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Short Report

'Thinking for two': a case study of speech and language therapists working through assistants

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Abstract

Background: Many speech and language therapists (SLTs) in the UK work with speech and language therapy assistants, and the numbers of SLT assistants is expected to grow. There has been very little empirical investigation of how SLTs feel about this situation or the effect on working practices of working indirectly.
Aims: To investigate SLTs' opinions on working with SLT assistants in a small-scale research case study.
Methods & Procedures: The study design was a case study of five SLTs delivering intervention within a research intervention project. Prepared questionnaire and formal interview techniques were used to elicit opinions on working through assistants, and a content analysis was performed.
Outcomes & Results: Although respondents could see value in working through assistants, they stressed the time required to do so and the difficulties of adapting and updating therapy plans when working indirectly.
Conclusions: The study suggests a variety of factors that have to be carefully managed if SLTs are to work competently through assistants.

Keywords: service delivery, speech and language therapy, assistants, indirect therapy, efficacy research.

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Introduction

Speech and language therapy (SLT) services, in line with other health service professions in the UK, are committed to appropriate 'skill mix'. This can involve the employment of speech and language therapists' assistants (SLTAs), a term covering support workers who do not hold SLT professional qualifications and who work under the direction of a qualified clinician (RCSLT 1996: 295). Frameworks detailing the roles of assistants (Williamson 2002) and standards to assist local services training and employing assistants (RCSLT 2003a) have been developed. These clarify the working relationship between SLT and SLTA as follows:

> The qualified speech and language therapist holds the ethical and legal 'Duty of Care' for the patient/client and consequently for the standard of duties delegated to a support practitioner. All clinical decisions concerning the client are therefore the responsibility of the qualified speech and language therapist, including client selection for therapy, admission to the caseload and discharge from the service. A therapist must always be responsible for the work undertaken by an SLT support practitioner.
>
> (RCSLT 2003a: 2)

The number of assistants has been growing in the UK. Overall numbers of SLT support staff, including assistants, increased in England from 288 whole-time equivalents in 1995 to 438 in 2002 (Department of Health 2003). A review of SLT services to children in Scotland (Scottish Executive 2003: 95) showed 521 SLTs working with 69 SLTAs in 2002, a ratio of 7.5:1. Earlier, Law *et al.* (2000), reporting on 133 children's SLT services across England and Wales, noted a higher average ratio of SLTs to SLTAs, at 9.5:1. SLT is listed as a 'shortage occupation' in the UK (Home Office 2004), with an acute shortage of suitably qualified and skilled workers in the resident population, and in England the Department of Health is committed to a health workforce where support staff extend their skills to undertake work previously carried out by regulated professionals, with proposals to regulate such staff (Department of Health 2004). Further increases in the numbers of assistants to therapists are therefore anticipated.

At around the time that SLTAs began to be employed in UK health services, the Research and Development Division of the Department of Health commissioned a study to determine the feasibility and effectiveness of using SLTAs with different client groups in different parts of the country; to determine what SLTAs at that time did in everyday practice, and to assess the training and supervision they would need to maintain professional standards of service (Van der Gaag and Davies 1993). This study was never published in full, although a series of influential papers resulted (Davies and Van der Gaag 1992a, b, Van der Gaag and Davies 1992a, b). Since then, the literature has concentrated on how SLTAs have been trained and integrated into therapy services (cf. RCSLT 2003b), but there has been little empirical investigation about how SLTs feel about working through assistants. It seems timely to open discussion of such issues, to throw light on some factors that allow SLT/SLTA alliances to flourish.

Aims

This paper aims to reflect SLT opinions on working through assistants in a specific case study context. It relates only to one half of the partnership, and further work on SLTA perspectives would be welcome.

Methods and procedures: the case study

The case study involved five SLTs working with SLTAs in pairs over a school year. The SLTs are participant researchers, reflecting upon their own experiences. Their practice was part of the research project 'A Randomised Controlled Trial and Economic Evaluation of Direct Versus Indirect and Individual Versus Group Modes of Speech and Language Therapy for Children with Primary Language Impairment (PLI)', a large-scale randomized controlled trial with blind assessment of outcome. The project compared direct therapy by SLTs with indirect therapy via SLT assistants; both modes delivered to children individually and in groups, and children allocated to continue with their current level and type of therapy from local services. The research also analysed the costs and effectiveness of the different modes of therapy delivery. The children were aged 6–11 years, attended mainstream schools, had non-verbal IQ scores above 75 on the WASI (Wechsler 1999), had receptive and/or expressive language scores on the *CELF-III*^{UK} (Semel *et al.* 2000) of <-1.25 SD, no reported hearing loss ($>$20 dB) and no speech, motor, dysfluency or other impairment that would necessitate direct SLT intervention.

Intervention took place in school settings in the cities of Glasgow and Edinburgh, UK, with some children transported from school to a group held in a different school. Groups were of two to five children. Areas of language intervention and therapy activities were coordinated via a therapy manual, as outlined in McCartney *et al.* (2004).

Intervention was delivered three times per week in 30–40-minute sessions for up to 22 hours. Over 120 children received research intervention in two 4-month phases during the school year. The maximum number of children (including grouped children) with whom therapy was carried out in either phase by one person was nine, apart form a short overlap period between phases when it rose to 11. SLTs planned therapy for children seen by themselves and by their paired SLTA to a maximum of 19 during an intervention phase.

Non-verbal IQ measures were undertaken by the research team, including SLTAs, under the supervision of a research psychologist. Because the test publisher requires non-qualified staff who collect data for IQ assessments to have a degree in psychology, SLTAs were recruited who met this criterion. They also had experience of working with children: one as a qualified nursery nurse, three as classroom assistants, and one as an unqualified teacher and pupil counsellor for children with behavioural problems in a European country. Before starting intervention, they undertook in-service training provided by the research team and a recognized 2-day training course for SLTAs, observed local SLTAs at work and were trained to carry out assessments. As intervention began, they were introduced to the therapy manual (McCartney *et al.* 2004) and given a copy to use throughout.

SLT/SLTA pairs were set up from the start to encourage strong relationships to form. It was intended that pairs would be maintained throughout the project, but one SLTA left towards the start of Phase II and was replaced by a trained and experienced SLTA seconded from the local SLT service, where she was in the process of being graded as a technical instructor.

Factors specific to this case study

Any case study describes a particular context, which makes generalization to different circumstances insecure. However, the opportunity to gain 'insider' views

from those with intimate knowledge of the issues can be invaluable (Robson 2002: 382). Several features specific to this study should be noted.

SLTAs' background

Recruiting SLTAs with a degree specifically in psychology was a distinctive feature of the project, but the fact that SLTAs had a degree is not in itself particularly unusual. In the UK, applicants to professions with postgraduate entry routes, such as educational and clinical psychology, SLT and school teaching, frequently seek to demonstrate working experience with children in addition to possessing a relevant first degree. Some obtain this experience working as assistants, including classroom assistants and SLTAs. For such individuals work as an assistant is a step to career advancement (Farrell *et al.* 2000), and they do not intend to remain long in assistant posts. The project was unusual in recruiting in the first place from this pool of workers only. In contrast, there are individuals who view their work as assistants as a more permanent position: such a person was seconded to the project when one of the first group of SLTAs resigned.

Research SLTs

Respondents in this study are the five SLTs who carried out the research intervention. They were recruited with a range of working experience. Since they joined the project knowing that around half of their work would be through assistants they may have been differentially predisposed to working in this way. However, none had previous experience of working directly with SLTAs.

Intervention

The relatively small number of children, the regular and predetermined amount of therapy and the circumscribed time period are factors specific to this study and its basis in research. Only children with PLI as defined above were involved, and intervention areas and activities were selected from the therapy manual to accomplish targets set by the research SLTs. There was therefore relative homogeneity in intervention procedures. The numbers of children recruited were also controlled by the research design and timescale, and entailed some rapid >increases in numbers and 'busy periods'. Random allocation meant that children were not specifically selected for groups, or for assistant- or SLT-led intervention, as would be usual in clinical practice. Time-tables and geographical scatter meant that SLT/A pairs usually had to alter schedules if SLTs were to visit SLTAs' children during the intervention period, and this could be difficult to organize.

Despite these particular circumstances and the small-scale, the case study might be of interest given the paucity of existing research. It does not claim to represent the wider clinical picture.

Methodology

The study sought to elicit informed, considered accounts from SLTs, reflecting upon their experiences and relating professional opinions to be collated and disseminated.

A methodology was required that encouraged a range of individual opinion to be expressed but allowed commonalities to emerge, and respected the social relationships existing within the research team. Respondents agreed that a jointly constructed list of questions would be prepared to allow reflection before responding. A draft set of questions covering potentially relevant issues was constructed by the first author, based on pertinent issues raised by Van der Gaag and Davies (1993) and further questions that had arisen during project management and in auditing compliance with the therapy manual. These were circulated amongst the research SLTs, who added to and amended questions, resulting in the final set as appended (see appendix A, with prompt question noted). Preparing questions in this way may omit issues relevant to individuals, and joint preparation and construction can lead to discussion amongst respondents which may well influence individual replies. Respondents had also worked within a coherent research team where some of the questions had already been debated. These factors serve to reduce the independence of responses, and may limit the variance uncovered by replies. However, prepared questions also tend to focus respondents on relevant replies (Silverman 2001: 92–93), and to allow thoughtful responses to be offered.

The possible response methods were in writing, by dictation or via interview. Interview was preferred by most respondents as taking least time and allowing for immediate clarification of responses. Interviews were carried out shortly after completion of the research intervention period by the first author. Respondents brought written notes on their intended answers, and all five agreed to answer all questions, read out verbatim by the interviewer. The interview was audio-recorded, with contemporaneous notes written by the interviewer. The only supplementary questions from the interviewer were to clarify ambiguous points or referents, and to ask if there was any further information.

Interviews were transcribed using English orthography supported by the interviewer's and respondents' notes including all points raised and clarification questions. Extraneous revisions, rephrasing, phatic comments and social remarks were omitted. Individual transcripts were circulated to respondents, who checked and altered them to reflect their intended meanings, and wrote in any further comments (member checking). The final written version was used for analysis.

Reporting responses

In an exploratory study such as this within a fairly new research topic there is a danger of premature data selection, closing down avenues for future investigation. With a small number of respondents and a complete set of answers it was decided to report each SLT's comments, noting the number of respondents offering similar comments (numbers in brackets) and illustrating with quotations, in quotes. This provides a content analysis of the respondents' stated appreciations of their work with assistants.

Outcomes and results: SLTs' responses

Responses are cross-referred to the sections and question numbers in the appended set of questions (see appendix A).

Section A: Planning together (questions 1–9)

1. *Was a specific time set aside with your assistant to plan therapy?* In Phase I, four SLTs had 1 day per week available for SLT/A liaison, and to plan both their own and SLTAs' caseloads, and the fifth had 1.5 days. In Phase II, the figures were 0.5 days (4) and 1 day (1). One SLT mentioned that after-school time was also available if necessary.

2. *Do you think the amount of planning time you had with your assistant was too little/appropriate/too much?* All SLTs agreed that this time had been adequate. One commented that when a number of new children began therapy at the same time planning time became more pressurized, but two noted that planning time was generous, 'bordering on too much', and 'much more than you'd ever get in real life … we could have done it with less'.

3. *How was planning time used?* All pairs used planning time to set, list and prioritize therapy targets for children; to suggest activities for each target, and to discuss whether a target had been met. Three SLTs commented on changes that took place as intervention progressed: as SLTAs became more confident and experienced, the planning time per target was reduced and/or SLTAs made more suggestions.

4. *What were the main queries from your assistant with which you had to deal?* As well as SLTA questions on therapy planning, SLTs had noted questions on what to say to parents and teachers (2), what to write in homework diaries when these were used (1); how to carry out therapy tasks (3); specific resources to use (1); where to go next (1); child responses (1) and what to do if things 'weren't working'(1).

5. *Had you expected to plan in these ways?* All SLTs had expected to plan in these ways.

6. *Did the way in which planning time was used change within a phase?*

7. *Did the way in which planning time was used change between Phases I and II?* All SLTs commented that the ways in which planning time was used changed within and/or between intervention phases. Planning time shortened (5), with less need for detailed explanations (4). Assistants' questions moved from the specifics of how to undertake tasks to monitoring child progress (1), they prepared more materials (1) and made more suggestions (1) as time went on. This was likely when children received intervention in language areas with which the SLTA had become familiar (2).

8. *Did you have enough time to plan your own therapy?* All SLTs found time to plan their own therapy, although three noted some strain at busy periods as new children came into the project.

9. *Have you any further comments on planning?* One SLT stressed the importance of planning well in advance, and ensuring her SLTA understood 'the full rationale behind the target and how it was going to progress', to encourage the SLTA to be more autonomous. Another stressed the need to encourage SLTAs to ask for explanations when they failed to understand, to encourage equality and team working. Three commented on planning 'blind', and would have liked more opportunity to meet the SLTAs' caseload children, since they had not had the opportunity to develop interventions and 'pass on' children whom they knew well to assistants. One also commented on the reciprocal nature of the issue: the research design allowed much more planning time than would be allocated in NHS clinics, but if SLTs had known the children well less planning time would have been needed.

Section B: SLT and assistant training (questions 10–13)

10. *What further training for you (if any) might have helped you to work with an assistant in Phase I?* None of the SLTs could think of any specific training that would have benefited them personally before working with assistants. One would have liked more detail about the training the SLTAs had received; two would have welcomed discussion or observation with SLTs experienced in working with SLTAs, and one of these would also have welcomed written NHS protocols giving advice.

11. *What further training for assistants (if any) might have helped your assistant to work with you in Phase I?* There were consistent opinions about what further training of assistants might have been helpful. All five felt it would have been useful for SLTAs to watch therapists (from within or outside the team) working with children more frequently than was possible in the project; one detailing joint working and one further 'shadowing' of the SLT pair working with children from the SLTA's caseload. One SLT also felt it would have been helpful for SLTs to watch assistants. Three suggested that more time to read, become familiar with and try out activities from the manual before starting therapy would have been helpful to assistants.

12. *In Phase II of the project you were working with an experienced assistant. What difference if any did this make?* Working with a (by then) relatively experienced SLTA in Phase II made a large difference to SLTs. All five commented that planning time decreased because SLTAs were familiar with at least some therapy targets and activities. Comments such as, 'less time required to plan, and less stressful', and 'It made my job a bit easier really' summed up SLTs' responses. Three noted other changes in their SLTA, who had become more self-reliant, confident and/or flexible. One however expressed some wariness in case increased confidence would involve her SLTA in 'taking on too much of a therapist's role', e.g. when giving feedback to parents and teachers. This SLT ensured all suggested activities and information were checked with her before being passed on, and so defused the risk of any inappropriate action.

13. *Have you any further comments on training?* Three SLTs offered further comments on SLTA training. One suggested further support for SLTAs going into schools and talking to teachers; one a further training course after assistants had some practical experience, and the third a questionnaire asking SLTAs about their training needs, along with more observation of SLTAs.

Section C: Undertaking therapy (questions 14–22)

14. *SLTs noted that 'observation' of a child was important in setting targets for therapy. How was this managed when working through an assistant?* Opportunities to observe children working with SLTAs were limited after the start of therapy, affecting the adaptation of therapy targets. One SLT asked her assistant to tape record or give written examples of child talk, which became a routine matter for the SLTA. This therapist and another also organized timetables to allow some extra observations.

The use of audiotape is an obvious way to obtain information about child language output at a distance, and a prompt question was asked to probe this area. Only the SLT mentioned above listened to tapes. Comments on recording from non-users were mixed. One commented: 'We didn't actually do that [i.e. tape record] for any of the children, but that would have been quite good. Taping would have meant that I could observe (or hear) quite often'. Another was less sure: 'I still think

recording is not the same as seeing them in the flesh. Listening to a tape recording of a child you don't really know'; and a third, 'I would think of tapes as a last-ditch approach, and would prefer to observe the child, and discuss and ask questions'.

15. *How was day-to-day information exchanged with classroom teachers when working through an assistant?* SLTs met children's classroom teachers at the start of intervention, and the project sent written information to parents and teachers about targets set, therapy aims and child progress at predetermined times. However, day-to-day contact with teachers and parents had also to be managed. All SLTAs talked to teachers, and one SLTA was encouraged during Phase II to arrange regular meetings with the classroom teachers of group children who moved from their own school for therapy. Two SLTs noted that they spent time with their SLTA preparing in advance what the assistant would say to teachers; the other three did not mention this. Three SLTs said that SLTAs had passed teacher queries to them that the SLTA could not answer. Little use was reported of telephone calls or writing by SLTs to build relationships with teachers, although one set up homework diaries and encouraged class teachers to read them, and another mentioned packs of worksheets for parents' and teachers' use. A potential problem was raised by one SLT, who commented that, although teachers had had the respective roles of SLTs and SLTAs formally explained, 'I think teachers just assumed assistants were always the therapist, coming in to do the therapy'.

16. *How was ongoing information exchanged with parents when working through an assistant?* Much communication with parents was also through SLTAs. As stated, one SLT used homework diaries, with the activities entered discussed with her SLTA, and all five SLTAs also phoned parents, at least at the start of therapy. All SLTs commented upon the issues related to liaising with parents through SLTAs. Opinion was mixed. The SLT who had concentrated upon her SLTA understanding the rationale behind therapy noted that when the SLTA contacted parents: 'We were spending so much time on the reasons and the "whys" and the "hows" that it seems to be working well. I have quite a lot of confidence in her ability to do it'. The other SLTs commented rather more negatively upon the fact that assistants were better placed to give feed-back to parents than the SLT: 'Because although I knew about the child and what therapy we were doing I didn't "know" them, because I wasn't seeing them to have a real feel for them and exactly how they were working'. It was 'done through [an assistant], because she knew the child best'. 'But I didn't speak to them [parents]. Again, because I felt like I would not have had all the information.' 'Contact with parents was somewhat lacking.'

17. *How did your assistant use the therapy manual?* All SLTs agreed that their SLTA read the therapy manual, and were directed to do so by SLTs, but also received guidance about therapy directly from the SLT. The manual acted as a useful back-up resource.

18. *Were there any particular areas of therapy with which your assistant needed more help?* One SLT reported that the narrative and colourful sentences sections of the manual were the areas where SLTAs needed most help, and another grammar in general and colourful sentences in particular. Judging the difficulty level of therapy activities caused some problems, one therapist requiring to adapt tasks to the needs of older children, and another intervening when her SLTA used language tasks at too high a cognitive level for one child, following a published pack. She said, 'I think also I had assumed that that was common sense, when actually it's not. It's therapy'.

19. *Looking back, what changes if any to the manual might have helped your assistant?* All agreed that changes to the manual would have been helpful, listing layout (2; one suggesting a bullet-point format); a better index (2); more time to read it before intervention began (1), and the inclusion of case study examples (1) and examples of activities (1).

20. *How prestructured did therapy sessions become?* SLTs varied in the amount of ‘control’ they exercised by prestructuring therapy sessions with three reporting lessening control over time. One started with highly structured therapy, ‘to build up the confidence, and to get used to working with the children, and to get used to actually carrying out the sessions and carrying out therapy’. This amount of control backed off, but was reintroduced when new therapy targets were used, going into detail about the order of tasks and how to tackle them. A second therapist also started off with a high level of structure, but backed off during a busy period, feeling, however, ‘I could have structured things a bit more in that busy middle period’. A third broke the session down into periods of five minutes, with activities for each, until the SLTA became used to how long tasks should take. She maintained this structure for ‘a good few’ weeks. She worked with the experienced seconded assistant in Phase II, and noted how much more quickly the detailed structure could be dropped: ‘within two weeks’. A fourth SLT made suggestions for activities for each target, but left to the assistant the decision about how to organize these within the week, and the fifth also presented options concerning the sequencing of therapy targets within and across sessions, but with clear advice on what she thought best.

21. *How was report writing organized between you and your assistant?* Reports on children seen by SLTAs were discussed in pairs. In Phase I, all SLTs were heavily involved in composing the text of reports, and checked the final versions. In Phase II, two SLTs had their assistant write the reports after discussion, which the SLTs checked and altered as necessary.

22. *Have you any further comments on undertaking therapy?* Four SLTs gave further comments on undertaking therapy. One commented on working through an assistant: ‘It has taken up a lot of time, but it’s really paying off now’. The other three were less positive. One noted the need to keep updated on how therapy was progressing and ensuring that the assistant had enough to do between discussions. She worried that assistants would not be aware of when to move on to something new, or when to change activities if ‘the child’s not clicking to it for some reason’. Two others also felt the limitations of not really knowing the children. One said it had been very hard to plan ‘not really having a feel for a child’s more functional communication’. The other therapist echoed these opinions: ‘I would have liked more contact with [assistant’s] children, to feel they were mine, not hers’.

Section D: Personal opinions (questions 23–27)

23. *On the whole, how did working through an assistant compare with working directly with a child?* One therapist was very positive, noting that working through assistants took time (and that sufficient time had to be allocated to the process) but that the time was well spent. She felt she had a stronger input into exactly how targets should be implemented than when working through classroom assistants employed by education services. The other four expressed more profound reservations. One

repeated that it was necessary to rely heavily on the assistant to take note of and reflect back changes in the child's performance, and that assistants could vary in their ability to do this. Another noted similar uncertainties. Due to losing the 'subtleties' observed when working directly with a child, 'I found it much harder. I was less confident about the targets I was setting and the prioritization of those'. A third commented that working through an assistant and working directly with a child, 'didn't compare at all–they are just poles apart. It was almost like they were [assistant's] children, and it was quite hard to take ownership of these children, to see them as my indirect children. I thought they were [assistant's] children. Because I didn't know them'. She also found planning difficult, especially for complex children, without seeing them carrying out tasks: 'I was gathering information, but I wasn't gathering it myself so I couldn't see how he'd done them [therapy tasks] or how long it had taken him to do them and so on'. The last SLT summed up the situation as: 'It is not as rewarding as working yourself with a child. It is not as flexible. You don't really know how therapy is progressing and rely on your questions and assistant's answers, but it is hard to get a feel for how a child is doing'.

24. *Can you list three benefits of working through an assistant?*

25. *Can you list three 'dis-benefits' of working through an assistant?* Fourteen benefits were listed (one SLT listing only two) and 13 'dis-benefits' (two SLTs listing two). These comments were grouped post-hoc according to the potential recipients of the benefit, as benefits and 'dis-benefits' for SLT service delivery, for children in therapy and for SLTs personally, as in table 1.

Comments on benefits and 'dis-benefits' were differently distributed, with the greatest number of relative benefits ascribed to service delivery through increased capacity and time savings for SLTs, and most difficulties foreseen in planning and monitoring therapy for children and for SLTs' work patterns.

26. *It is likely that in some services the amount of work SLTs carry out through assistants will increase. Can you please comment upon how you view this prospect?* This question was answered by all SLTs reflecting upon their experiences in the project. All felt that increased use of assistants was possible if certain essential factors pertained:

- Adequate planning and supervision time was essential, and the opportunity for SLTs to get to know children. This had to be built in to caseload management time (3).
- Training was needed to match SLTAs' abilities. The academic excellence, interest, understanding and ability to learn rapidly shown by the project assistants could not be assumed to be typical, and training and support needed to be adapted accordingly (2).
- SLTS, SLTAS, parents and teachers had to be made aware of the roles of and differences between SLTs and SLTAs (1).
- Careful selection of those children who would receive therapy from assistants was needed (1).
- Dangers of lessening intrinsic rewards of the job for SLTs had to be recognized, although it could be satisfying for SLTs to help SLTAs develop skills (1).

27. *Are there any other points you would like to make?* Overall, opinion on the desirability of extensive working through assistants varied however. Examples of the range of opinion are illustrated by one SLT saying, 'I certainly think it can be done, and I think it could be done well. I do certainly think it is a positive step, and I'd be

Table 1. Benefits and 'dis-benefits' in working through SLTAs

	Benefits for:	'Dis-benefits' for:
SLT service delivery	*Ten comments:* More children could get therapy (four comments) Time spent on SLTAs could 'pay off' in competent staff SLT time could be saved SLTAs could be cheaper than SLTs SLTAs could be useful for intervention in straight-forward language delay/might free SLTs to carry out more specialist work (three comments)	*Three comments:* High time demands in starting off work with an SLTA Danger of problems if an SLTA stepped beyond an agreed practice in the absence of an SLT Inability of SLTAs to handle complex cases
Children in therapy	*One comment:* 'Change of face' might benefit a child	*Five comments:* Difficulty honing therapy aims and planning (two comments) Lack of monitoring child responses 'on line' and adapting targets accordingly/ 'You don't have the same insight into the child' (three comments)
SLTs	*Three comments:* Discussing with an SLTA: 'really helps you yourself to be sure about your reasoning and your rationale for working with the child' Experienced SLTAs could make useful suggestions about games to use SLTs could feel less isolated working in a team with SLTAs	*Five comments:* Might be less time for planning SLTs' own caseload Lack of opportunities for liasing with and building a relationship with parents and teachers (two comments): Use of assistants could suggest to others that 'anyone could do' therapy, under-estimating the complexity of planning and preparation involved (two comments)

happy to see the profession moving the way that we are, moving forward with assistants given enough support', but with another saying, 'It does strike me as slightly back-to-front to say there's not enough SLTs, and there never will be. I think it would be nice to say there's not enough, you need more, let's try and get more'.

Discussion

To the extent that they reflect SLTs' opinions, the findings of this case study are potentially relevant to current therapy practice in the UK. Despite a well-supported, prepared range of therapy activities, adequate planning time and very good personal relationships, SLTs' work through assistants was not unproblematic. There was a firm commitment amongst four of the five respondents to planning and updating therapy by working directly with a child (question 23). These SLTs seemed to be reflecting some of the problems involved in 'thinking for two' noted by Van der Gaag and Davies (1993). Other forms of information exchange, such as written or taped examples and the use of language probes, were little used and were not seen by all therapists as acceptable alternatives to working personally with the child (question 14). It would appear that for at least some therapists, getting to know a

child and the ongoing subtle cues obtained whilst undertaking direct language therapy form an important part of decision-making and therapy planning, and cannot easily be replaced. For such therapists a period of therapy to uncover ways of mediating a child's language learning may be needed, both before they outline a therapy plan for an assistant and at regular intervals to update. This can be possible in many NHS contexts, and would considerably alleviate the anxieties expressed by these four SLTs in fulfilling their duty of care.

The present case study suggests other ways in which bridges might be made, such as improved training for assistants and therapists (questions 10, 11, 13), working with experienced assistants (question 12), which has implications for selection and retention of SLTAs, and better documentation of therapy plans and activities (questions 18, 19). It is also likely that more focused protocols to encourage systematic probing, data recording and collection of language samples are required to make such 'distant' methods of monitoring more useful to SLTs (question 14).

If working through support workers is to increase, it appears sensible to ensure that it is rewarding to therapists–otherwise they might not be persuaded to continue in practice, and this area requires careful management. The benefits listed for working through assistants related mainly to increased throughput of caseload and service delivery factors, rather than benefits for children or SLTs (table 1). One SLT listed three benefits for services, but noted, 'There were no benefits for me'. Approaches that increase SLTs' work satisfaction may be required.

Improved client throughput can of course in itself be satisfying for therapists, as one commented: 'Obviously it is horrible to have to see children sitting on waiting lists for so long, and it is one way to manage some of that'. Involving SLTs in strategic planning of caseload management involving SLTAs could become a source of personal satisfaction for them. Using SLTAs for 'straight-forward' problems (table 1), leaving SLTs to concentrate their own direct input in more specialist areas makes sense, although SLTAs will still require to be managed. Good supervision of assistants, fostering their skills and achievements, can be gratifying (question 26) and could contribute to SLT skill development. The SLTs in this study gave clear information (question 26) about what was needed for good working practice to flourish, and this should prove to be a helpful list.

Conclusion

Despite its small scale and research basis, this case study has uncovered some relevant issues to be managed. SLTs' opinions and fears remained cognate with those expressed over a decade ago (Van der Gaag and Davies 1993) and were expressed in a study where responding SLTs were recruited specifically to work with SLTAs. The issues raised could also have resonance in classroom situations, where SLTs work with classroom assistants employed by education services, and within consultancy models of service delivery in schools (Law *et al.* 2002), and may affect how fast and how well skill-mix progresses. The opinions of SLTs need to be sought and their goodwill and skills kept 'on board' if intervention through SLTAs is to flourish, and if support workers in the NHS are to be truly supportive.

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Appendix A: Working with assistants. Interview questions for SLTs—final version

You have had a chance to read these questions. Please first tell me the numbers of any questions to which you do not want to respond. I will score these out.

Thereafter I will record your answers and take written notes. We will stick to the order of the questions: we each have a copy and I will also read the question aloud for the tape. There are prompts under some questions, which we will try to cover. However, please do make any other points or comments as we go through.

If you have written out any answers, please remind me to take these away as well.

A Planning Together

1. Was a specific time set aside with your assistant to plan therapy? (When, how much time?)
2. Do you think the amount of planning time you had with your assistant was too little/appropriate/too much?
3. How was planning time used? (To explain how a session would be conducted; to select therapy targets; to answer SLTA questions; other.)
4. What were the main queries from your assistant you had to deal with?
5. Had you expected to plan in these ways? (Or how otherwise?)
6. Did the way in which planning time was used change within a Phase?
7. Did the way in which planning time was used change between Phases I and II?
8. Did you have enough time to plan your own therapy?
9. Have you any further comments on planning?

B Assistant Training

10. What further training for you (if any) might have helped you to work with an assistant in Phase I?
11. What further training for assistants (if any) might have helped your assistant to work with you in Phase I?
12. In Phase II of the project you were working with an experienced assistant. What difference if any did this make?
13. Have you any further comments on training?

C Undertaking Therapy

14. SLTs noted that 'observation' of a child was important in setting targets for therapy. How was this managed when working through an assistant? (Were there any problems with this? Were there any benefits of this? Were any adaptations made, such as use of tape recordings?)
15. How was day-to-day information exchanged with classroom teachers when working through an assistant? (Were there any problems with this? Were there any benefits of this? Were any adaptations made, such as use of writing?)

16. How was ongoing information exchanged with parents when working through an assistant?
(Were there any problems with this? Were there any benefits of this? Were any adaptations made, such as use of writing?)

17. How did your assistant use the therapy manual?

18. Were there any particular areas of therapy that your assistant needed more help with?

19. Looking back, what changes if any to the manual might have helped your assistant?

20. How prestructured did therapy sessions become?

21. How was report writing organised between you and your assistant?

22. Have you any further comments on undertaking therapy?

D Your Personal Opinions

23. On the whole, how did working through an assistant compare with working directly with a child?

24. Can you list three benefits of working through an assistant?
1
2
3

25. Can you list three 'dis-benefits' of working through an assistant?
1
2
3

26. It is likely that in some services the amount of work SLTs carry out through assistants will increase. Can you please comment upon how you view this prospect?

27. Are there any other points you would like to make?

Thank you for your help in compiling and answering this questionnaire.

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