, the professions of audiology and SLT have been closely connected as many children and adults with hearing impairments also experience language and communication difficulties. Audiologists identify and quantify hearing impairments, plan a rehabilitation pathway, and assist hearing-impaired people to improve their quality of life. Audiologists can work in the public-, private- and educational-sectors delivering care or in research settings developing new knowledge and treatment options. Audiologists are associated with the education of the Deaf community and work closely with ear, nose and throat medical specialists. The practice blends the application of science and technology with health care (New Zealand Audiological Society, 2018a and 2018b). Audiologists usually work in hospitals or in audiology clinics. They may progress to management positions or establish their own practices. The New Zealand Audiology Society states that it currently represents more than 300 audiologists, many of which work in independent clinics (although a figure was not available).

Behaviour Specialists

Behaviour specialists provide positive-behaviour support to individuals whose challenging behaviour impacts significantly on their quality of life or the quality of life of the people around them (Health Care New Zealand, 2018). Allied health or education professionals who specialise in positive behaviour support can work as behaviour specialists, such as SLTs, OTs, psychologists, social workers and teachers. Behaviour specialists work across contexts to ensure a holistic approach to treatment. Explore Specialist Advice is the national provider of behaviour support services in New Zealand funded by the Ministry of Health (Health Care New Zealand, 2018). Some professionals named above who work in private practice may also offer behaviour support.

Multidisciplinary Teams

In health settings in particular, SLTs often work as part of multidisciplinary teams due to the complex nature of the work. In fact, van der Marck *et al.* (2009) state that in many areas of neurology, a multidisciplinary approach is common practice and urge this approach to be used when supporting individuals living with Parkinson's disease due to the impact this condition has on many aspects on a person's life. Insalaco, Ozkurt and Santiago (2007), asked final-year SLT, OT, and physiotherapy students who worked in a multidisciplinary team in stroke rehabilitation about their understanding of each other's roles. The students described a good understanding of each other's roles and described some of the positive aspects of working in a multidisciplinary team as the exchange of different ideas and participatory learning.

Speech-Language Therapy in Health Contexts

According to Bleile *et al.* (2006), approximately 40% of the American SLP workforce are based in health care settings, including hospitals and residential and non-residential health care settings, such as aged care facilities and supported living for individuals with intellectual disabilities; working across a range of areas, such as dysphagia (swallowing disorder), aphasia and AAC.

Speech-language therapists may also work in nursing homes and other long-term care facilities. It is a common occurrence for the elderly to experience social isolation caused by sensory loss and long-term care facilities, such as nursing homes, plenty of communication partners are available, but often potential opportunities are not being realised or of little therapeutic value. The SLT might provide therapy and / or staff training in these settings to increase the resident's quality of life (Erber, 1994).

Projected global population growth combined with disability rates appear to ensure that demand for speech-language therapy services will continue to increase. With approximately 10% of the global population (650 million people) having some form of disability (Robb, 2010). Due to a growing and increasingly aging population, demand for health and rehabilitation services is increasing; a shortage of SLTs and other specialists to meet the growing demand is predicted (Mashima & Doarn, 2009). According to Davey (2007), New Zealand has an ageing population, much like the rest of the developed world. It is projected that by 2036, around 1 in 4.5 New Zealanders (1,258,500 million) will be aged 65-plus; an increase of 77% or an additional 547,300 people compared to 2016. A related issue and potential challenge for service delivery is the distribution of populations between urban and rural contexts. In the 2006 New Zealand census, 69,786 people stated to live in highly rural / remote areas, challenging traditional provision of therapy (Statistics New Zealand, 2018d). Mashima and Doarn (2009) suggested that the use of tele-health may offer a possible solution to this problem. Nevertheless the demand for allied health services including speech-language therapy is likely to increase as the population grows and ages. Understanding the current level of services available in the private sector will form an important basis on which to develop models for future service needs.

Each of the allied health professions described above also have roles within the education system. Approximately 2 out of 5 SLPs in the USA worked in schools in 2016; most others worked in healthcare facilities, such as hospitals (United States Department of Labor - Bureau of Labor Statistics, 2018). Speech-language therapists work within the education system alongside a range of other professionals in addition to classroom teachers and other school staff. The following section briefly summarises some of these professions.

1.2.3. *The Education Professions*

Psychologists

Educational psychologists working for the MoE investigate, assess and work with children and youth who have difficulties that reflect in their behaviour, thoughts and emotions. An overarching aim of their work is to help children, youth and their families to develop to their full potential (New Zealand Psychological Society, 2018). Psychologists often work in private practice and individuals requiring their support pay privately, however, some psychologists may receive their funding from government agencies such as Oranga Tamariki and the Ministry of Health among others (New Zealand Psychological Society, 2018). Psychologists might work in the public sector for the Department of Corrections, DHBs, the Ministry of Defence, the police force, Psychological Services, Special Education within the MoE, or social welfare agencies such as Child Youth and Family. Psychologists practicing privately might provide services on an individual basis or in a group practice with other psychologists or other health professionals (The New Zealand Psychological Society, 2018). The Ministry of Health reported the total workforce in 2010 to be 1,345, with 438 being employed by DHBs, 106 in special education, and 407 in private practice (Ministry of Health, 2018).

Music Therapists

Music therapy involves provision of therapeutic activities based around musical instruments and activities (Music Therapy New Zealand, 2011). Music Therapy has been reported to be effective in developmental contexts by supporting language and intellectual development (Music Therapy New Zealand, 2011). The use of music and music therapy also has reported wider benefits for children and adults in supporting individuals and groups in times of loss, grief, and physical pain. Reported benefits include enhanced rehabilitation, extended movement, improved physical co-ordination, and a reduction of stress and tension (Music Therapy New Zealand, 2011). Additionally, music can enhance cultural and spiritual identity,

provide emotional support during times of change or crisis, improve memory, increase imagination and assist in processing thoughts.

Music therapy is provided by highly-qualified practitioners. In New Zealand, a Master's degree is required to become a music therapist. Interestingly, music therapy is a registered profession under the Health Practitioners Competency Assurance Act (New Zealand Legislation, 2018). New Zealand Registered Music Therapists (NZRMTh) must adhere to the Code of Ethics and have to undertake continued professional development and clinical supervision to maintain their registration. Music Therapy New Zealand is a member of the Allied Health Aotearoa New Zealand (AHANZ). No precise information is available about the number of registered musical therapists and their workplace settings in New Zealand. However, Music Therapy New Zealand lists 47 private music therapists on their website (Music Therapy New Zealand, 2011).

Speech-Language Therapy in Education

In New Zealand, there are two main employment opportunities for SLTs seeking a career in education; working for the MoE or working for special schools. Those SLTs working for the MoE provide services for students attending mainstream schools (Ministry of Education, 2013). Some SLTs will travel from school to school to provide therapy and work alongside the school's special education needs coordinator (SENCO). The nature of service delivery is mainly consultative; SLTs complete assessments and based on these assessments, advice what the teaching-team can do to support the student. For example, a SLT might assess a child who has autism spectrum disorder and provide the teacher, teacher aides, school staff and families with a series of intervention strategies (e.g., the use of visual communication strategies such as visual schedules and timers). The SLTs will provide training and education as part of this process, and attend meetings where appropriate. Intermittently, SLTs will provide one-on-one therapy, this also serves as demonstration to other educational staff; the focus is on up-skilling

staff (teachers and teacher's aides) supporting a particular student rather than providing one on one therapy sessions. Due to high case-loads, the frequency of contact is often intermittent.

The service mentioned above is available for children up to 8 years of age only; once a child turns 8, it is considerably harder to access free speech-language therapy; educational support may be available directly through schools as most schools have access to a special education grant that they can spend on, for example, specialist teachers (Ministry of Education, 2013). An exception to this is children on the Ongoing Resource Scheme (ORS) who qualify for free intervention until the age of 21. The majority of these children attend special schools, satellite classes that are run by special schools but located on the site of regular schools, or special education units in regular schools. Often, these education options employ their own SLT. Some children who receive ORS funding, attend regular classrooms in mainstream schools; often these children are seen by SLTs working for the MoE.

Children with significant communication disorders qualify for free services offered through the MoE. The criteria to qualify are as follows:

- Very difficult to understand.
- Significant language delay or disorder.
- Difficulty developing social skills (interacting with others).
- Have a stutter.
- Voice difficulty that makes it very difficult for them to communicate with other people

(Ministry of Education, 2013).

Schools that serve specific population groups are known as special schools. For example, a school that is dedicated to children who have complex physical, intellectual and behavioural needs. Most special schools employ their own SLT to support students and teaching staff (Ministry of Education, 2018). In special schools, SLTs often work alongside other

professionals, such as teachers, OTs, physiotherapists, and psychologists in an interdisciplinary manner.

Overall, teachers appear to have a positive opinion about speech-language therapy services; however, some teachers stated that they have some uncertainty the role of the SLT with certain student groups and the adequacy of their training in behaviour management, reading, multicultural issues, and teaching English as a second language (Sanger et al, 1995). Speech-language therapists in special schools are employed under the same contract as teachers, the Primary Teaching Collective Agreement, and can join the teacher's union (NZEI Te Riu Roa); other health professionals in schools are usually employed under a support worker contract. The role of SLTs in special schools is to reduce the impact that the students' communication difficulties have on their ability to access the curriculum. The SLTs in special schools often work in a consultative manner with teaching staff, whilst also being able to provide one-on-one therapy where required. The SLTs will attend Individual Education Plan (IEP) meetings and support the process of identifying and prioritising goals for the individual student. Most special schools acknowledge that good communication skills form the basis for all other learning (Hewett, Firth, Barber, & Harrison, 2011) and therefore place high value on speech-language therapy services. The SLTs in special schools adhere to the MoE's guidelines in terms of the service delivery model. Local Level Service Agreements (LLA) determine the responsibility regarding dysphagia management for students attending a special school; this may look different from region to region but usually the health SLT working for the Child Development Service (CDS) of the DHB completes the assessment and creates the management plan. The school-based SLT supports the implementation of the plan in the school setting and monitors its efficacy.

In the US, a critical shortage of SLTs working in public schools has been reported (Edgar & Rusa-Lugo, 2007). Even though SLTs enjoyed working with children in a school setting, stress

and burnout contribute significantly to the shortages of school-based SLTs (Ferney Harris *et al.*, 2008). Workload, role ambiguity, salary, and caseload were reported as being the main reason for low job satisfaction (Edgat & Rusa-Lugo, 2007).

Communication disorders often persist from childhood, through adolescence into adulthood (Paul & Norbury, 2012). This creates a need for speech-language therapy services throughout childhood, adolescence and adulthood. However there is very limited publically-funded support available to children after the age of eight. This is despite our knowledge that a communication disorder, regardless of its severity, may impact on a child's academic achievement or social wellbeing with often reaching into adulthood (Paul & Norbury, 2012). For children with less severe communication disorders, a short period of SLT intervention is often enough to foster their development and prevent negative long-term consequences (Paul & Norbury, 2012). This gap in speech-language therapy service availability often results in families of children who present with less severe communication disorders, or whose child is older than eight years of age, looking for alternatives, such as speech-language therapy private practitioners.

1.2.4. *Speech and Language Therapists in Research Settings*

Bleile *et al.* (2006) reported approximately 5% of SLTs in the USA work exclusively in research settings. Internationally, universities are the main employers of SLTs pursuing a research career. As practical experience is a requirement of SLT training, most universities have a publically-accessible clinic as part of their teaching and research programmes. Speech-language therapists in non-government agencies may also engage in research. An example from New Zealand is the Stuttering Research and Treatment Trust (START), that combines the delivery of treatment for stuttering with active co-ordination of and contribution to research projects (START, 2018).

1.3. Regulation of SLTs Internationally

Internationally, the SLT profession is subject to central or regional government regulation. In Ireland, private SLTs are registered with the Irish Association of Speech & Language Therapists (IASLT) and may also be member of Independent Speech Therapists of Ireland (ISTI; previously known as IASLTPP). According to information obtainable on their website, ISTI is a body established to assist private clinicians to maintain high standards of private speech-language therapy services to members of the public and to provide the public with a means to locate the qualified private therapist for their specific needs (ISTI, 2018). All members are also registered with CORU (the name CORU originates from the Irish word 'coir' meaning fair, just, and proper; it is not acronym) the body regulating Health and Social Care Professionals, and must have at least two years' experience before entering private practice (Independent Speech-Language Therapist of Ireland [isti], 2017). In the USA, SLPs and audiologists must be registered with the ASHA in order to practice (ASHA, 2018a). In the UK, the 'Association for Speech-Language Therapists working in Independent Practice' (ASLTIP) provides a platform for private practitioners; its members are registered members of both the RCSLT and the Health and Care Professions Council. Registration with the Health and Care Professions Council for therapists has been compulsory since 2000 to help ensure members provide evidence-based services. Australia and New Zealand are the only Southern Pacific countries with established speech-language therapy professions. In Australia, SLPs must be a member of their professional association, Speech Pathology Australia, in order to practice.

In Aotearoa – New Zealand, speech-language therapy is not a registered profession and membership of the NZSTA (New Zealand's professional SLT body) is not mandatory in order to practice. However, most employers do require SLTs to be eligible for NZSTA membership. To be eligible for membership, the clinician must have completed a recognised degree in speech-language therapy. For example, a BSLP (Hons) or MSLP from the University of Canterbury, a BSLT from Massey University or a MSLT(Prac) from the University of Auckland.

Some employers require clinicians to be members of the NZSTA as this ensures they undergo regular supervision, adhere to the Code of Ethics and aim to implement evidence-based best practice. Neither of the above applies for clinicians working in private practice. No data in regards of the nature of accessing sources to support evidence-based practice for SLTs in New Zealand – especially those working in private practice – is available. Some SLTs working in Private practice who are also part on NZSTA, have set up a Special Interest Group (SIG), this group serves as platform to share resources and conduct peer supervision. Members of the NZSTA have to provide proof of engaging in continued professional development (CPD) by submitting a CPD log.

1.4. Evidence-Based Practice

The term evidence-based practice (EBP) originated from the medical professions and is described as a form of clinical decision making that combines current best evidence, clinical expertise, and client's values to ensure the best possible therapy provision and outcome for the client. (Ratner, 2006). Sackett *et al.* (2000) described EBP as the conscientious use of current best evidence in making decisions about patient care. Melnyk & Fineout-Overholt (2014) define it as a problem-solving approach to practical practice and administrative issues that integrates three main points:

1. A systematic search for the most relevant evidence to answer a question and its critical appraisal.
2. The use of one's own practical expertise.
3. Incorporating patient preferences and values.

(Melnyk & Fineout-Overholt, 2014)

The ASHA describes EBP as an approach in which current, high-quality research evidence, practitioner expertise, and client preferences and values are combined when making clinical decisions (ASHA, 2005). Although the definition of EBP is well documented and may appear

straightforward, its application when practicing is often difficult to achieve (Ratner, 2006). In order to provide high-quality health-care, clinicians should aim to implement EBP (Vallino-Napoli & Reilly (2004). Ratner (2006) investigated the transition of EBP to clinical practice in the area of speech-language therapy and found that:

“events experienced by other disciplines raise questions about defining acceptable forms of evidence for treatment effectiveness and efficacy, the potential roles of nonspecific or common factors, therapist quality in achieving therapy outcomes, and eventual applications of EBP that may overly confine which treatments are considered acceptable and reimbursable” and came to the conclusion that “bridging between research evidence and clinical practice may require us to confront potentially difficult issues and establish thoughtful dialogue about best practices in fostering EBP itself”.
(Ratner, 2006: p. 1)

Metcalfe *et al.* (2001) examined clinicians' attitudes to research and the barriers to implementing EBP in four professions; dietitians, OTs, physiotherapists and SLTs. The majority of clinicians agreed that implementing research findings was important when providing therapy. However, clinicians also identified some of the barriers that makes this difficult to achieve. Barriers fell into two categories: 1) Problems with literature; and, 2) institutional barriers. Problems with the literature were individuals' inability to understand the statistics used, literature not being assembled in one place (i.e., a lack of review articles), implications for practice not being made clear, results that conflict, methodological problems, a lack of replication and poor generalisability (Metcalfe et al., 2001). Institutional barriers included inadequate facilities, insufficient time, isolation from colleagues and doctors not co-operating with change. They concluded that clinicians valued research findings, but had problems accessing and understanding the literature, which was perceived as flawed and incomplete. This suggests a need for improvements being made during clinicians' education and a need to make research more accessible for clinicians.

1.5. Code of Ethics

Speech-language therapists across the world, as with all health professionals, must adhere to a professional code of ethics in order to work in an ethical manner that safeguards the welfare of clients (Robb, 2010). Ethics are the moral principles that govern a person's or an organisation's behavior (Speech-Language and Audiology Canada, 2016). The code of ethics for Speech-Language and Audiology Canada (SAC) were developed in accordance with the principles of biomedical ethics as outlined by Beauchamp and Childress (2001). These include:

1. Respect for autonomy;
2. Beneficence: Balancing the benefits of intervention against the risks and costs. The member or associate should act in a way that benefits the patient or client;
3. Non-maleficence: Avoiding the causation of harm. If intervention involves even minimal harm, the harm should not be disproportionate to the benefits of intervention;
4. Justice: Ensuring that patients or clients in similar situations are treated in a similar manner.

Most health professionals adhere to a code of ethics when practicing (Allsop, & Saks, 2003). The code of ethics is a framework and focused guide to advise professionals on their expected conduct and to support day-to-day decision making (ASHA, 2018a).

In 2004 Vallini-Napoli and Reilly, set out to explore how SLTs in Victoria (Australia) seek information, identify possible barriers interfering with this process, the sources of evidence that guide SLTs practice, and their attitude towards research; they sent out a questionnaire to 697 SLTs of which 54% responded. They found that the majority of SLTs were familiar with the term EBP and acknowledged the importance of research. All SLTs stated to have access to evidence, however, many reported that they infrequently accessed these sources due to time constraints.

For SLTs practicing in Aotearoa – New Zealand, the NZSTA requires all clinicians to comply with its “Principles and Rules of Ethics”; the NZSTA notes that ethical practice and professionalism are integral values for its members to adhere to. The before-mentioned document guides the practice of clinicians along with providing a framework to review possible breaches of ethical practice and is also used by the NZSTA’s Ethical Committee. The document outlines five Principles:

- “Beneficence and non-maleficence: The goal of clinical practice is to enhance the wellbeing of clients / families. SLTs will prevent harm and not knowingly cause harm” (ASHA, 2016a: p. 1)
- “Professional Competence: SLTs have the responsibility to achieve and maintain the highest level of professional competence and performance” (ASHA, 2016a: p. 2)
- “Promotion and Development of the Profession: SLTs have a responsibility to support the development of speech-language therapy as a profession and to promote public understanding of the profession” (ASHA, 2016a: p. 2)
- “Professional Integrity: SLTs will act honestly, consistently and in a trustworthy manner with all clients, colleagues and professionals” (ASHA, 2016a: p. 3)
- “Fairness: SLTs have a responsibility to work in a way that is fair to all” (ASHA, 2016a: p. 3)

1.6. Cultural Considerations for SLTs Practicing in Aotearoa

Speech-language therapists working in Aotearoa – New Zealand must adhere to the Treaty of Waitangi. For Māori, language is toanga (a precious treasure), and its loss can, therefore, be detrimental to the wellbeing of the individual and their whānau (Walker, 2004; McLellan *et al.*, 2013). Brewer *et al.* (2014), recognised that how someone with aphasia (a language impairment caused by an injury and affecting the production or comprehension of speech and

the ability to read or write) experiences this condition is influenced by their culture. In order to provide effective treatment, they proposed that SLTs must understand the impact on aphasia from their client's perspective. Brewer *et al.* (2014) explored the effects of aphasia on Māori and their whānau (extended family) and found that aphasia may have a significant effect on roles and relationships within their whānau. Brewer *et al.* (2014) also found that whilst there are some inherent difficulties, people with aphasia can meaningfully participate in their community with the active support of whānau.

The New Zealand Disability Strategy states that disability services should be accessible to and culturally appropriate for disabled Māori and their whanau (Office for Disability Issues, 2016). However, it is not yet well-established in the SLT field what makes their service 'accessible' and 'culturally appropriate'. Brewer *et al.* (2015) assessed the service provision for Māori with aphasia and SLTs' perceptions of what an 'accessible' and 'culturally appropriate' service entails. Three factors determined the service provided to Māori with aphasia: 'individual clinician factors', 'resources' (human and non-human), and 'ways of working'. Individual clinician factors included the clinician's knowledge, attitudes, and willingness to make connections. 'Resources' included the people, funding, assessments, and available therapy materials. 'Ways of working' included team culture, expectations, timing and location of SLT appointments and session content. Because these factors vary between the different regions of Aotearoa, the service provided to Māori with aphasia for variable. The results showed that SLTs strive to provide an accessible service that is culturally appropriate for Māori with aphasia (Brewer et al, 2015). Understanding the services available to support culturally and geographically diverse populations is essential to the ongoing development of the profession and support for clients.

1.7. Speech-Language Therapists in Private Practice

International data suggests that SLTs are increasingly likely to work in private practice contexts. Data from the USA states about 5% of SLPs reported to work in private practice part- or full-time (Bleile, Ireland, & Kiel, 2006). Within 10 years this figure had increased to 19% of SLPs (United States Department of Labour - Bureau of Labour Statistics, 2018). Similarly, 62.5% of members of Speech Pathology Australia state that at least some of their work is private practice-based (Speech Pathology Australia, 2017). In Germany, most clinician's work in private practice as most privately obtained health insurances cover speech-language therapy; only a small number of SLTs work in the public system (Deutscher Bundesverband für Logopädie, 2017). A similar situation is being anecdotally reported in other countries. Although no exact number is available for the UK and Ireland, both countries have associations specifically to support independent practitioners.

The ASHA regularly conducts surveys of private SLP practices and collates this information in a publicly-accessible report. The latest available report from 2015 includes the following highlights:

- 97% of clinicians held a Master's degree; the minimum degree required to practice.
- A median of 19 years of experience.
- Respondents worked mostly in the health sector.
- 37% of respondents worked part-time and 64% full-time.
- Respondents worked predominantly with paediatrics, including infants, toddlers, pre-schoolers and school-aged children (53%), treating language and articulation / phonology disorders.
- 47% worked with adults, mainly focusing on dysphagia and aphasia.
- Respondents who were practice owners reported working between 1 – 50 hours each week with a medium hourly wage ranged from \$43 to \$50; home visit charge out rates were reported to average \$70

- Private practitioners are often reimbursed for their services via public and private health plans.
- Direct invoicing to clients was reported as the most common source of payment. (ASHA, 2015)

Similar to ASHA, Speech Pathology Australia regularly surveys its members. However, no private practice-specific survey has been reported by Speech Pathology Australia. A stimulus paper that developed as a starting point for the project “Speech Pathology 2030: Making futures happen” revealed the following about the Australian SLP workforce (Speech Pathology Australia, 2016):

- 2.3% were male.
- Nearly half are under the age of 35.
- Only 17.6% speak a second language, compared to 23% for the general Australian population.
- Most hold Australian citizenship.
- Only 19 members identify as Aboriginal and/or Torres Strait Islander; at least ten times this number would be needed to be representative of the broader Australian community demographics.
- The highest level of educational attainment of most SLPs was a Bachelors Degree (79%). However, an increased number of clinicians were noted as holding a postgraduate degree.
- 38% are employed by the public sector; only a small proportion work in non-government organisations (5.3%) and academia (0.3%).
- A number of SLPs worked across more than one context.
- In 2011 the majority of SLPs were working part time, at an average of 30 hours per week. Average hours worked was lowest for 35-44 year olds, at 26 hours. In 1996, 55-64 year olds worked an average of 25 hours per week. In 2011, this increased to

31 hours. Similarly, across the same period, those older than 65 years increased their average weekly hours from 8 hours to 21 hours.

Although this international data is of interest, there is a lack of specific data about SLTs working on Aotearoa – New Zealand. What is known is there are currently 55 private therapy practices advertised on the NZSTA website. Many of these are likely to consist of more than one SLT, therefore the precise number of SLTs working in private practice in New Zealand is unknown. To ensure SLTs in Aotearoa – New Zealand meet the needs of the individuals requiring speech-language therapy, it is essential to understand the true extent of private speech-language therapy services and clinicians offering services in New Zealand.

1.8. Summary

In summary, this review has provided an overview of the SLT profession around the world, paying particular attention to the history of the profession, the scope of the profession, preservice training and entry requirements, regulation of SLTs, evidence-based practice, the code of ethics, and cultural considerations for SLTs practicing in Aotearoa – New Zealand, focusing on SLTs in private practice. International data and anecdotal reports suggest that the number of SLTs providing private practice services is significant and increasing. It is important to have accurate and up-to-date data about professional services available. As speech-language therapy is not a registered allied health profession in New Zealand, specific data is limited. There is an urgent need to describe the scope of speech-language therapy services available through private practitioners and the professional needs of this group of professionals. This study aims to address this need.

The research questions underpinning this study were:

1. What are the demographic characteristics of private practice SLTs working across Aotearoa – New Zealand?

2. What is the scope of private practice speech-language therapy services available in New Zealand?
3. What are the perceived professional development and supervision needs and supports of private practice SLTs?
4. What is the respondents' understanding and use of evidence-based speech-language therapy practices?

2. METHODS

2.1. Ethics

Ethical approval for the study was obtained from the University of Canterbury's Human Ethics Committee. See Appendix 1 for a copy of the ethics approval letter.

2.2. Study Design

This study employed a mixed-method approach in order to answer the research questions. Firstly, a quantitative survey tool was developed for distribution to private practice SLTs working in Aotearoa – New Zealand. Second, a small subset of survey respondents participated in semi-structured interviews in order to further explore the research questions and the issues raised in survey responses. The following section describes the development of the survey instrument.

2.2.1. *Survey Development*

An online survey using Qualtrics® software was developed. See Appendix 2 for a full list of survey questions. According to McBurney (2001), using open-ended questions makes it more likely to discover something not anticipated by its designers as it allows respondents to answer in their own words. Closed questions on the other hand are designed to make it easier and faster for the respondent to answer and allow for greater efficiency analysing findings. Both quantitative (e.g., demographic and service provision information) and qualitative data (e.g., respondents perceived professional needs) were sourced using both open-ended and closed questions. Open-ended questions were mainly used to allow respondents to extend on the answer of a closed-ended question.

The survey consisted of six main sections with example questions were:

1. Demographic Information of Participants (e.g., age, gender, and year of graduation)
2. Practice Information: (e.g., “What was the main reason for entering private practice?”)
3. Professional Supports and Needs (e.g., “Are you member of the professional body, NZSTA, and what do you see the key benefits to be?”)
4. Evidence-Based Practice (e.g., “Please explain what the term ‘Evidence Based Practice’ means to you”)
5. Professional Needs (e.g., “What supports do you wish you had?”)
6. Open Feedback (e.g., “Is there anything else you want to share?”)

2.2.2. Pilot Survey

A pilot of the survey was reviewed by the author’s supervisors (experienced SLTs) and three SLTs working in private practice in New Zealand. Feedback included a preference for closed questions to support the ease and speed of survey completion and the inclusion of a section on fees charged for services. Their feedback was integrated in the final survey (see Appendix 2 for full list of survey questions).

2.3. Survey Distribution

Considerable effort was made to identify and send the survey to all SLTs working in private practice in Aotearoa – New Zealand. To maximise the exposure of the survey to potential respondents, the author conducted online searches for private SLT practices. Example search terms used during the online searches were “speech language therapy” and “New Zealand”. Additional search strategies included the Yellow Pages® directory, and listings in newspapers, as well as viewing the listings on the NZSTA website. Furthermore, the author contacted the manager of the NZSTA’s Special Interest Group for SLTs working in private practice and asked her to inform members about the upcoming survey and enquire who may be able to partake in

this important study. The final survey was distributed via a link posted in the Facebook® group “SLTs in Private Practice NZ” which has over 150 members, and via a link e-mailed to the SLTs identified in the searches described above.

2.4. Survey Data

Responses to the survey were collated via the Qualtrics® system. Quantitative data was tallied within response categories, relating to the four overarching questions this study sought to answer. Each one of these overarching questions consisted of multiple sub-questions (e.g., for overarching question 1, responses to a total of 6 questions were analysed). Responses to open questions were collated and analysed for themes. For example, when participants were asked if there was anything else they would like to share, themes such as “frustrations with the public system” and “the wish for greater networking” were identified.

2.5. Interviews

Forty-seven survey respondents indicated they were available to participate in follow-up interviews (see Appendix 3 for interview questions). The intention was to select a small random sample to interview in order to further explore several points highlighted by the survey responses. Four participants were randomly selected and approached to be interviewed (see below for relevant demographic information). A focus of these interviews was participants’ understanding of EBP and engagement in professional development opportunities to support their provision of services. Interviews were conducted over the telephone or in-person.

2.6. Transcription and Data Analysis

In order to identify the themes and questions asked during the interview, transcripts from the survey were read over and initial themes identified. Transcripts were then re-read and themes finalised. The themes identified and reported in the results section are likely to have

implications for SLTs working in private practice, the NZSTA, and the speech-language therapy profession in New Zealand. All interviews were recorded using a Samsung Galaxy Note 8 and then transcribed. See Appendix 3 for the guiding questions used in the interviews. Data were analysed thematically and conclusions drawn. Implications of the survey results were discussed.

3. RESULTS

3.1. Survey Findings

A total of forty-nine people agreed to participate and started the survey, however, not all participants answered all questions; therefore, the number of responses for each question varied slightly. For example, only 38 participants gave information regarding the fees charged for their services. Data from a total of 49 surveys were analysed. This includes 26 partially completed surveys.

3.1.1. Demographic Information

What age and gender were participants? (n=48)

A majority of participants (48%, n=22) stated to be between 40 and 49 years old (Table 1). Only 2 participants identified as male and 46 as female.

Table 1. Age distribution of survey participants.

Age Group	Number of Participants
20 – 29	5
30 – 39	11
40 – 49	22
50 – 59	8
60 – 69	2
Total	48

What is the ethnicity and status of citizenship of participants? (n=48)

The majority of participants identified as New Zealand European (67%, n=32); only one participant as Māori. Other ethnicities mentioned were Indian (n=2), British (n=7), Australian

(n=3), Canadian (n=1), and Asian (n=1). Forty-two of the participants who answered this question stated to be a New Zealand citizen (88%).

What languages do participants speak? (n=48)

The majority of respondents (98%, n=47) stated English; one participant stated German as their primary language. Ten participants reported speaking more than one other language; some added “not fluent” to their answer, however, these responses are still reflected in the answer.

What is the most recent qualification of participants? (n=47)

Thirty-six participants (77%) stated that their most recent qualification was an undergraduate degree (i.e., a Bachelors degree) and eleven participants (23%) stated to hold a Postgraduate Masters degree. No participant indicated holding a PhD.

At what educational institute did participants complete their training? (n=48)

Participants were given the opportunity to select between the three Universities who offer degrees in Speech-Language Pathology / Therapy in New Zealand or select ‘overseas’ when they did not train in New Zealand. Twenty-nine participants (60%) stated to have completed their training at the University of Canterbury; two participants stated that they completed a Speech-Language Therapy training alongside their Teaching Degree at the Teacher’s College in Christchurch prior to speech-language therapy becoming a specific Bachelors degree. Sixteen participants completed their degree outside of New Zealand, and one participant at the University of Auckland.

When did participants graduate? (n=48)

The majority of participants (72%, n=34) graduated between 1991 and 2010 (Figure 1). Six of the participants stated to have graduated between 2011 and 2015 which means they had less than 10 years' experience at the time this study was completed. One person answered "2019", this response has not been included as the survey was completed during 2017.

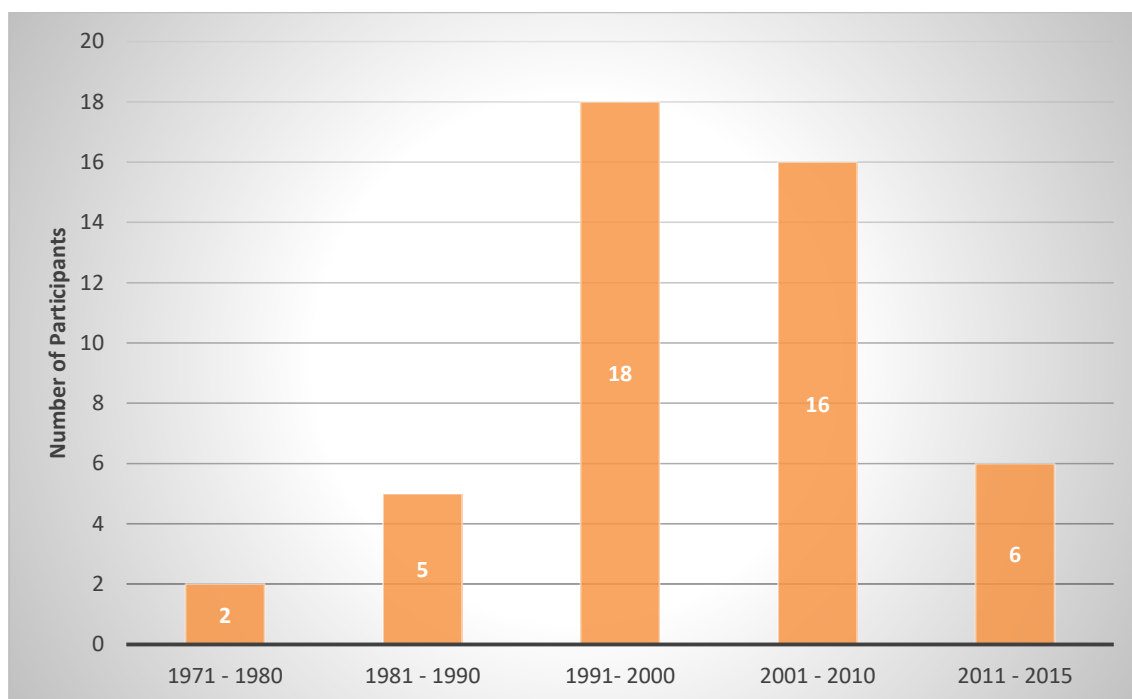


Figure 1. Graduation year reported by participants.

3.1.2. Practice Information

When did participants enter private practice? (n=48)

A sharp increase in SLTs entering private practice was observed between 2000 and 2017 (Figure 2). Interestingly, this coincides with the year(s) most participants graduated, suggesting that a large number of SLTs entered private practice soon after graduation.

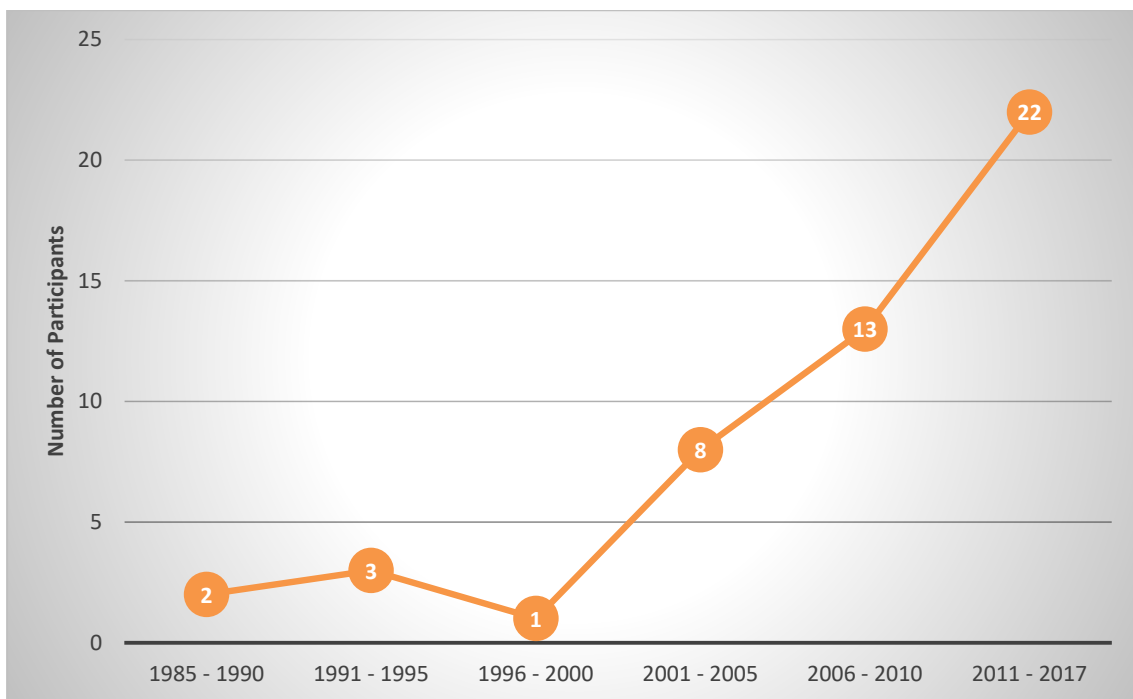


Figure 2. Year of entering private practice.

Do participants work full- or part-time on private practice? (n=44)

Fifteen participants stated to work in private practice full-time, whilst the majority (66%, n=29) stated they worked part-time (in private practice). This number aligns with Australia, where the majority of SLTs working in private practice also state to be working part-time. Seven of the participants who stated they work part-time in private practice also work somewhere else; the MoE and special schools were reported as other place of employment by two participants each; followed by DHBs, universities, and non-profitable trusts which were mentioned by one participant each.

What was the main reason for participants to enter private-practice? (n=49)

All participants gave more than one reason. The majority of participants (46%, n=27) reported that their main reason for entering private practice was “flexibility around other commitments”. “The ability to provide evidence-based practice to all who would benefit from it in the way I want to; without restrictions forced upon me” and “no other jobs available / supplementing part-time employment” was given by twelve participants each (25%). Other reasons included the variety of caseload, personal challenge and financial rewards (Figure 3).

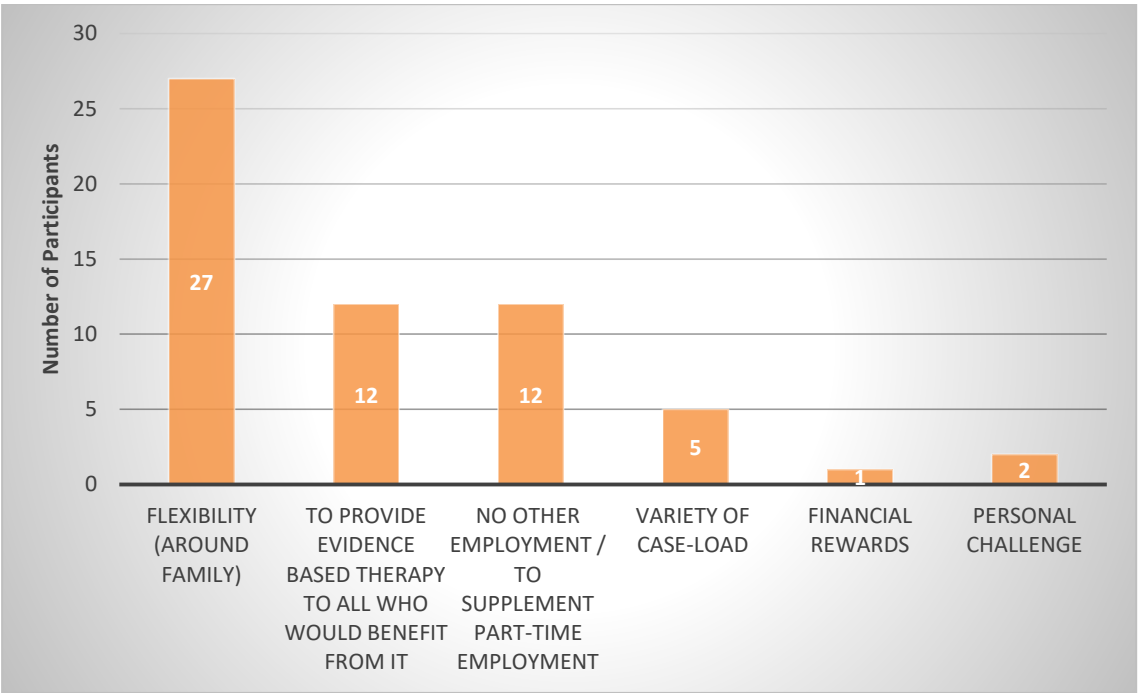


Figure 3. Reasons for entering private practice.

What areas do participants service? (n=49)

It appears that a number of SLTs are servicing more than one geographical area (Figure 4). Private practices are represented across all areas of New Zealand, with the West Coast (of the South Island) being the only exception. Not surprisingly, the area with the most practices was Auckland, New Zealand's largest city.

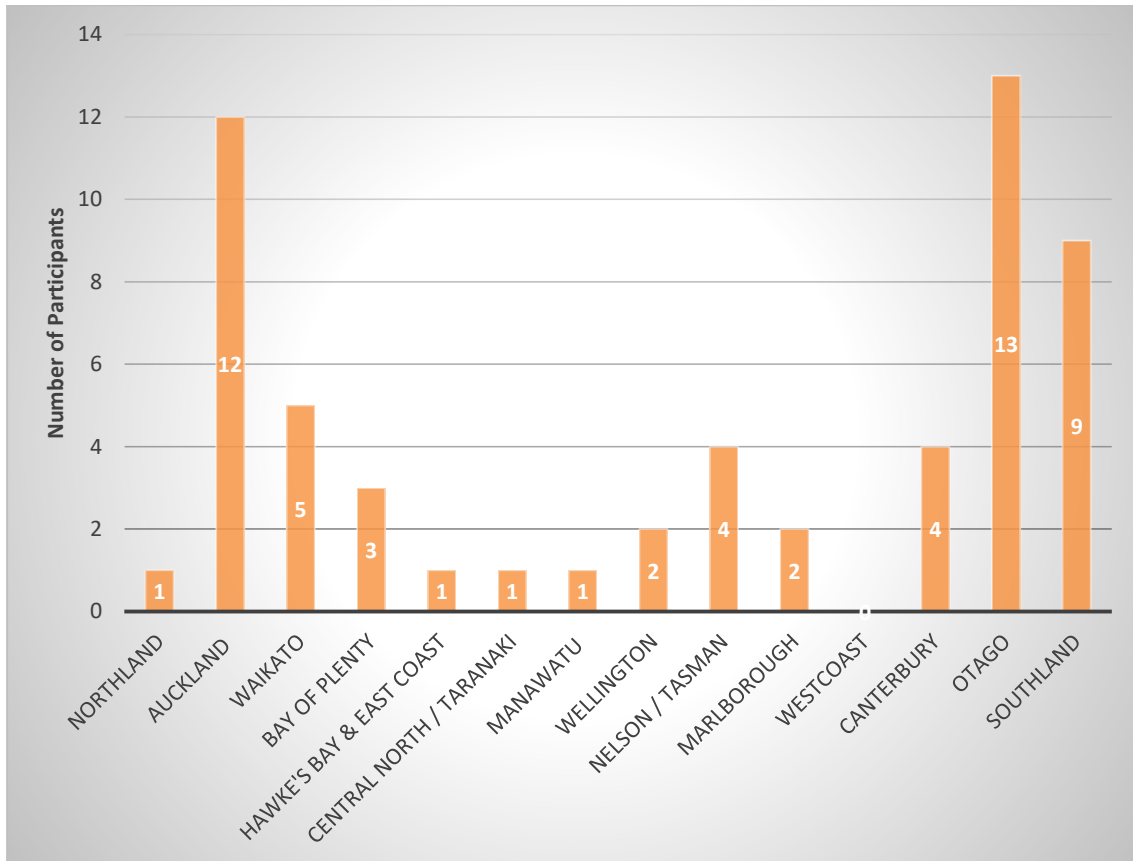


Figure 4. Areas serviced by private speech language therapists.

Where are clients seen? (n=46)

The majority of participants (54%, n=25) stated that they see clients at their practice and in the client's everyday environment (school / home visits). Sixteen participants stated seeing clients at home / school only and five participants see clients exclusively at their clinic. For participants who see clients in both environments, the home / school to clinic ratio was 3:2.

Employment status? (n=41)

The majority of participants (76%, n=31) stated to work by themselves; eleven identified as being practice owners who have employees and six participants stated that they were presently employed by an SLT in private practice. Eight of the eleven practice owners shared whom they were employing. Seven stated to employ SLTs only with one participant stating 'other'.

What are the sizes of practices? (n=7)

Seven practice owners who employ other professionals shared how many staff they employ and the correlating full-time equivalent (FTE; Figure 5).

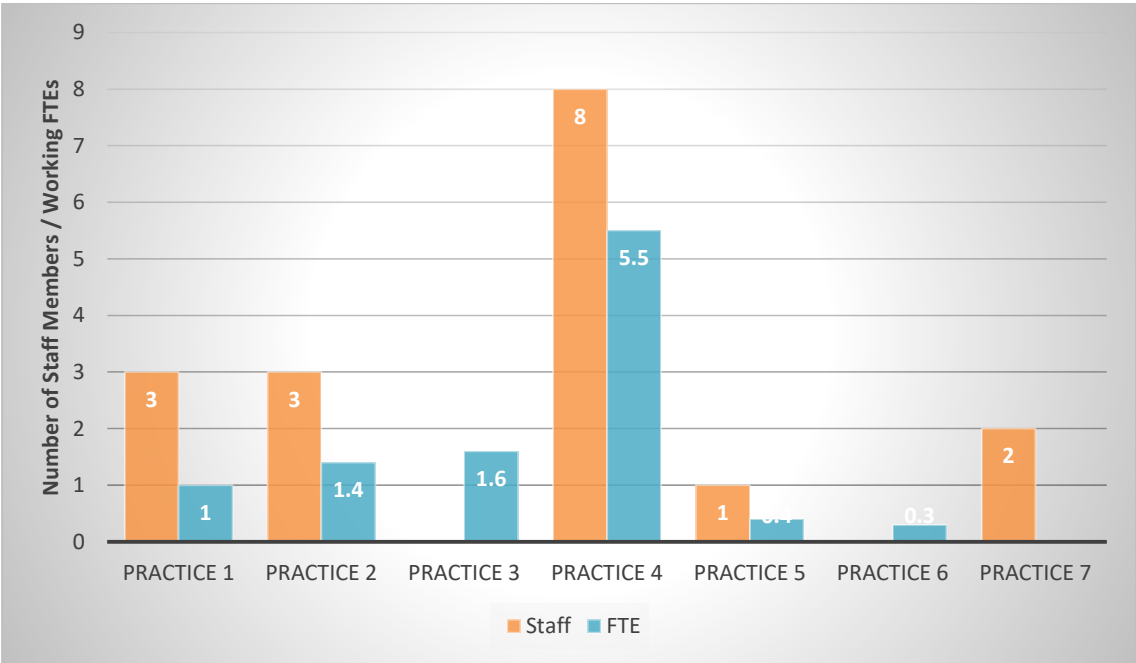


Figure 5. Size of private practices represented as the number of staff and the capacity of work-time represented as full-time equivalents (FTEs).

What are the practical interests and areas of speciality of participants? (n=49)

All participants listed more than one area of interest and speciality. More responses were received for areas of interest than what participants specialised in, however, it appears that

most participants specialised in what they were interested in (Figure 6). It seemed that most participants specialised in general speech-language delays / disorders, acquired communication disorders (aphasia, dysarthria) and intellectual disabilities.

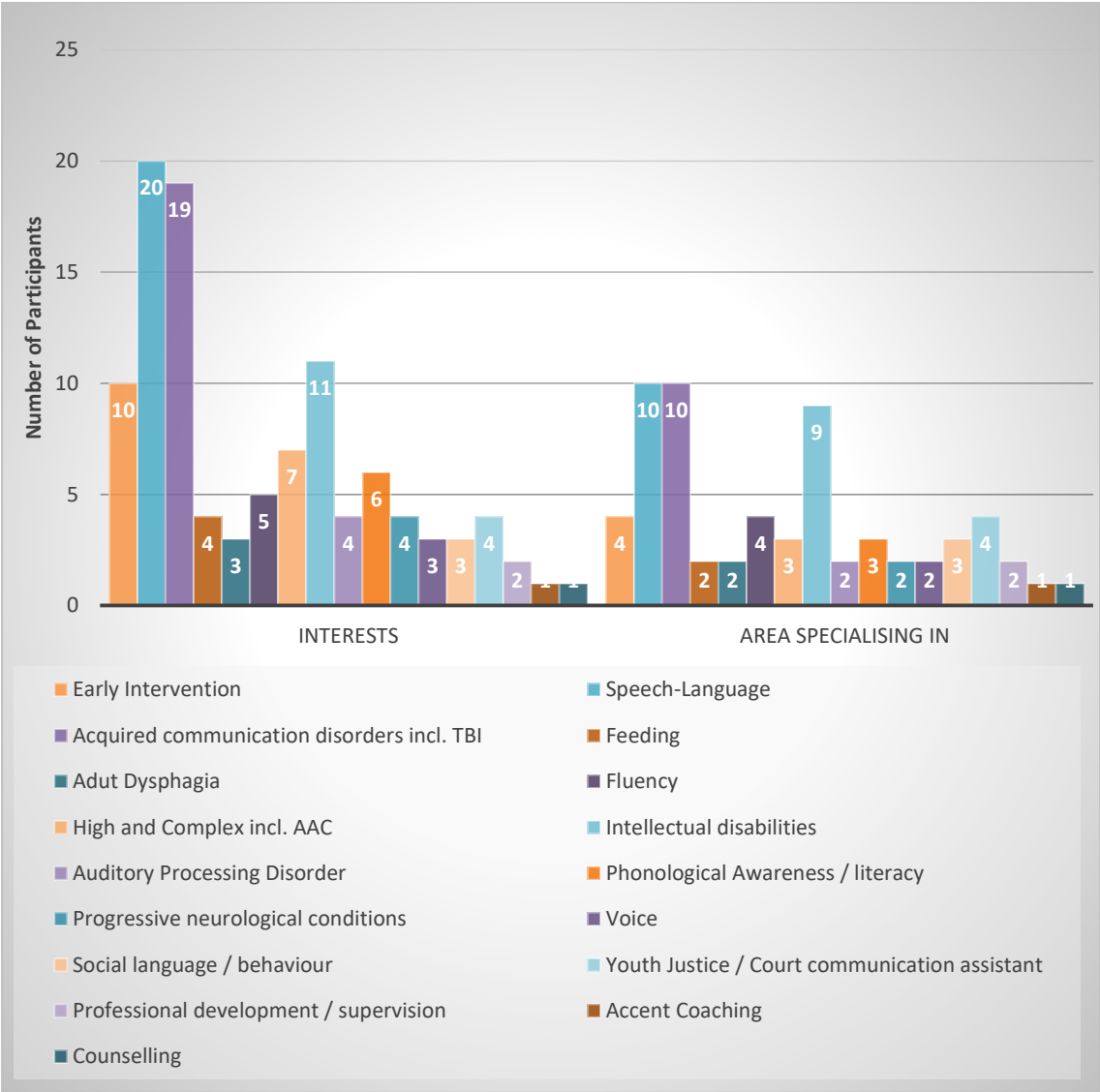


Figure 6. Practical interests of private speech language therapists and the areas they currently specialise in.

Where are referrals sourced from? (n=49)

Most participants (59%, n=29) stated that they receive the majority of their referrals through private advertising / word of mouth, eleven participants stated to receive referrals through ACC

and other professionals (such as general practitioners), and nine participants stated to receive their referrals through schools. The MoE and Ministry of Health were mentioned as referral sources by 3 and 2 participants respectively. Other referral sources included other SLTs, Oranga Tamariki (High and Complex Needs Service) and the legal system.

What language(s) do clients speak? (n=49)

Most participants (78%, n=38) reported that the primary language of their clients was English; two participants reported that Mandarin was the primary language of their clients. Twenty-eight participants answered the questions that enquired whether their clients speak another language besides English. Most participants (39%) stated that their clients did not speak any other language, followed by Te Reo Māori (16%, n=8), Mandarin (10%, n=5) and Samoan (8%, n=4).

How much do participants charge for services? (n=38)

Charges for one-on-one assessments were mostly over \$140 and one-on-one intervention sessions centred around \$100-119 (Figure 7).

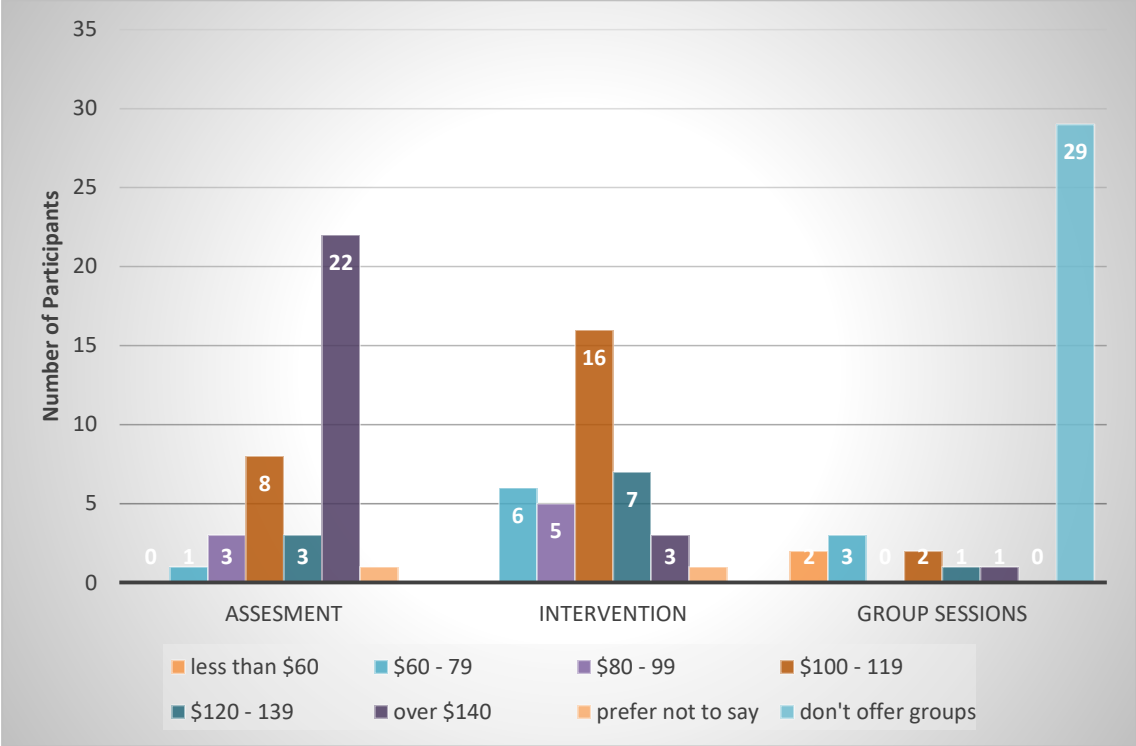


Figure 7. Fees for services.

3.1.3. Professional Supports and Needs

Perceived role of NZSTA (n=38)

The majority of respondents (89.5%, n=34) reported to be members of the NZSTA. Of those, 15 participants stated that having access to professional development services, current research and to attend the annual conference as the main benefits; this was closely followed by networking with other SLTs (12 participants), and quality assurance (7 participants). Other roles reported included “it is the professional thing to do”, “supporting the profession and NZSTA”, and “have to be member in order to work”. Participants who were not members of the

NZTSA stated that they decided against becoming member as the cost of being a member is too high.

What other bodies (if any) are participants members of? (n=19)

Of the 19 respondents to this question, the majority (58%, n=11) stated that they are not member of any other professional bodies; three stated to be member of ASHA. Other responses included Speech Pathology Australia (n=1), Laryngology Society of Australasia (n=1), Australian Voice Association (n=1), International Fluency Association (n=1), Intermediaries for Justice in England (n=1), and one participant reported to previously have been a member of the Royal College of Speech and Language Therapists.

Do participants attend SIGs / collaborate with other SLTs? (n=38)

Most participants (92%, n=35) expressed that they attend SIGs or collaborated with other SLTs; however the frequency and nature of this collaboration varied between the participants. The majority (53%, n=20) reported to attend professional supervision at least monthly, followed by monthly informal collaboration with colleagues (37%, n=14) and annual attendance at professional development events (32%, n=12).

How are professional learning development / supervision accessed? (n=38)

Most participants (38%, n=15) stated that they access professional learning development (PLD) and supervision through personal contacts, followed by their employers (37%, n=14), and the NZSTA (29%, n=11). Other responses included online courses (n=6), ASHA (n=2) and ATANZ (n=1).

When did participants last attend a PLD? (n=36)

The majority of participants (25%, n=9) attended a PLD event in the last month. Six participants stated to have attended a PLD in the last three months, five in the last two weeks, five in the last twelve months, four in the last 6 months, and four in the last nine months. Only three participants stated that it had been over one year since they last attended a PLD.

What role plays social media when accessing professional developments? (n=38)

The majority of respondents (97%, n=37) stated to access social media to access knowledge / collaborate with colleagues. All 37 participants stated to use Facebook®, followed by YouTube® (45%, n=17). Pinterest and Twitter were used by three and two participants respectively.

What supports do participants feel facilitate their ability to satisfactory complete their work? (n=37)

Perhaps unsurprisingly considering the statistic above, having access to online learning opportunities as well as access to resources were named as the two most beneficial areas named by 22 (60%) and 20 (54%) participants respectively, followed by support with administration tasks (27%, n=10), organisational skills (n=9), access to PLDs and articles (n=6), ability to work in an enjoyable way (n=5), client progress (n=4), and supportive family (n=4).

What supports do participants wish they had? (n=37)

Increased networking, including with SLTs working in the public sector, such as the MoE, was identified by 15 participants (41%) as something that would enable them to implement EBP more readily. This was followed by the wish for greater support when setting up a private practice from the NZSTA. This includes setting guidelines around private practices, including

fees and facilitating networking / sharing of resources and knowledge (n=9), and sharing of resources (n=7), including PLD opportunities.

3.1.4. Evidence-Based Practice (EBP)

What is participants understanding of EBP? (n=37)

The majority of the participants (97%, n=36) stated that it is research based; that it also integrates clinical experience, and takes into account client / family preferences was stated by another 4 and 3 participants respectively. Only 6 participants mentioned all three criteria and one participant did not mention any of the criteria.

Did participants' university training programme include a specific course in evidence-based practice? (n=35)

Seventeen participants stated that their degree did not include a course on EBP; 18 participants stated that it did.

On average, how often do you review research / professional readings? (n=36)

All participants stated to review research regularly. The majority (44%, n=16) stated to review less often than once a fortnight; eight participants reported to review research weekly, and twelve participants fortnightly.

What did participants perceive the barriers to providing EBP to be? (n=37)

Twenty-five participants (68%) named "Access to professional readings and PLD", often due to the high cost, as the main barrier, followed by time constraints (n=15) and a lack of ability to analyse research articles (n=6; Figure 8).

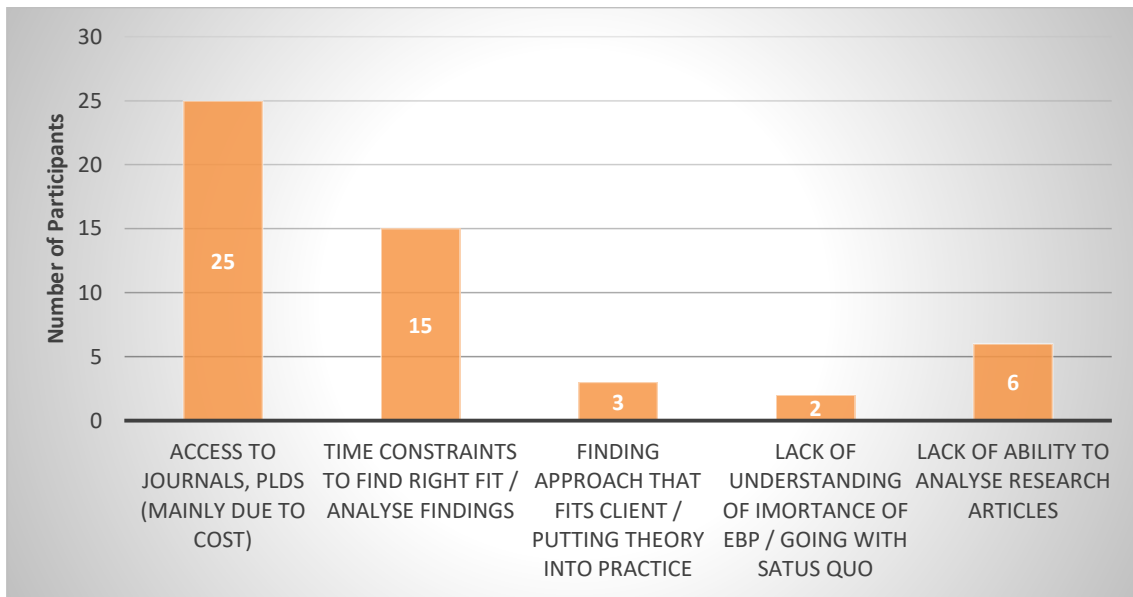


Figure 8. Perceived barriers of implementing evidence based practice

Any other thoughts participants wanted to share?

A total of 16 comments were noted in responses to this question. Many participants provided multiple comments. Some of the key themes identified and supporting comments included:

- Frustration with the public sector:

“Entering private practice was the best decision of my life; not only does it result in greater job satisfaction for myself but the fact that I can work with my clients without restrictions being placed upon me, leads to better outcomes for them.”
- The isolating nature of private practice work:

“Working in private practice can be isolating, it would be great to network more effectively with one another and share resources.”

- The competitiveness of private practice work:
 “Sometimes I feel like other SLTs (working in private practice are scared I am going to steal their clients and so are reluctant to share knowledge and resources”.
- The challenges of collaboration with SLTs working in the public system:;
 “It is really hard to build effective relationships with SLTs working for the MoE. I am not sure why, sometimes I feel like we (private practice SLTs) are frowned upon by them; they never invite us to their PLD events, even when we ask”.
- Gratefulness for the study:
 “Good luck with this this important study; we do not have enough information on this”.

3.2. Follow-Up interviews

Most participants stated that they would be available for a follow-up interview. However time constraints limited these to four interviews of randomly selected survey respondents. All interviewees were female, however, employment status and years in service and years working in private practice varied among them, with two working in private practice full-time and two part-time; one participant graduated the year before the survey and entered private practice shortly after graduation, the other participants were more experienced clinicians, however, the exact time working and time spent working in private practice is unknown. Three interviews were completed over the phone and one in person. Participant responses to question in the interviews expressed similar issues by survey respondents. The following section notes the question or topic discussed, response themes and example responses provided by participants.

How satisfied they are with the current work environment for private clinicians in NZ?

Themes of “Independence” and “Flexibility” were reported. For example, participants stated that overall they are happy with the situation they are in, especially being able to work in a way they want and providing evidence best practice without constraints. An example quote was:

“Working in private practice allows me to structure my day the way I want; this is perfect as I have young children at home”.

What can be improved?

Reported themes included “Increase in support”, “Access to PLD” and “Guidance” from the NZSTA. For example, one respondent identified the situation in Ireland where SLTs working in private practice have their own governing body. Interviewees expressed the wish for guidelines regarding setting up a practice and access to PLDs / research articles; most interviewees stated that they find it hard to be able to afford PLDs. A supporting quote was:

“It is really hard to even know how to go about setting up a private practice, yet alone be successful and know I am doing what others are doing – especially when it comes to setting guidelines around fees. It would be great if we had more support from the NZSTA”.

What is working well?

Key themes reported included “Independence/ Self-determination” and “Making a difference”. All interviewees agreed that the most satisfying thing about working in private practice is to be able to carry out therapy in a way they want and believe is best practice: frequent, one-on-one, and being able to take on clients with less severe communication needs. Interviewees expressed that families and schools appreciate their work and dedication and schools often ask if they can access funding to contract them rather than relying on the public service. A supporting quote was:

“I left the MoE because we were not able to treat children who were not “severe” enough, when we all know that these children would benefit hugely from our work”.

How can NZSTA be more effectively support private practitioners?

Similar to above, interviewees expressed the wish of more support through NZSTA. Suggestions included: guidelines regarding starting a practice, setting fees (to reduce competitiveness amongst private practitioners), access to resources, PLDs (at a reduced price), and supporting networking. Also, promoting our profession and its value in the wider community was at the top of the list; interviewees often find that members of the public / other professionals do not know what a SLT does and how this work may be of benefit. A supporting quote was:

“Sometimes I come across professionals, such as teachers and even SENCOs that do not know what we do or the benefits of our work”.

What government initiatives could support your work?

Themes identified included “more flexibility for the agencies accessing SLT support” and “increased funding for SLTs”. Restructuring of the funding systems was discussed. Directing the money directly to schools (as opposed to the MoE) allowing schools more flexibility with funding, so that they can manage their own speech therapy provision. More funding for families to access speech therapy. A supporting quote was:

“I come across of families and even schools who would like to be able to choose their own SLT – not the one provided by the MoE – they cannot do this at the moment if they cannot afford to pay”.

Do you think current levels of fees you charge remunerate / reward you for your time and other issues related to fees?

A key theme identified was “Remuneration does not equate to time worked”. All interviewees agreed that, no, the price they are charging does not reward them for their time and work. Supporting quotes included:

“If this was our family’s sole income, even if I was working full-time, we would be living on the street”.

However, in order to reach the clients who need their services, they feel like they cannot charge more. Supporting quotes:

“Most families who need our help the most are from as low socio-economic area”.

“The nature of communication difficulties usually requires ongoing therapy for a period of time, therefore, the individual sessions cannot be too expensive; this is different compared to other professions”.

The point of people not knowing the value of speech therapy work and therefore not being willing to pay more, came up again. Interviews again expressed the wish for NZSTA to set guidelines around fees and, increase awareness of the value of speech therapy.

How does working in private practice result in higher job satisfaction?

Themes identified included “Lack of satisfaction working in public service role” and “greater flexibility”. Interviewees agreed that, in the public sector, it was difficult to provide quality, evidence based therapy due to resource constraints. Some interviewees stated that moving to a consultative model of therapy provision lead to reduced job satisfaction. Long wait-lists and a tight criteria as to whom they could pick up were also points mentioned. Interviewees stated

that being able to build a relationship with the client and their family, as well as being able to provide functional, relevant and frequent therapy was the most satisfying point; this was closely followed by reduced administrative work. Supporting quote:

“I can see my clients as often as I want and do not have the same amount of paperwork”.

What does a typical ‘treatment session’ and ‘assessment’ look like?

All interviewees follow a similar process. The areas where they differed the most was of administrative nature; some have assessment / intervention agreements that they ask caregivers to sign before the session, others rely on verbal agreements only; some charge extra for reports, others include reports in the cost of the assessment or provide a verbal report only (they may provide a written report upon request).

Assessment comprised of

All interviewees stated that a typical assessment consists of a case history, observations, a screen followed by a thorough assessment. Usually, completion of assessment takes 1 – 2 hours and is completed in a variety of settings, sometimes over two sessions.

Treatment

The most common time for a session is between 30 – 45 minutes. Some interviewees stated that they write a summary at the end of each session while others do not provide written feedback. Usually, parents or educational support workers present during the session and SLT provides education/ training during session and provides resources to practice. Most interviewees see clients at home or school to make the session as functional as possible.

What other key issues are SLTs working in Private practice facing?

Key themes identified included “Growth of private practice services” and “Quality of services” and “New graduates working in private practice”. All interviewees agreed that private practices are growing. Of concern was the amount of SLTs entering private work upon graduating from university without experience. As speech therapy is not a registered profession, concerns over quality assurance was expressed. Supporting quote:

“There seem to be a lot of new graduates not being able to find a job and go straight into private practice. This worries me as they will not have the same access to supervision as new-graduates working in bigger teams”.

With a growing private sector, competition is growing; interviewees expressed that they would like to network more but have to be protective of their clients / area serviced in order to survive financially. Supporting quote:

“As there is more than one of us servicing the same area, I am careful that I get enough work”

In summary, these results provide insight into a section of the private practice SLT workforce in Aotearoa – New Zealand. The following section reviews these findings in contrast with the existing knowledge base before considering the clinical implications, study limitations and potential future research directions.

4. DISCUSSION

This study set out to investigate the demographic and service provision information for private speech-language therapy practices in Aotearoa – New Zealand. An online survey was developed and completed by 49 respondents. This data was complemented by interview data from four interviews with randomly selected survey respondents. The study aimed to answer four overarching research questions related to respondent demographics, scope of services available, respondents' professional needs, and knowledge and use of evidence-based practice.

The first research question focused on the demographic characteristics of SLTs working in private practice. This question was answered by participants' responses to 6 questions on the survey. Results indicated that SLTs working in private practice are predominantly female and represent a range of ages. Only one respondent (2%) identified as male. This suggests a significant imbalance when contrasted with the general New Zealand population and the typical SLT client base; with communication disorders being more prevalent among males (Norbury & Paul, 2012). However, this finding was consistent with Australian data reporting 2.3% of SLPs identifying as male (Speech Pathology Australia, 2016). The gender imbalance evident in speech-language therapy is also observed in other health and education professions. For example, only 7.4% of nurses in Aotearoa – New Zealand identify as male (Nursing Council of New Zealand, 2018), similarly, only 22% of all registered physiotherapists in New Zealand are male (Physiotherapy Board of New Zealand, 2018b). Further research to determine if this gender imbalance has any influence on service provision and client outcomes is needed.

The median age group of respondents was 40 – 49 years. This slightly differs to Australia where SLPs in private practice were reported to be younger on average, with nearly half stating they were 35 years or younger (Speech Pathology Australia, 2016). However, the average age

of the SLT workforce in Aotearoa – New Zealand seems to be reflected in other health-professions; 45 percent of registered nurses who identify as New Zealand European (67% of the workforce) are aged 50 or over; 27% are aged under 40 (Nursing Council of New Zealand, 2018). Additionally, 26% of OTs working in DHBs were recently reported to be aged between 25 and 34 years (Occupational Therapy Workforce Assessment, 2017).

The results suggest that SLTs in private practice are mostly New Zealand European, with only one participant identifying as Māori. Therefore, the results suggest that the current workforce of private SLTs does not reflect the ethnic balance of the wider New Zealand population. In the latest census available online (2013), 598,602 people or 15% of New Zealand's population identified as Māori (Statistics New Zealand, 2018b). No respondents identified as Asian, yet New Zealand's Asian population is increasing at a steady pace (Statistics New Zealand, 2018a). However, when contrasted with the Australian workforce, a similar picture is evident. Only 19 members of Speech Pathology Australia identified as Aboriginal and/or Torres Strait Islander. Ten-times this many would be needed to be representative of the general Australian community (Speech Pathology Australia, 2016). This imbalance is also observed in other New Zealand professions. Eighty-seven percent of physiotherapists are of New Zealand or European ethnicity and only 4.4% identify as Māori (Physiotherapy Board of New Zealand, 2018b). A similar picture is seen within the nursing workforce where only 7% of registered nurses identify as Māori and 4% identify with at least one Pacific ethnicity (Nursing Council of New Zealand, 2018). In 2016, only 3% of OTs working in DHBs identified as Māori. Traditionally in New Zealand the rate of non-engagement and / or early termination for Māori accessing health care seems to be high (Bolitho, 2006). Further research is needed to determine the level of influence that ethnic imbalance in the health care workforce has on client engagement and outcomes.

Aotearoa – New Zealand has three official languages; English, Te Reo Māori, and New Zealand Sign Language. In the 2006 census, 671,658 people in Aotearoa, stated they were multilingual (able to speak more than one language). The findings of the current study, suggest that a significant number of the respondents' clients are multilingual. However, only ten respondents reported to speak another language in addition to English. Two participants stated to speak some Te reo Māori. This is potentially representative of the broader population with 4.1% (257,110 people) reporting to speak Te reo. One respondent indicated knowing some New Zealand Sign Language (an official language) which is used by 24,090 people (Statistics New Zealand, 2018c). No participant indicated they spoke Samoan, Hindi, or Northern Chinese (including Mandarin). Yet these languages are New Zealand's third, fourth and fifth most spoken languages (Statistics New Zealand, 2016c). In Australia, only 17.6% of SLPs speak a second language, this is below the figure for the Australian population of 23% (Speech Pathology Australia, 2016). Taking into account the client's native language during assessment and / or treatment is paramount to ensure best possible outcome for the client and to honour and preserve their cultural identity during therapy (Kohnert, 2013). Most participants reported that the primary language of their clients is English; two participants reported that Mandarin was the primary language of their clients. Most participants said that their clients did not speak any other language besides their primary language, followed by Te Reo Māori (n=8), Mandarin (n=5) and Samoan (n=4). In England, the majority of SLTs who work with children reported to work with at least one bilingual child (Winter, 2009). Further research to determine the extent to which private practice SLTs implement best practices when supporting bilingual clients is needed.

The most recent qualification information provided interesting comparative data with the USA and Australian contexts. A total of 77% participants (n=36) noted their most recent qualification was an undergraduate degree (e.g., a Bachelors degree) and 23.4% stated they held a Postgraduate Masters degree, and no one had a PhD. In Australia, 78.9% reported to

hold a Bachelors degree. In the USA, nearly all (97%) of clinicians held a Masters degree. This is the clinical entry level degree required to practice. In contrast, 40% of New Zealand-trained registered nurses, and 30% of all registered nurses, hold a Bachelors degree (Nursing Council of New Zealand, 2018). A potential area of contrast between New Zealand and other countries is the difference in years of experience of SLTs in private practice. Six participants stated to have graduated between 2011 and 2015 (i.e., less than 10 years' experience before entering private practice). A majority of participants (72%, n=34) graduated between 1991 and 2010. In the USA, private practice clinicians reported to have a median of 19 years of experience at the time of survey. Although it is not clear how much experience they had upon entering private practice.

The survey also explored where participants completed their training. Participants were given the opportunity to select between the three Universities who offer degrees in Speech-Language Pathology / Therapy in New Zealand or select 'overseas' when they did not train in New Zealand. Two participants stated that they completed their speech-language therapy training alongside their teaching degree at the Teacher's College in Christchurch prior to speech-language therapy becoming a specific Bachelors degree. Sixteen participants completed their degree outside of New Zealand. Twenty-five percent of all registered nurses trained overseas. This included 40% of these being trained in the UK (Nursing Council of New Zealand, 2018).

Results suggest a sharp increase in SLTs entering private practice between 2000 and 2017 (see Figure 2). Interestingly, this coincides with the year(s) most participants graduated, suggesting that a large number of SLTs entered private practice upon graduation. Fifteen participants stated they worked in private practice on a fulltime basis while 29 participants (66%) reported working (in private practice) part-time. Seven of the participants who stated they work part-time in private practice also worked in another SLT role. For example, for special

schools or MoE. This contrasts with Australian data which indicates that 38% of private practice SLTs are employed in the public sector and only a small proportion work in non-government organisations (5.3%) and academia (0.3%). In the USA, private practice clinicians work mostly in the health sector. In the USA, 37% of private practice clinicians worked part time and 64% full time. In 2016, 1,607 New Zealand physiotherapists reported to work in private practice (Physiotherapy Board of New Zealand, 2018b).

The underlying motivations for respondents to work in private practice appeared to be freedom and flexibility. The majority of participants (46%, n=27) reported that their main reason for entering private practice was “flexibility around other commitments” and “the ability to provide evidence-based practice to all who would benefit from it in the way I want to; without restrictions forced upon me” and “no other jobs available / supplementing part-time employment” was given by twelve participants each. Other reasons included the variety of caseload, personal challenge and financial rewards.

The second research question investigated the scope of private practice services available across New Zealand. This question was answered by participants’ responses to eleven questions on the survey. Private practices are available across a majority of geographical areas of the country. The West Coast of the South Island appeared to be the only exception. Most respondents reported to be servicing more than one geographical area. Not surprisingly, the area with the most private practices is the Auckland metropolitan area. This is consistent with the area covering over 1,415,550 people (33% of New Zealand’s population; Statistics New Zealand, 2016d). These findings suggest the need for further investigation into how well the need of individuals living in rural areas are met. If these needs are not being met, there is an opportunity for private practice SLTs to offer alternative models of service to meet this need (e.g., tele-health services).

The majority of participants (54%, n=25) stated that they see clients at their practice and in the client's everyday environment (school / home visits), sixteen participants stated to see clients at home / school only and five participants see clients exclusively at their clinic. For participants who see clients in both environments, the home / school to clinic ratio was 3:2. No precise international data was available for comparison, however, SLPs in USA reported to charge more for home-visits, suggesting that they also see clients in a variety of environments (ASHA, 2015). Working in private practice appears to be undertaken primarily on an individual basis with three quarters of respondents (n=31) indicating working by themselves. Eleven identified as practice owners with employees and six participants stated that they were presently employed by an SLT in private practice. Eight of the eleven practice owners shared whom they were employing; seven stated to employ SLTs only with one participant stating 'other'; it appears that most practice owners employ other SLTs mainly on a part-time basis as the reported full-time equivalent per practice is lower than the number of staff employed.

All participants listed more than one area of interest and speciality area of service (Figure 6). It seemed that most participants specialised in general speech-language delays / disorders, acquired communication disorders (e.g., aphasia, dysarthria), and intellectual disabilities. This contrasts with USA data indicating 53% of SLPs working in private practice work predominantly within paediatrics, mainly treating language and articulation / phonology disorders and 47% work with adults, mainly focusing on dysphagia and aphasia.

A range of referral sources and fee structures were reported. Most participants (59%, n=29) stated that they receive the majority of their referrals through private advertising / word of mouth, eleven participants stated to receive referrals through ACC and other professionals (such as general practitioners), and nine participants stated to receive their referrals through schools. The MoE and Ministry of Health were mentioned as referral sources by 3 and 2 participants respectively. Other referral sources included other SLTs, Oranga Tamariki (High

and Complex Needs Service) and the legal system. In terms of fees, most SLTs reported to be charging between \$100 and \$119 for a treatment session. Feedback from participants was that they did not feel this amount reimbursed them sufficiently for their work. Practice owners in the USA reported a medium hourly wage ranging from \$43 USD (\$60 NZD) to \$50 USD (\$69 NZD); home visit rates were reported to be \$70 USD (\$96 NZD). An online search of private physiotherapy practices revealed that most physiotherapists charge clients around \$30 per forty minutes for injuries that are eligible for AAC and \$75 for fully privately funded treatments (Physio NZ, 2018; J. Marr Physiotherapy, 2018). In contrast, private OTs in the USA typically charge about \$150-200 for an initial evaluation, then \$50-400 per hour, depending on the type of service and the provider (Cost Helper Health, 2018).

The third research question aimed to identify SLTs professional supports and needs. This question was answered by participants' responses to eight questions on the survey. The majority of participants (89%, n=34) reported to be members of the NZSTA. Of those, fifteen stated that having access to professional developments, current research and to attend the annual conference as the main benefit of being a member; this was closely followed by networking with other SLTs. Participants who weren't a member, stated that they decided against becoming member as the cost of being a member is too high. The majority of participants (n=11) stated that they are not member of any other professional bodies; three stated to be member of ASHA. Other responses included Speech Pathology Australia (n=1), Laryngology Society of Australasia (n=1), Australian Voice Association (n=1), International Fluency Association (n=1), Intermediaries for Justice in England (n=1), and one participant reported to previously have been a member of the RCSLT.

Participants were asked if and how often they collaborate with other SLTs. Most participants (92%, n=35) expressed that they attend SIGs or collaborated with other SLTs regularly; however the frequency and nature of this collaboration varied between the participants. The

majority of participants (53%, n=20) reported to attend professional supervision at least monthly, followed by monthly informal collaboration with colleagues (37%, n=14) and annual attendance of professional development events (32%, n=12). Most participants (38%) stated that they access PLDs and supervision through personal contacts followed by their employers (37%, n=14), and the NZSTA (29%, n=11). Other responses included online courses (n=6), ASHA (n=2) and ATANZ (n=1). The majority of participants attended a PLD event in the last month (25%, n=9). The majority (97.37%, n=37) stated to access media to access knowledge / collaborate with colleagues. All 37 participants stated to use Facebook®, followed by YouTube® (n=17). Pinterest and Twitter were used by three and two participants respectively.

Increased networking, including with SLTs working in the public sector, such as the MoE, was identified by fifteen participants as a support system they would like to extend on. This was followed by the wish for greater support when setting up a private practice from the NZSTA. This includes setting guidelines around private practices, including fees and facilitating networking / sharing of resources and knowledge (n=9), and sharing of resources (n=7), including PLD opportunities. This highlighted the need for the NZSTA to support, guide, and perhaps facilitate networking amongst SLTs across work-settings.

The final (fourth) question this study set out to answer was participant's understanding of EBP. This question was answered by participants' responses to 4 questions on the survey. The ASHA provides the following description: "[EBP is] an approach in which current, high-quality research evidence is integrated with practitioner expertise and client preferences and values into the process of making clinical decisions" (ASHA, 2005). When asked to provide a definition, the majority of the participants (97%, n=36) of the participants stated that it is research-based; that is also integrates clinical experience, and takes into account client / family preferences was stated by another four and three participants respectively. Only six participants mentioned all three criteria and one participant did not mention any of the criteria.

Seventeen participants said that their training did not include a course on EBP; 18 stated that it did. All participants stated to review research regularly. The majority (44.4%, n=16) stated to review less often than once a fortnight; eight participants reported to review research weekly, and twelve fortnightly. Twenty-five participants named "Access to professional readings and PLD", often due to the high cost, as the main barrier to implementing EBP, followed by time constraints (n=15) and a lack of ability to analyse research articles (n=6; Figure 11). Perhaps unsurprisingly, having access to online learning opportunities as well as access to resources were named as the two most beneficial areas when it came to implementing EBP, named by 22 and 20 participants respectively (Figure 12). This highlighted the need for universities to ensure that graduates have the skills to source, analyse and apply research findings.

4.1. Study Limitations

Several study limitations were identified. Although a great effort was made to identify SLTs working in private practice and ensuring that they have access to the survey, it is possible that some SLTs who work in private practice were not aware of the survey and therefore, did not have the opportunity to participate, hence a full picture of the workforce may not have been obtained, especially in regards to areas serviced (location). Furthermore, participation in the study was voluntary, therefore, results, and especially in regards to EBP may be skewed as only clinicians who believe that they are implementing EBP would have partaken in the survey. It is perfectly feasible that the face of private practices in New Zealand changed between the time the survey was conducted and the time results were documented in this thesis.

4.2. Future directions

It is recommended that the private SLT workforce be surveyed regularly to monitor the changing face of the profession, considering the amount of private practices in Aotearoa – New

Zealand seems to be growing and to ensure the professional development needs of clinicians working in private practice are being met. The development of comprehensive data collection and updating of this regularly is recommended to:

- ensure that this sector of the profession is understood,
- provide the NZSTA with comprehensive data,
- for Universities to understand where graduates might head after completion of qualifications – and so programmes can better meet these needs, geographical availability / cost of services etc.

The implications of the discussion topics above for the NZSTA may be the following:

- Take more leadership in supporting private practices, as occurs in Ireland
- Set fees
- Support access to PLDs
- Provide guidelines
- Facilitate networking opportunities
- Continue to promote the SLT profession and raise awareness on the value of SLTs
- Explore options of approaching the appropriate government departments to discuss the option of restructuring the way funding is allocated
- Aim to ensure that the SLT profession reflects the population of NZ by attracting males and other ethnicity groups to the profession

Universities offering a degree in speech-language therapy may desire to look into increasing the bilingual skills of their graduates by, for example, offering Te Reo Māori and New Zealand sign language courses. Universities must ensure students graduate with the skills to source and analyse research findings so that they are able to, once working, use EBP. Furthermore, universities have the responsibility to ensure graduates are culturally sensitive and well-informed about the cultures they might encounter whilst working as a SLT.

5. CONCLUSIONS

Private practices are continuing to grow across Aotearoa – New Zealand. Participants of this study agreed that going into private practice has many advantages, such as no restrictions on who they chose to provide services to, the ability to provide EBP and high client contact. However, some challenges and concerns were also expressed. A sharp rise in the opening of private practices were noted between the years 2000 and 2017; the trend looks as though this is projected to continue. It is unclear what has contributed to this rise, however, the majority of participants in this study reported that the main reasons for entering private practice (apart from flexibility), were a lack of other paid employment or only part-time employment and the ability to work in a way that is satisfactory. Of concern was the amount of SLTs entering private work upon graduating from university without experience as it becomes harder to find employment; this concern was strengthened by the fact that a number of participants expressed they do not have the skills to source, analyse and apply research findings.

As speech-language therapy is not a registered profession in Aotearoa – New Zealand, concerns over quality assurance were expressed. As most private SLTs work in isolation (only a small number of participants stated to employ other SLTs or to be employed by other SLTs), a desire to strengthen professional networks, including these with SLTs working in the public sector, like the MoE, was expressed by most participants. However, participants also stated that working in private practice is a competitive field, especially when this is the sole source of income, and that this appears to lead to reduced willingness to collaborate. It was agreed that this may negatively impact upon outcomes for client. The nature of communication disorders requires often long and ongoing therapy which limits the amount one can charge per sessions, also clients often do not see the amount of paperwork / preparation that is required before or after a session and appear surprised when clinicians attempt to charge for non-contact time. Participants stated that they feel as though private SLTs are “frowned upon” by SLTs working

in the public sector and often encounter roadblocks when making collaborative efforts. Despite the abovementioned challenges, it is clear that participants make an effort to attend opportunities for collaboration, both formal (SIGs) and informal; most participants stated to do this monthly.

Overall, a wish for NZSTA to take on a more leading role in supporting clinicians working in private practice was expressed this may include facilitate greater collaboration, set guidelines regarding fees and service provision, and continue to raise the profile of the professions. As the increase in private practices is a fairly new development in New Zealand and SLTs do not have to be registered with the professional body, no guidelines regarding the services offered by SLTs in Private practice exist. This may potentially be worrying as it is up to the individual SLT to ensure their services are of high-quality and evidence based. Furthermore, a lack of regulation and support raises questions as to whether the professional needs of SLTs in Private practice are being met. Therefore, It is recommended that the private workforce be surveyed regularly to monitor the changing face of the profession, especially considering that the amount of private practices in Aotearoa – New Zealand seems to be growing. This will help to ensure that the professional development needs of SLTs working in private practice are being met.

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7. APPENDICES

Appendix 1. Ethics approval letter.



UC
UNIVERSITY OF
CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE

Secretary, Rebecca Robinson
Telephone: +64 03 369 4588, Extn 94588
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2017/20/LR

12 May 2017

Max Gleissner
Communication Disorders
UNIVERSITY OF CANTERBURY

Dear Max

Thank you for submitting your low risk application to the Human Ethics Committee for the research proposal titled "Private Practice Speech-Language Therapy Services in Aotearoa - New Zealand".

I am pleased to advise that this application has been reviewed and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 9th May 2017.

With best wishes for your project.

Yours sincerely

pp. R. Robinson

Associate Professor Jane Maidment
Chair, Human Ethics Committee

University of Canterbury Private Bag 4800, Christchurch 8140, New Zealand www.canterbury.ac.nz

F E S

**Survey of Private Practice Speech-language therapists working in
Aotearoa-New Zealand
(for entry into Qualtrics system)**

1. Demographic Information

- Age (please select from range)
 - 20-29; 30-39; 40-49; 50-59; 60-69; 70+
- Gender: (free entry)
- Ethnicity: (free entry)
- NZ citizen: (Y / N)
- First language: (free entry)
- Other languages spoken fluently: (free entry)
- Most recent Speech and Language Therapy Qualification (s):
 - Select from:
 - Undergraduate (Bachelor)
 - Postgraduate (Master)
 - PhD
- Year of Graduation:
- I received my Professional qualification from
 - Massey University
 - University of Auckland
 - University of Canterbury
 - An overseas University (please state) (free entry)

2. Practice Information

- I entered private practice in: (Select from year list)
- My main reason(s) for going into private practice were: (free entry)
- Geographical Areas serviced (location of clinic): (check all that apply)
 - Northland, Auckland, Waikato, Bay of Plenty, Hawkes Bay and East Coast, Central North / Taranaki, Manawatu, Wellington, Nelson Districts, Marlborough, West Coast, Canterbury, Otago, Southland
- Nature of service provision:
 - Clients come to my clinic or a centre
 - I see clients at school / their home

- Both ____ % at clinic ____ %home/school
 - I work
 - a. Full time
 - b. Part time

in private practice
 - Part time:
 - a. I also work for (a school, MoE, DHB): (free data entry)
 - b. Approx. FTE in PP:
 - c. Approx. FTE other place of work:
 - I employ other Speech-language therapists (Y/N)
 - How many? FTE and Individuals
 - I am employed by a Speech-language therapists (Y/N)
 - I employ other Health or Educational professionals (Y / N):
 - a. Yes: please list professions and state number
 - My clinical interest area(s) is / are:
 - I specialise in:
 - I receive most my referrals through (private / GP / schools / ACC):
 - Primary language (s) of my clients:
 - Other language (s) spoken by my clients:
 - For one-to-one **assessment** sessions I charge
(select from: Less than \$60 per hour; \$60-\$80 per hour; \$80-\$100 per hour; \$120-\$140 per hour; over \$140 per hour, prefer not to disclose)
For one-to-one **therapy** sessions I charge
(select from Less than \$60 per hour; \$60-\$80 per hour; \$80-\$100 per hour; \$120-\$140 per hour; over \$140 per hour, prefer not to disclose) -
For small group sessions I charge
(select from Less than \$60 per hour; \$60-\$80 per hour; \$80-\$100 per hour; \$120-\$140 per hour; over \$140 per hour, prefer not to disclose)
3. Professional Supports
- NZSTA member? (Y / N)
 - a. Y – I see the benefits of being a member to be: (free entry)
 - b. N – please comment why not: (free entry)
 - Do you formally (special interest group (SIG) or informally collaborate with other SLTs working in private practice? (Y / N)
 - a. SIG
 - b. Informal group
 - c. How often?

- Are you member of any other professional body? (Select from ASHA / RCSLT/ Speech Pathology Australia/ Irish Association Speech and Language Therapists / Speech and Audiology Canada/ Other)?
 - How often do you access professional supervision?
 - How often do you attend Professional Learning and Development events?
 - When was the last the time you attended a professional development opportunity?
 - How do you access PLDs / supervision? (e.g. through NZSTA?)
 - Do you use social media to access new knowledge / collaborate with colleagues? (Y / N)
 - a. Which platforms do you use for this (e.g., facebook / youtube etc.)
 - b. Any particular online sites or resources (TalkLink / we speak PODD)?
4. Evidence-based Practice
- How would you define the term “Evidence-based Practice”?
 - Did your University training programme include an specific course in Evidence-based Practice?
 - On average how much time (per week) do you spend reviewing research / professional readings?
 - What are barriers to the provision of best-evidence based practice?
5. Professional Needs
- What supports facilitate your ability to satisfactory complete your work?
 - What supports do you wish you had?
6. Additional Information
- Any other information or thoughts you would like to share?
7. Are you available for a follow-up interview? (please provide your contact information below)

Appendix 3. Interview questions.

Interview questionnaire:

- 1) How satisfied are you with the current work environment for private practitioners in NZ?
 - What can be improved?
 - What is working well?
 - How can NZSTA be more effectively support private practitioners?
 - What government initiatives could support your work?

- 2) Thinking about fees –
 - a. Do you think current levels of fees you charge – remunerate/ reward you for your time?
 - b. What issues related to fees?

- 3) In the survey the main reason for entering Private Practice was because respondents found working in the public sector (MoE / DHB) unsatisfactory –
 - What do you think was unsatisfactory?

 - How does working in Private Practice result in higher job satisfaction?

- 4) What does a typical 'treatment session' and 'assessment' look like? (duration, what is included e.g. written summary, provision of resources, 1:1 only or also training of communication partners)

- 5) What other key issues are SLTs who work in Private Practice facing?